SOCIETIES' PROCEEDINGS

ROYAL SOCIETY OF MEDICINE—SECTION OF LARYNGOLOGY

President—Mr CHARLES A. PARKER, F.R.C.S.Ed.

FIFTH ANNUAL SUMMER MEETING

Manchester, June 15 and 16, 1923.

Chronic Hyperplasia of the Upper Jaw: Its Relationship to Other Osseous Tumours and to Otosclerosis—DOUGLAS GUTHRIE, M.D. (The paper is published in the *Journal of Laryngology and Otology*, November 1923, Vol. xxxviii., No. 11, p. 575.)

DISCUSSION.

Mr LAYTON said that the disease occurred in the chimpanzee. He considered it was a very interesting subject and hoped Dr Guthrie would continue his investigations. In his (Mr Layton's) opinion, the causes of hypertrophy of the upper jaw particularly required investigation. He would like to hear Dr Guthrie's views as to the possibility of some microbic infection being the original cause.

Mr F. H. WESTMACOTT said he had been interested in these cases for a considerable time, and thought the point which required special investigation in the clinical aspect of these cases—in differentiation from other diseases of the bone of the superior maxilla—was the swelling in the canine fossa; in other diseases it encroached upon the orbit and the nose. He (the speaker) had not seen any case which was not limited by the orbital plate; it never invaded the internal wall. It always affected the antrum.

Dr GUTHRIE (in reply) said that with regard to Mr Layton's suggestion of microbic infection causing the hyperplasia, the microscopic appearances gave no support to such a view of the etiology. As to the question of carious teeth—the study of literature would rather suggest that dental caries was rare, and in the specimens which he showed there was no caries. Regarding Mr Layton's reference to nodular growth in the upper jaw of a chimpanzee, he (the speaker) thought that this was probably a case of "osteitis fibrosa" (see paper, by Knaggs, in current number of *British Journal of Surgery*). Mr Westmacott's suggestion as to the transition from this disease to sarcoma was very interesting. In the case of the kidney, the possibility of the transition between adenoma and sarcoma had been raised by Mr John Fraser, of Edinburgh.

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Societies' Proceedings

Some Clinical Observations on the Lingual Tonsil—J. ARNOLD JONES, O.B.E., F.R.C.S.Ed. (The paper is published *in extenso* in the *Journal of Laryngology and Otology*, September 1923, Vol. xxxviii., No. 9, p. 465.)

DISCUSSION.

Mr C. A. PARKER (President) stated that, at one time, he had made a good many observations as to the possible connection between abnormalities of the lingual tonsil and the various symptoms sometimes attributed to it, and he had come to the conclusion that, on the one hand, there might be considerable changes in the tonsil without any symptoms whatever, and, on the other hand, there might be many symptoms without any changes being present. It was perfectly true that relief of symptoms might be obtained by cauterisation of the lingual tonsil, but the same relief followed cauterisation of the posterior wall or lateral bands of the pharynx, or the application of any form of counter-irritation to any part of the pharynx. He did not think the lingual tonsil was responsible for the symptoms described.

Dr WILLIAM HILL said that, having seen a number of these cases with X-ray reports, he had never found bismuth remaining behind in the deep pharynx, a fact which showed that there was no obstruction to swallowing. Mr Jones had exhibited X-ray plates with bismuth in the deep pharynx, and although he would not say his own researches were exhaustive, Mr Jones had found what he (the speaker) had not discovered. In his (Dr Hill's) opinion, it was not advisable to rely too much upon the radiographer's report on the œsophagus.

Mr M. VLASTO said that a good many of the cases which Dr Jones had reported had probably no organic basis. The term "dysphagia" was used indiscriminately to denote difficulty or pain on swallowing. This had often given rise to misunderstanding. He attributed more importance—as an expression of local affection of the faucial region—to pain produced by a dry swallow than to that produced by the swallowing of food.

Dr P. WATSON-WILLIAMS said that in his experience the lingual tonsil was very seldom responsible for pathological symptoms. Of course it did participate in inflammatory conditions of the throat, and it might be the seat of rheumatic or septic infection, abscess, etc., but such cases were few and far between. He had seen cases of most extraordinary hypertrophy of the lingual tonsil in which there had been an incessant cough; as the patients failed to get relief, he had felt it necessary to operate and remove the hypertrophy. He did not think he had cauterised the lingual tonsil for twelve years at least, though many years previously he had frequently attributed symptoms to the lingual tonsil, and used the cautery, as he now believed, unnecessarily. He took the opportunity of explaining definitely why he could not accept the lingual tonsil as being the essential cause of all the symptoms described by Mr Arnold Jones.

Sir WILLIAM MILLIGAN said that he had taken a particular interest in the lingual tonsil. Although he was indebted to Mr Jones for raising the point, which was worth discussing, he (Sir William) would say at once that, during the whole of his professional career, he had never been able

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to associate more than one or two cases of enlarged lingual tonsil with any definite clinical condition. He thought the symptoms described were purely nervous. They occurred, as a rule, in highly excitable women as a local expression of a general nervous condition. He thought there was considerable risk in surgical interference with the lingual tonsil; cases had been recorded in which very severe and dangerous hæmorrhage had occurred. At the same time, one would take risks if one could definitely associate clinical symptoms with pathological conditions. So far as his experience went, the lingual tonsil was a very harmless organ.

Mr TILLEY said he also thought that the symptoms described as the result of enlargement of the lingual tonsil were of nervous origin. Mr Lennox Browne—the chief upholder of the significance of varicose veins at the base of the tongue—mentioned spasmodic wry-neck and paralysis of the deltoid as symptoms of the condition. He (Mr Tilley) had seen several cases in which cauterisation of the lingual tonsil had failed to cure local discomfort, so that he came to the conclusion that any improvement was due to imagination. That opinion was expressed twenty-five years ago. Probably several of those present would remember the very sharp controversy which occurred about that time. He (the speaker) could not bring himself to believe that so many laryngologists could have overlooked the significance of this region, had there been truth in the theory. It was quite uncommon to find these symptoms in men, whereas they were frequently present in women who led sedentary or unhealthy lives, and more particularly at the time of the menopause. He thought these facts pointed to the symptoms being of nervous origin, rather than due to any local lesion in the lingual tonsil. As to the relief obtained from cauterisation or local applications of pigments, he thought patients would get equal relief if they were applied to the back of the neck.

Mr H. J. BANKS-DAVIS said that the majority of students nowadays seemed under the impression that it was useless to enucleate the tonsil with the guillotine unless the lingual prolongation was enucleated at the same time, and they were taught that unless the tonsil was removed by dissection, the patients would not get the relief required. This was quite untrue. He was under the impression that the lingual tonsil was a mucous gland, and that, in consequence, its function differed from that of the faucial tonsil.

Mr W. S. SYME said he agreed that one did not generally look to the lingual tonsil as a cause in cases of difficulty of swallowing, etc. At the same time, he was quite convinced that he had seen a few cases in which an enlarged lingual tonsil had caused symptoms of spasmodic cough and difficulty in swallowing, and in which the removal of the enlargement had resulted in relief of the symptoms.

Mr ARNOLD JONES (in reply) said he was glad that his paper had, at any rate, brought about a discussion. He believed he had been misunderstood, because he did not contend that it was necessarily the presence of an enlarged lingual tonsil which caused the symptoms, but that it was something which occurred in that area analogous to what occurred in the "sensitive areas" of the nose in spasmodic rhinitis. In none of his cases had he met with sufficient hypertrophy of the lingual tonsil to justify removal. He maintained that cauterisation of the lingual tonsil area

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undoubtedly brought relief, and if such a simple measure could produce absolute comfort in cases of spasmodic cough, and in some cases of dysphagia, he did not see why it should not be more widely used. The position he had taken up in his paper was, that this area had been overlooked. He thought that in these days of high grade surgery a small region like this, which offered no opportunities for heroic operations, was likely to escape notice. He (Mr Jones) thought it called for more attention than it apparently received at the present time.

The Treatment of Large Foreign Bodies Impacted in the Gullet—D. R. PATERSON, M.D. (The paper is published *in extenso* in the *Journal of Laryngology and Otology*, October 1923, Vol. xxxviii., No. 10, p. 513.)

DISCUSSION.

Sir WILLIAM MILLIGAN said that the removal of some foreign bodies presented extraordinary difficulties, and he considered that if the foreign body was in the respiratory passage, there was every reason for urgency. If it was in the œsophagus, however, one could take one's time, within reasonable limits. He was glad to hear Dr Paterson lay stress upon the value of dilating the œsophagus during examination. He thought this was of enormous importance, and added materially to the ease and safety with which one could remove the foreign body. There were some foreign bodies, for instance safety-pins, which were difficult to remove, since they were liable to tear the walls of the œsophagus. If open and with the point upwards, a problem presented itself which demanded careful consideration. The question arose as to whether it would not be better, after having located the pin by means of X-rays, and also by the use of the œsophagoscope, to perform an external operation at once. Everyone who had had experience of these cases knew how difficult it was to prevent the point of the pin lacerating the wall, and once the wall was lacerated—even a minute abrasion—there was the risk of septic infection. Therefore, he (Sir William) was of opinion that endoscopists were neglecting to some extent the value of the external operation. It was true that they could remove *almost* every foreign body *per vias naturales*, but not *every* foreign body could be so removed; in these exceptional cases, although they might be successful in removing the foreign body, they certainly subjected their patients to a great amount of risk in their attempts.

He showed a photograph of a laceration of the œsophagus caused by a sharp pointed bone—which had been impacted in the gullet for several days. The patient was vomiting small quantities of blood, and before anything could be done, a severe hæmorrhage occurred and death followed. He also referred to the case of a girl, who was said to have vomited a pint of blood the day before she was seen. There was a history that she had swallowed a foreign body (a bone), and on examination a small granulation was seen on the posterior wall of the œsophagus, opposite the arch of the aorta. He (the speaker) had decided to leave things alone, and the patient had been put back to bed. The following day the patient had another violent hæmorrhage and died, and, at autopsy, a bone which had perforated the aorta had been found immediately under the granulation. In

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that case there had been unnecessary delay in sending the patient to hospital. He (Sir William) thought that all foreign bodies which were jagged, pointed and sharp in any way, should be removed immediately, simply because the movement of the œsophagus tended to produce laceration and perforation. Another important point was that, in many cases, the foreign body (for instance a large piece of bone) so filled the œsophagus that one could see no lumen at all. In those conditions he (the speaker) thought they ought to make more use of hooks—not only one hook, but two hooks—one on either side of the foreign body, so as to get it sufficiently dislodged to be able to pass a pair of forceps round or over it.

Dr WILLIAM HILL said that most foreign bodies with jagged points were not in the gullet at all, but in the deep pharynx, and the sooner they were removed the better. One must never forget that these foreign bodies perforated very quickly, and it might be advisable to resort to the external operation. Familiarity with the operation made one more ready to embark upon it, and he (Dr Hill) thought this was a much safer plan than devoting, say, three-quarters of an hour to trying to turn a foreign body with a hook. He agreed with Sir William Milligan that, with the constant movement of the gullet, the jagged point tended to go deeper and deeper into the tissues and to produce mediastinitis, which was nearly always fatal.

Mr T. B. LAYTON, referring to Dr Paterson's remarks on the importance of careful observation before attempting to remove a foreign body, asked how long Dr Paterson thought it was justifiable to wait before attempting removal.

Mr F. H. WESTMACOTT said that in a large number of cases endoscopists were called upon to remove small dentures from the lower œsophagus. He (the speaker) thought they should institute a propaganda against the manufacture of these small dentures, as they were the cause of a considerable amount of trouble and danger. Dentures ought to be made to cover completely the whole of the palate. With regard to Mr Layton's question as to whether one ought to delay the removal of a foreign body or remove it at once, the two sides of the question had already been summarised by Sir William Milligan. He (Mr Westmacott) thought that in all cases one ought not to neglect the call to remove a foreign body, even although it might not be found in the suspected situation when the examination was undertaken. Copper coins ought to be attacked immediately, as in a few hours they corroded the wall of the œsophagus.

Mr W. G. HOWARTH said that, in his experience, large solid pieces of bone were the most dangerous foreign bodies, because of their jagged nature, and also because they were extraordinarily septic, and it was in cases of this nature that the possibility of external operation was most urgent. The external operation was comparatively easy in the upper part of the food passage, but what was to be done when the body was impacted at the level of the aorta? Was one to approach it from the back, or was it better to adopt the anterior method by taking out a rib and displacing the heart? There were advantages in both methods: certainly the frontal approach gave a very good view, and drainage could be satisfactorily arranged for.

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Mr E. MUSGRAVE WOODMAN said he agreed with Sir William Milligan and Dr Hill on the question of external operation. The operation which Mr Howarth had mentioned was comparatively easy, but it was not free from danger. The œsophageal wall was composed of soft tissue and had no serous coat.

Mr H. SMURTHWAITE said that in the case of a child, said to have swallowed a foreign body, the statement of the mother should not always be accepted. He (the speaker) had shown at the last Meeting of the Section, the case of a child, aged six months, who had swallowed the whistle from a rubber toy, and who had been seen by a surgeon three weeks previously. The child developed difficult breathing, and was sent into hospital. He (Mr Smurthwaite) had located the foreign body lying at the level of the tracheal bifurcation. Although it could easily be seen through the bronchoscope, it could not be removed—all his forceps being too large to pass down so small a tube—but it was ultimately successfully removed with a hook which he specially designed for the purpose. He certainly thought blunt hooks ought to be used in selected cases.

Dr PATERSON (in reply) said that the discussion had brought out what he wanted to know, and he was glad that his own opinion had been endorsed. He had been pleased to hear Mr Howarth's remarks with regard to external operation. He (Dr Paterson) had only seen the operation by an external route carried out once, and that was for a foreign body which had been impacted from fifteen to sixteen years in the lower part of the gullet, just behind the heart. The question was, whether something ought to be done at once to save the patient's life, and a colleague of his undertook the operation : it was found—what one had suspected from the examination—that there were such dense adhesions that the safest policy was to leave the foreign body alone. In this case he was impressed by the readiness with which the foreign body could be approached at such a low level.

Diseases of the Thyroid Gland in their Relation to Laryngology — F. HOLT DIGGLE, F.R.C.S. (The paper is published *in extenso* in the *Journal of Laryngology and Otology*, October 1923, Vol. xxxviii., No. 10, p. 522).

DISCUSSION.

Mr HERBERT TILLEY said he wished to relate two cases of great interest. One was that of a female with left vocal cord paresis, which he (Mr Tilley) thought was due to a thyroid tumour behind the sternum. Breathing was difficult, and the patient was hoarse. The difficult breathing was caused by pressure on the trachea, and the hoarseness by paresis of the left abductor. He (the speaker) sent the patient for operation to Mr James Berry, who removed from underneath the sternum a very large dermoid cyst. In this case the left vocal cord remained paralysed. He (Mr Tilley) did not know what was the experience of members as regards this class of case, but he thought that when once recurrent paralysis of the vocal cord was definitely established, one very rarely found recovery from the paralysis after operation. The second case had occurred within

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the last three weeks. On examination of the larynx, the glottis could scarcely be seen at all. On operation by Mr Trotter, a simple tumour of thyroid tissue was found underneath the thyroid cartilage and invading the ventricle. It was necessary to remove the greater part of the thyroid cartilage in order to remove the tumour, and the patient made a good recovery, though great anxiety was caused for the first forty-eight hours by severe intralaryngeal swelling. It was the only case of this kind he had known, in which an extension of thyroid gland had invaded the larynx.

Mr H. SMURTHWAITE said that, during the last few years, he had had the opportunity of seeing a large number of thyroid cases, and had examined each larynx to see if there was any paralysis before and after operation. He had not come across a genuine paralysis of the cords from simple thyroid enlargement.

Mr DIGGLE (in reply) said that, with regard to Mr Tilley's remark about recovery after paralysis of the vocal cords, he (the speaker) was of the opinion that if the paralysis had existed longer than nine months, there was little chance of recovery. As regards Mr Tilley's last remark about the removal of the thyroid, he thought that it had been shown that it was not sufficient merely to remove the isthmus of the thyroid.

Evolution of the Nasal Cavities and Sinuses in relation to Function—J. F. O'MALLEY, F.R.C.S. (The paper will appear in a future number of the *Journal of Laryngology and Otology*.)

A Clinical Note on the After-treatment of Empyema of the Maxillary Antrum (Denker's Operation)—D. LINDLEY SEWELL, M.B.

ABSTRACT.

Mr SEWELL said that he believed Denker's operation to be the most efficient because of the facilities which it offered for the complete inspection of the antral cavity. He did not pack the cavity after completion of the operation, but he held in position the mucous membrane flap from the antro-nasal wall by means of a strip of ribbon gauze. This was removed on the fourth day, and in the majority of cases no further packing was employed, nor was the antral cavity irrigated. Mr Sewell regarded irrigation as impeding rather than helping the recovery of the lining mucous membrane of the antrum and considered that it should be employed only in the minority of cases—in those in which recovery was slow. He had found solutions of silver nitrate very useful in the treatment of indolent cases.

Sir WILLIAM MILLIGAN said that it was his custom to perform the Denker's operation. The lines of treatment had been sketched out very well by Mr Sewell. There were two points before the Section, viz.: (1) Whether irrigation treatment should be carried out after operation, or not; (2) the method of dealing with the flap. The only question he would like to ask Mr Sewell was in connection with cases in which a concomitant ethmoidal affection was present, which frequently kept up a certain amount

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of intranasal discharge. He (the speaker) did not allow the antrum to be irrigated for ten days. He thought it essential that the buccal opening should be allowed to heal at once. He never packed the antrum.

Mr BANKS-DAVIS said they were all indebted to Mr Sewell for his interesting and practical paper. He was very interested in the fact that he did not irrigate afterwards, as he (the speaker) adopted that method himself. Had Mr Sewell any special means of dealing with the crusts which formed in the nose after operation, and were often so distressing to the patient?

Mr T. B. LAYTON said that since he paid a visit a few years ago to see Sir William Milligan operate, he had never sewn up the buccal wound, and his patients seemed to have far less swelling of the face, and the wound seemed to heal up quicker. He was very interested to learn that Mr Sewell opened up the wound four days later, and removed the packing. He had always taught his patients to wash out the maxillary antrum after operation, and for that reason removed a bit of the inferior turbinal, because he had had a case where he had not done so, and found it difficult to teach the patient to pass the cannula afterwards. He had come to the conclusion that the question of washing or not, was not so important as the solution used, and that physiological saline was a better lotion for the nose than any antiseptic lotion. He doubted if it were possible to put an antiseptic into the nose which had the slightest effect on the micro-organisms, unless it was so strong that it did harm to the mucous membrane. He found hypotonic solutions irritating to the nose. Hypertonic solutions were less so, but he believed that physiological saline was better than either.

Mr J. F. O'MALLEY said he always made an opening under the anterior end of the turbinates. He never made a buccal opening, and never washed out the antrum. The only point in favour of washing out was that it had a very satisfying effect upon the patient.

Mr A. J. M. WRIGHT said he thought that the wound healed up much better without a buccal opening. With regard to washing out, he had never been able to discontinue it entirely. He still found there were cases of chronic antral suppuration in which one had to carry out post-operative washing out.

Dr DOUGAS GUTHRIE said that in a great many cases so severe a procedure as a Denker's operation was not required, provided a sufficient amount of the anterior wall of the canine fossa was removed in the more usual Caldwell-Luc operation. In the Canfield technique, the operation was practically a "Denker" performed intranasally. He suggested the use of an oily spray in the after-treatment to prevent the formation of crusts.

Mr GRAHAM BROWN said he thought there was more sinus trouble in Queensland than in this country. In a certain number of antral operations, the result was not satisfactory; there was some persistence of muco-purulent discharge. He (the speaker) thought the thing to aim at first was a good view of the antral cavity; and for this reason, during the last five years, he had been doing all his antral operations under local anæsthesia. By this method there was practically no bleeding. He did not remove any

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portion of the inferior turbinal. He did not think a flap was essential; he had tried it, and did not think much was gained by it. He packed the antrum with a rubber glove, which was removed within twelve hours; he began washing out on the fourth day, when he invariably found that the buccal wound had healed. For washing out, he used eusol solution (1 in 6), and followed that almost immediately with a lotion practically identical with Wright's solution. He persisted with the washing out, gradually decreasing the number of applications. He thought it was an essential procedure; it was a mistake to leave an antrum unirrigated. A point to consider was, that frequently the anterior ethmoidal cells were involved in the suppurative process, and these required attention.

Dr IRWIN MOORE said he never carried out any after-operation packing, nor did he suture the buccal incision. In most of his cases he operated by the intra-nasal route, which was, in his experience, satisfactory in the majority of cases: the chief point to aim at to ensure success, was to make the nasal opening as large as possible. He avoided washing out for four or five days, and then he invariably used an ordinary saline solution, and later, he found the best treatment was to wipe out the antrum occasionally with argyrol 25 per cent.

Mr SEWELL (in reply) said he did not make a practice of suturing the buccal wound, because he had never found any difficulty in the natural closing of the wound except in two cases. In the usual antral case he had never had any trouble about the closing of the wound. As regards the formation of crusts, these were very difficult to deal with, and what he found most efficacious was to leave in over-night a piece of gauze with vaseline, as carried out in the treatment of atrophic rhinitis. In certain cases where there is not only suppuration of the antrum, but extensive ethmoidal and frontal sinus disease, the great trouble was crusting. He thought Mr Guthrie had really described Canfield's operation. He (Mr Sewell) had only tried it on two occasions, and it seemed to him that the operation was merely Denker's carried out through the nose—that is to say, under more difficult conditions.

Demonstration illustrating Certain Pathological and Surgical Points in the Treatment of Malignant Disease in the Upper Jaw—E. MUSGRAVE WOODMAN, F.R.C.S.—Slides were shown demonstrating the microscopic appearances, under both low and high power, of the various types of malignant tumour found in this region. Attention was called to a particular type of tumour of a general acinous formation, in which characteristic cells were conspicuous by their vacuolation. These tumours had been diagnosed by Professor Shattock as malignant endotheliomata. Sections of a cross-section of a normal ethmoidal labyrinth were demonstrated, and the remarkable resemblance to the tumours mentioned above was pointed out. Two series of coloured photographs of operations were recorded, as illustrating the extensive growths which can now be dealt with successfully. The first depicted an extensive epitheliomatous ulcer below the eye, which necessitated the removal of the eyeball

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and exposed the dura mater at the base of the brain; the second showed an extensive growth in the antrum, which had perforated the skin of the face below and above the orbit. Photographs taken both before and after operation were exhibited.

Mr W. S. SYME said that he had several times operated on malignant growths of the upper jaw. In one case of sarcoma (upper jaw, sinuses and nose) in which he thought he would get the best view, he made the incision down the middle of the face and split the nose. In that way he was able to get into all the accessory cavities and remove the growth from the sinuses. Very little disfigurement occurred, and the patient lived a good many years. He (Mr Syme) considered that in dealing with these cases, one owed a great deal of the success to diathermy. He was not convinced as to the value of radium in these cases. He had seen great destruction caused by radium, and, though he did not know what the experience of others had been, he personally would be very chary in using it.

Mr G. WILKINSON asked Mr Woodman whether, in the case of rodent ulcer cases which had become epitheliomatous, he found it necessary to dissect the glands in the neck, or if it was usual for the glands to escape infection in this class of case.

Mr MUSGRAVE WOODMAN (in reply) said that he considered this work came well within the specialty, because general surgeons, without intimate knowledge of the anatomy of the air cells, were not in a position to eradicate malignant disease of the upper jaw. He agreed that the effect of radium was very destructive. One of his patients had a very extensive sarcoma of the jaw which was removed, and was followed by recurrence in the cheek. He (Mr Woodman) applied 150 mg. of radium, and a month later the whole of the front of the face fell out. In reply to Mr Wilkinson, he was of opinion that glands in the neck did not tend to become involved, but in all cases of epithelioma, whether the glands were obviously affected or not, they should be excised widely and completely on the same side of the neck.

Sarcoma of the Left Tonsil—Sir WILLIAM MILLIGAN, M.D.—Male, aged 57, with difficulty in swallowing for six months, loss of weight, anæmia, deafness in left ear; firm lobulated growth springing from the left tonsillar region, filling mouth and displacing soft palate: an enlarged cervical gland was freely movable.

Microscopic report: round-celled sarcoma. On 12th May 1923, insertion of radium tube 40 mg. On 26th May 1923, almost complete disappearance of growth; the general condition was improving.

Sir WILLIAM MILLIGAN (in reply to questions) said he had not done anything more than apply radium in order to demonstrate its very rapid and immediate effect. He intended to remove the rest of the tonsil by diathermy.

Epithelioma of Soft Palate and Left Anterior Faucial Pillar—Sir WILLIAM MILLIGAN, M.D.—Male, aged 59, with sore throat and otalgia of three months' duration. An ulcerated and

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vascular growth involved a portion of the soft palate, left anterior faucial pillar and posterior surface of the uvula: infiltration of the tissues, but no palpable glands.

Microscopic examination: epithelioma. 25th May 1920: diathermy under general anæsthesia. 2nd June 1923: complete freedom from all symptoms since June 1920. There was now a small nodule upon the posterior pharyngeal wall, with a hard and indurated base. No pain was complained of.

Mr W. S. SYME said that the whole question of diathermy was so extensive that one hesitated to say much. In this case there certainly appeared to be a recurrence, which one would be well advised to remove by diathermy. One difficulty he (the speaker) had found in connection with these cases was, that the scar formed was very firm, and that the jaws became firmly fixed together. He would like to know if others had had the same experience. In one of his cases operated upon by diathermy a year ago, there was a growth declared inoperable by ordinary methods—involving both upper and lower jaws, and a large mass of glands. No recurrence followed in the mouth. Several months later the glands atrophied to the size of the thumb or smaller, and became very hard and firm. They were removed and found to be fibrous. He wondered if others had seen these changes—which were evidently a process towards cure—taking place in the glands after removal of the primary growth by diathermy.

Sir WILLIAM MILLIGAN (in reply) said that there was a small recurrence on the posterior wall, which he intended to diathermise at once. He had observed fixation of the jaw after extensive diathermy, and did not know what to do in such cases except to advise exercise. With regard to the question of removal of the glands, when glands were present, he usually dissected them out by a block dissection.

Epithelioma of the Right Vocal Cord: Laryngo-fissure—Sir WILLIAM MILLIGAN, M.D.—Male, aged 62, was first seen 14th June 1915, complaining of loss of voice for twelve months. Examination showed a cauliflower growth occupying the posterior two-thirds of the right vocal cord, which was fixed. 20th June 1915: laryngo-fissure; cord removed; alar cartilage was not removed. Microscopical report: epithelioma. 6th June 1923: no symptoms beyond a husky voice.

Laryngeal Growth (Tuberculoma)—Sir WILLIAM MILLIGAN, M.D.—Male, aged 56, with progressive loss of voice for nine months and slight expectoration; no bacilli found; history of left-sided pleurisy and gradual loss of weight; an enlarged gland in neck.

Mr HERBERT TILLEY thought the case was one of chronic tuberculosis, first, from the clinical appearances of the larynx, and secondly, because the patient had a rapid pulse and looked a sick man. He suggested that the evening temperature should be taken for a week.

Mr A. J. M. WRIGHT said he was also of the opinion that this was a case of tuberculosis. It reminded him of a male patient, a somewhat older

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man than the case shown, with no definite signs of tuberculosis in the chest. He (the speaker) had performed a laryngo-fissure on the assumption that the case was malignant. The patient very rapidly went down hill and died shortly afterwards of pulmonary tuberculosis.

Mr H. J. BANKS-DAVIS said that the patient was referred to him as a case of laryngeal paralysis, considered by his physician as thoracic in origin. When he (Mr Banks-Davis) first saw the patient, there was some swelling of the left ventricular band in addition to the laryngeal paralysis. When he next saw him, there was no question as to the swelling. He again saw him a month ago, and the œdema had increased. At first, he thought it might be a case of malignant disease of the larynx, but now he considered it was tuberculosis. Whether there was any malignant disease in conjunction with it, it was impossible to tell. He would be very chary of doing anything to the larynx, unless a portion of the swelling was examined microscopically.

Mr W. S. SYME said he considered that the lesion was more extensive than one would expect to find with tubercle; the colour and appearance generally being more suggestive of malignancy than of tubercle. He advised that nothing should be done until a definite diagnosis had been made.

Sir WILLIAM MILLIGAN said he was of the opinion that it was a mixed infection—a chronic tuberculosis which had become malignant, because no tubercle bacilli had been found in the sputum. There were no clinical signs of tuberculosis of the lungs, and the patient had a sub-normal temperature. Again, there was a certain amount of fixation on that side, as noticed by Mr Syme—an amount not usual in a case of tuberculosis, and that suggested superadded malignancy. There was also very rapid loss of weight—much more than one would expect to see in tuberculosis. He thought there was also some superficial ulceration. He certainly did not propose to do a laryngo-fissure, but to remove the gland in the neck first, and have it microscoped. If it proved to be malignant, then he would remove a small portion of the growth by the direct method, have it microscoped, and be guided by the result. He thought it might prove to be a mixed infection.

Postscript.—A portion of tissue was removed and microscopically showed tuberculous disease without any evidence of superimposed malignancy.

Tuberculous Growth in Left Naris — Sir WILLIAM MILLIGAN, M.D., and D. LINDLEY SEWELL, M.B. — Female, aged 32, with gradual blocking of left nasal passage and widening of nasal bridge. Examination showed a papillomatous-looking mass springing from the region of the vestibule and anterior portion of nasal septum. Septal spur removed from left nasal passage three years previously. Has this possibly been a traumatic infection? The growth was removed and base seared with galvano-cautery point. Microscopic examination: tubercular growth with caseation.

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Royal Society of Medicine

Orbital Cellulitis: Invasion of Frontal Sinus: Osteomyelitis of Frontal Bone—Sir WILLIAM MILLIGAN, M.D., and FRANK WRIGLEY, M.D.—Male, aged 15, was first seen 18th April 1923, after two days' illness; left eye proptosed; conjunctiva injected and chemotic.

19th April: the left frontal sinus was considered normal; incision made through upper eyelid and pus evacuated; mixed streptococcal and staphylococcal infection. Marked œdema over frontal region supervened; left eye eviscerated; left frontal sinus opened—no pus found.

28th April: condition of patient serious; œdema spreading over forehead; three incisions made over scalp down to bone.

1st May: temperature high, rigidity of neck, Kernig's sign, right side.

4th May: high temperature, rapid pulse, œdema over whole of left side of frontal region. Copious discharge of pus from orbit.

5th May: operation (Sir William Milligan). Frontal sinus reopened and found full of pus and granulation tissue; outer table of skull removed over left frontal area; whole of wound painted with pure carbolic acid and left open; fomentations applied; gradual recovery from time of operation to date, the only drawback being the development of an abscess in the neck, which has now been drained.

Mr J. F. O'MALLEY said the case reminded him of a patient whom he had seen some years ago in a fever hospital. A diagnosis had already been made of frontal sinus disease, but on examination he (the speaker) had found pus in the ethmoidal region, and had come to the conclusion that the trouble had started in that region, and was due to the effect of changes in the mucous membrane induced by the scarlet fever.

Sir WILLIAM MILLIGAN (in reply) said that he understood from Mr Wrigley that there was no accessory sinus disease at all. He (Sir William) did not know the cause of the orbital cellulitis. The boy was very ill when he was sent to the infirmary. He (the speaker) opened the frontal sinus which he found infected, removed the outer table of the skull, and applied pure carbolic acid to the raw surfaces. The boy had made good progress, and he hoped would recover altogether. Examination of the pus showed a streptococcal infection.

Postscript.—23rd July 1923: the boy is now quite well.

Sarcoma of Right Tonsil and Surrounding Faucial Region—Sir WILLIAM MILLIGAN, M.D., and FRANK WRIGLEY, M.D.—Male, aged 34, with swelling in throat accompanied by slight attacks of spontaneous hæmorrhage. Ragged and ulcerated hyperæmic mass occupied right side of fauces, firm, fixed, and involving tonsil, pillars of fauces and adjacent area of tongue. Mass spreads half-way over oro-pharynx, and for some distance down the pharynx. No palpable glands.

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Large round-celled sarcoma. Tracheotomy and diathermy. 22nd December 1921: tracheotomy tube removed. 25th December 1921: referred to Radium Institute.

Two Cases of Chronic Œdema of Orbit—F. H. WESTMACOTT, C.B.E., F.R.C.S.—(1) Male, aged 53, with œdema of left eyelid since January 1921: condition stationary since March, 1921: no pain, no nasal discharge; accessory sinuses clear; fundi normal; diagnosis invited.

(2) Female, aged 42. Œdema of right eyelids commenced five years ago at inner canthus: no pain; sight not affected; pus in right middle meatus. November, 1921: Ethmoidal and sphenoidal sinuses opened. Pus was present. No opening found into the orbit from ethmoidal labyrinth. Swelling varies, but is less than in 1921. Wassermann negative; diagnosis invited.

Mr HERBERT TILLEY referred to a similar case, which he had shown to the Section in London some five or six years ago, of a male who had served in the South African War, and had had malaria several times. In this case the same condition was present, except that it was bilateral, and he concluded that there was some local affection of the lymphatics. He suggested a bacteriological examination of the lymphatic fluid from the œdematous area.

Mr A. J. M. WRIGHT said he had seen a similar condition in a girl, aged 14. She had a marked degree of conjunctivitis, and it seemed to him (the speaker) that this was a possible means of entry of the infection.

Sir WILLIAM MILLIGAN said that he also regarded the condition as a chronic lymphangitis. There was a history of injury. He (the speaker) had seen two very similar cases, in both of which there had been a history of injury—abrasion and infection. In both those cases, tissue had been removed and microscopically examined, and was found to be chronic lymphangitis. He considered that both of the cases now shown were of a similar nature, and suggested microscopical examination of a piece of the tissue.

Mr WESTMACOTT (in reply) said he had hoped to elicit more information. In the first case, the man had not only had a mosquito bite over twenty-three years ago, but was also knocked in the eye by a cricket ball, and it was quite probable, as Sir William Milligan had suggested, that there had been some chronic lymphangitis. The nasal sinuses in this case were free. With regard to treatment, he was very grateful for the suggestions made. He would have the fluid examined, and also a piece of the tissue.

Sarcoma of Maxillary, Malar, and Frontal Bones—F. H. WESTMACOTT, C.B.E., F.R.C.S.—Male, aged 37. Sarcoma of maxillary antrum involved the orbital plate, canine fossa, malar bone,

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and external angle of frontal bone: excised on 13th September 1913, together with the ethmoidal labyrinth and opening up of sphenoidal cavity. Microscopic section showed round-celled sarcoma. No further symptoms until 23rd February, when the cheek bone became hardened and the eye proptosed, and there was pain in the first division of the fifth nerve. After application of radium, the pain subsided and prominence of the part receded.

Mr E. MUSGRAVE WOODMAN said this was a remarkable case, in which a very successful operation had been performed ten years ago, since when, the patient had remained apparently perfectly cured. Then, possibly from a neglected ethmoidal cell or from a small focus in the malar bone, recurrence occurred across the orbital bone and appeared below the eyelid. This was quite unlike round-celled sarcoma. It did not remain quiescent for ten years and then slowly reform. He thought Mr Westmacott, at the present time, need be in no anxiety about his patient. The eyelid was free from growth, and he advised excision of the eyeball and elimination of the growth. In a case of this kind, in which the palate was not involved, he suggested leaving a window in the palate through which the involved area could be from time to time inspected, or through which radium could be inserted at any period after the operation. The opening could be easily covered up by a dental plate.

Mr WESTMACOTT (in reply) said he was glad to have Mr Woodman's advice about this case, and would in future operations cut out a window in the palate.

Extensive Osteomyelitis of Frontal Bone—F. H. WESTMACOTT, C.B.E., F.R.C.S.—Male, aged 40, had, in March 1922, pain in right frontal sinus with purulent nasal discharge for several weeks. Turbinal resection and the ethmoidal intranasal operation on 29th April 1922. In October 1922, fluctuant swelling over whole frontal area.

Operation, 4th October 1922: Transverse frontal incision. Extensive cario-necrosis of outer and inner tables of frontal bone with dura mater exposed over area the size of a shilling. Both frontal sinuses opened to orbital margin and below it. Tube inserted in left sinus and inter-sinus septum removed. Recovery.

Tuberculosis of the Larynx—J. A. KNOWLES RENSHAW, M.D.—Male, aged 55, had had extensive tuberculosis for seven years. Secondary laryngeal tuberculosis appeared in 1919. Both vocal cords were affected throughout their length. There was much hyperplasia and congestion. Some ulceration took place over the left vocal process. Treated by vocal rest. Intratracheal injections of liq. iodi. and formalin sprays. The vocal cords resumed a normal outline. Slight congestion on the right side remains. The tuberculosis of the lung has been active throughout the treatment and still persists.

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Societies' Proceedings

Double Abductor Paralysis—A. A. SMALLEY, M.B. :—A male, aged 50, had, in February last, difficulty in breathing and hoarseness for two months; inspiratory stridor; cyanosis. Tracheotomy was considered: abductor paralysis almost complete; cords congested and rough; scars on soft palate; Wassermann positive. No evidence of other central or peripheral nervous lesion was found. He improved under treatment, but there is still injection of cords and abductor paralysis.

Chronic Cellulitis of the Face—G. E. ARCHER, M.B.—J. T. S., aged 26, had intranasal operation in 1920 (? attempted submucous resection), followed by œdema of the face. He was first seen in September 1922, with chronic cellulitis of the face with periodic exacerbation. Œdema never completely disappeared. Perforation of the septum, adhesions between right inferior turbinal and septum; no accessory sinus disease. Condition failed to yield to treatment, including autogenous vaccine.

In December 1922, patch of alopecia areata developed. February 1923, intranasal adhesions were severed. Facial massage and Faradism instituted. Since then the condition has slowly but distinctly improved.

Case of ? Clinically Malignant Disease of the Left Pyriform Sinus—F. HOLT DIGGLE, F.R.C.S.—Male, aged 54, early in 1922, noticed hoarseness and difficulty in swallowing. There was no improvement in spite of treatment. On 21st September 1922, the epiglottidean fold was found infiltrated and œdematous, with bulging of left wall of larynx preventing view of left cord. A mass of whitish granulations projected from left pyriform sinus to outer side of above swelling. Wassermann negative. Œdema, fatty degeneration of the heart, and chronic Bright's disease prevented operation.

On 18th October 1922: three radium tubes, each 1.5 millicures, inserted into left pyriform sinus (direct method, local anæsthesia).

23rd January 1923: four tubes inserted, each 1.5 millicures, under direct laryngoscopy. Since then two external applications of radium plates at intervals of six weeks.

17th May 1923: symptoms have disappeared. There is marked diminution of the swelling and a perfect view of the larynx is obtained. No limitation of movement of left vocal cord.

Demonstrations were given :—

By P. Watson-Williams, M.D., upon "A Method of Exploration of the Nasal Accessory Sinuses," and

By Irwin Moore, M.B., on "The Reduction or Destruction of Hypertrophied or Diseased Tonsils by Means of Caustic Soda and Slaked Lime" (London Paste).

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Ear

In the X-ray Department.—By J. M. W. Morison, M.B., on "Cardiospasm and other Diseases of the Œsophagus."

By E. W. Twining, M.R.C.S., L.R.C.P., on "Pirie's Method of Radiographing the Mastoid Cells."

By C. C. Anderson, M.B., on "Deep X-ray Therapy in Laryngological Conditions"; and

By A. Burrows, M.D., on "Methods of Application of Radium." (Cases shown.) (At the Radium Institute.)

ABSTRACTS

EAR.

A Case of Pedunculated Exostosis of the External Auditory Meatus. VALTER DAHLSTRÖM. (*Acta Oto-laryngologica*, Vol. v., fasc 2.)

The patient was a woman 26 years of age. The bony growth measured 10 mm. by 8 mm., with a pedicle 2 mm. in diameter, and was easily removed from its attachment to the lower and posterior aspect of the wall about 1 cm. from the meatal opening. The writer remarks that, although these growths are usually regarded as exostoses, their clinical course and slow growth suggest that they should perhaps be regarded rather as osteomata. In the case which he reports there was nothing to explain the origin of the growth.

THOMAS GUTHRIE.

The Significance of Retraction of the Tympanic Membrane. Professor S. CITELLI. (*Revue de Laryngologie*, November 1922.)

The writer comments on the number of cases examined by him showing marked retraction of the tympanic membrane, and increased obliquity of the handle of the malleus, without any Eustachian obstruction, and with little or no impairment of hearing. Further, in a number of cases of chronic tubal obstruction, he has found considerable improvement of hearing after inflation of the middle ear, though the retraction of the membrane and of the malleus has persisted. Citelli believes that this tympanic retraction is always a sign of former long continued Eustachian obstruction, and that the malposition of the malleus is due to a permanent contraction of the tensor tympani muscle, with some shifting of the head of the malleus in relation to the malleo-incudal joint. G. WILKINSON.

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