Societies' Proceedings

MEETING OF THE SECTION OF LARYNGOLOGY, ROYAL SOCIETY OF MEDICINE, 5 MAY 1967. DISCUSSION OF OPENING PAPER ON CANCER OF THE LARYNGO-PHARYNX.

H. J. SHAW (London):

I WOULD like to express my thanks to the two main speakers for their lucid and stimulating presentations of the surgical and radiotherapeutic aspects of this problem. Mr. Ellis has given us a timely reminder of the minute biology of carcinogenesis in the face of the natural body defences and a pragmatic account of the natural history of this disease in the laryngopharynx. But I was surprised that he should condemn attempts at classification as valueless. We must classify our cases in order to lend even an approximate meaning to our results, as I am sure he will concede. Thanks to the U.I.C.C. international agreement in this matter is now much closer.

I also found it hard to accept his advocacy of local excision of neck metastases with the quotation of success in so few cases without any comparative figures, especially after his strong criticism of "functional neck dissection" in the discussion of papers on partial laryngectomy at a meeting of this section last summer. His condemnation of indiscriminate transthoracic gut replacement operations is undoubtedly a valuable caution in the light of current enthusiasm.

I warmly congratulate Dr. Dalley on her able presentation of the detailed radiotherapy results from the Royal Marsden Hospital. I would also like to support her plea for treatment by irradiation for Stage I lesions of the laryngopharynx and its value in advanced disease as a palliative or in attempts to render such lesions resectable. I was glad to see that she emphasized the histological effect of irradiation on these tumours which so often deceives the observer by causing surface healing with marked regression, but leaves islands of viable tumour cells within the fibrous stroma. For the majority of patients with cancer in this region such a result surely points to the necessity for a combined attack as she suggests, using a medium total dosage of irradiation (3,000 or 4,000 r) followed by routine radical surgery at a short interval of 2 or 3 weeks. Resection should be based on the original extent of the lesion and should include elective neck dissection in many cases. In other words, a plan of treatment based on radical surgery but including preliminary medium dose irradiation. Consideration could also be given to completing the irradiation course immediately after surgery in selected cases.

When one compares the average gross 5-year survival results of no greater than 12 per cent. in a large series of cases treated primarily by irradiation and recently reported by Lederman (1967), with even one large and comparable series whose treatment was based on surgery, giving gross 5-year results ranging around 40 per cent. (Farr and Gerold, 1967), conclusions are scarcely in doubt.

https://doi.org/10.1017/S0022215100069024 Published online by Cambridge University Press

Societies' Proceedings

REFERENCES

FARR, H. W., and GEROLD, F. (1967) Memorial Center, New York---personal communication.

LEDERMAN, M. (1967) *J. Laryng.*, **81**, 151.

THE NINETY-FOURTH MEETING OF THE SCOTTISH OTOLARYNGOLOGICAL SOCIETY WAS HELD ON SATURDAY 13 MAY 1967, AT THE CITY HOSPITAL, EDINBURGH. THE PRESIDENT, MR. I. P. J. MACNAUGHTON WAS IN THE CHAIR.

BEFORE the meeting, the new Ear, Nose and Throat Unit at the City Hospital was open for inspection by members. This unit, of ninety-three beds, has been made available by upgrading existing wards to the highest modern standards, accommodation for all patients being provided in four-bed or single-bed rooms. Three completely new operating suites have been built, one of which is for endoscopy.

A demonstration of stroboscopy of the larynx was given by Dr. I. M. Farquharson and Mr. J. F. K. Anthony of the Department of Phonetics, University of Edinburgh.

The technique of histological sectioning of temporal bone was demonstrated by Dr. K. McLay.

After the business meeting, Mr. Anthony showed a film of movements of the vocal cords and the following short papers were read.

"A Glimpse of Otology in the Ancient World"
by Dr. A. Brownlie Smith.

"The Response of Oval Window Grafts to Acute Otitis Media"
by Dr. R. A. McNeill.

"A Case of Orf"
by Dr. J. B. M. Black.

In the discussion which followed, there was some difference of opinion as to how readily the middle ear in cats could be infected. Doubt was also expressed on the ability to withstand infection of the two cell thick membrane which survives after the absorption of gel foam.

Dr. A. Brownlie Smith presented three clinical cases. The first was a woman of 58 years, who had a glomus tumour of the right ear. This was first diagnosed in 1961, but exploration of the middle ear was not carried out until 1964, when a small glomus tumour was found arising from the promontory. The tumour was removed. Six months after operation, redness of the lower half of the middle ear was again seen and tympanotomy was carried out 9 months after the original operation, but no recurrence was seen. She remains well, but members agreed that there still appeared to be tumour, deep to the drum.

The second case was a man who had had a giant-cell tumour of the right maxilla, treated by radiotherapy 30 years ago. With this therapy the swelling subsided and he has remained well until he developed an oro-antral fistula after a dental extraction several years ago.

The third case was a man aged 38 years, who had a stapedectomy for otosclerosis in *May 1964*. A fat and polythene prosthesis was used. In *November 1966*, he developed sudden deafness in the operated ear and vertigo. The middle ear was explored and it was found that the polythene had perforated

https://doi.org/10.1017/S0022215100069024 Published online by Cambridge University Press

the fat. The strut was removed and a fat and wire prosthesis inserted. He has no hearing, but he has no vertigo.

Dr. C. D. Weir reported a case where there was sudden loss of hearing 5 years after stapedectomy, but the hearing recovered spontaneously.

Dr. A. G. Gibb thought some of these cases of deafness were of vascular origin, rather than due to any local cause in the oval window, and Dr. R. A. McNeill suggested that some were due to virus labyrinthitis.

Dr. B. A. B. Dale presented a boy of 16 years, with an angiofibroma of the nasopharynx, causing recurring severe epistaxis and nasal obstruction. In *January 1966*, only partial removal had been possible, through a transpalatal approach, and this had been followed by radiotherapy. Members agreed that tumour was still present, but that no further treatment was required meanwhile.

https://doi.org/10.1017/S0022215100069024 Published online by Cambridge University Press

https://doi.org/10.1017/S0022215100069024 Published online by Cambridge University Press