SOCIETIES' PROCEEDINGS

ROYAL SOCIETY OF MEDICINE—SECTION OF LARYNGOLOGY.

December 4, 1925.

President—Dr W. H. KELSON.

Congenital Stenosis of the Larynx*—PHILIP FRANKLIN, F.R.C.S.—The child died of pneumonia a few weeks after the meeting in December 1924, tracheotomy having been done for urgent dyspnœa. An examination of the specimen † confirms the fusion, to which the exhibitor originally drew attention, of dense fibrous tissue in the form of a wedge extending into the trachea well below the cords. It would therefore have been almost impossible to excise this tissue by any intra-laryngeal route. Should an operation be indicated in this type of case I suggest that a laryngo-fissure would be the only way to deal satisfactorily with it.

Sir WILLIAM MILLIGAN asked whether there was any history of a foreign body having been inhaled or swallowed and become impacted at the back of the larynx, so acting as a local irritant. The localised mass seemed to consist of inflammatory tissue.

Mr E. D. D. DAVIS said he had seen laryngo-fissure done in children for the removal of papillomata, and as a result they all had stenosis ; there was a definite risk of this happening in children after that operation. Not long ago he saw a well-developed man, aged 21, who had a very large web of the larynx, and the orifice of his larynx would only admit an ordinary pencil. He was quite normal, except that he complained of loss of voice. He refused to have any operation done.

Sir ST CLAIR THOMSON said that he had himself seen but few of these cases, and he would like those who had not seen such cases to listen to what had been handed down by tradition, and what Mr Franklin's case confirmed, viz., that these webs were so very tough that it was almost impossible to remove them by an intra-laryngeal operation. If they were traumatised in any way, that only increased the laryngeal stenosis. Recently he had seen a girl, aged 21, who was disappointed because he advised her to put up with a similar condition. She was a school teacher ; she had some voice, but she was unable to teach singing.

It was pointed out by Semon, many years ago, before cordectomy had been suggested, that laryngo-fissure tended to some extent to cause cicatricial narrowing. In some cases one was glad it did so, as it formed a new vocal cord. Cases were on record in which children had had laryngo-fissure done six, twelve—in one case eighteen—times for papillo-

* See *Journ. of Laryngol. and Otol.*, 1925, vol. xl., p. 191.

† Now in the Royal College of Surgeons' Museum, London.

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mata, but the operations did not cure, for they left such a stenosed larynx that a tube had to be worn for life. In this case, as Mr Franklin showed, the membrane extended down towards the subglottic region.

Mr HAROLD BARWELL suggested that in laryngeal stenosis in children —not necessarily of the congenital form—members should consider the advisability of prolonged intubation. At a meeting of the British Medical Association in 1909 (*Brit. Med. Journ.*, 1909, vol. ii., p. 1144), Bryson Delavan, of New York, described O'Dwyer and Rogers' method of intubating the larynx by anchoring the tube through the tracheotomy fistula in the neck. He (the speaker) had tried it in the case of two children of $1\frac{1}{2}$ and 3 years of age—one had been drinking out of a kettle and the other had had a hurried high tracheotomy done—and both did very well. The tubes were kept in for nine and ten weeks respectively, and the stenosis had not returned when the children were last seen, six months and two and a half years afterwards.

Mr FRANKLIN (in reply) said that there was no history of a foreign body. He watched the child for eighteen months and during that period there was never a sufficient degree of distress to indicate either the necessity to perform tracheotomy or to use intubation tubes. In this case the small opening between the cords would not permit the introduction of the smallest intubation tube. When the case was originally discussed, the question arose as to what should be done for the occasional stridor. He agreed with Sir St Clair Thomson that it was better to avoid operative procedures until such time as more urgent manifestations rendered them necessary. He pointed out that this specimen showed that the cause of obstruction in these cases was not the thin, bluish membrane described in the text-books.

Case of Sarcoma of the Nasal Septum *—PHILIP FRANKLIN, F.R.C.S.—The first pathological examination showed a chronic inflammatory condition; but a subsequent report was to the effect that it was a round-celled sarcoma. The patient's nose was now quite healed, and though secondary deposits might possibly appear later, there was at present no indication of sarcomatous tissue in the nose. All the tissue possible was removed at the operation, and subsequently Dr Finzi treated it with radium and X-rays.

Dr JOBSON HORNE said the subsequent history of the case seemed to confirm a dictum he had often expressed, that malignant disease was diagnosed more often than it existed.

Sir JAMES DUNDAS-GRANT asked whether Dr Jobson Horne referred to the difficulty of microscopical diagnosis. He (the speaker) thought it was often difficult to distinguish small round-celled sarcoma from an inflammatory growth. He had had a case with the late Dr Clayton Fox, in which that gentleman removed a portion of a growth on the side of the septum, and the microscope showed it to be a melanotic sarcoma. The growth was then completely eradicated but the diagnosis was confirmed by a subsequent recurrence of the disease, from which the patient died.

* *Journ. of Laryngol. and Otol.*, 1925, vol. xl., p. 325.

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Dr JOBSON HORNE (replying to Sir James Dundas-Grant) said melanotic sarcoma was a very definite and most malignant condition; he (Dr Jobson Horne) said he was referring to the large number of cases in which a chronic inflammatory condition was diagnosed and treated as sarcoma.

Perforation of the Palate—H. BELL TAWSE, F.R.C.S.—Female, aged 43, had intra-nasal trouble for many years, and operation was performed on both ethmoids in 1911 on account of nasal obstruction and crusting. She has douched her nose morning and night ever since. A tooth plate fitted June 1925 was never comfortable.

On 7th September 1925, a red spot appeared at the junction of the hard and soft palate, rather to the right side; soon after, a pin-hole perforation appeared. Potassium iodide was given.

26th September: first seen by exhibitor, the perforation being the size of a split pea. Diagnosis; tertiary syphilis; Wassermann reaction negative. Iodide increased to gr. xxx with liq. hydrarg. perchlor. ♏ xxx t.d.s. Small pustule appeared to the right of perforation; it burst, and a second perforation seemed probable.

The perforation became larger; Wassermann reaction again negative. Iodide and mercury stopped.

8th October: Injection of novarsenobillon; this caused so much upset that no more was given. Appearance of upper surface of palate suggested breaking-down gumma.

22nd October: Wassermann reaction negative. The iodide and mercury again administered.

1st November: Perforation larger, antisyphilitic treatment stopped and Emulsion ol. morrhuæ given.

21st November: Almost daily lavage of nasal sinuses for past three weeks. Inunction of oleate of mercury begun and continued daily.

Pathological and Bacteriological Reports.—Examination of material showed considerable number of polymorphonuclear leucocytes. No tubercle bacilli found; section from edge of perforation showed ulceration and thickening of epithelium with necrosis of submucous tissue infiltrated with polymorphonuclear leucocytes. No sign of tuberculous disease, or gumma formation, or malignant disease. The pathologist suggests that it is a simple inflammatory condition.

Examination under dark-ground illumination shows numerous organisms, but only an occasional spirochæte such as would be found in a normal mouth.

Stained films showed numerous organisms of various kinds, amongst which pneumococci appear to predominate. An occasional spirochæte was seen.

Mr H. TILLEY said the case reminded him of one which he had shown before the Section in pre-war days,* and he had asked Dr Lieven, of Aix-la-

* Tilley, *Diseases of the Nose and Throat*, 4th ed., 1919, p. 499.

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Chapelle, a recognised authority on syphilis, who was in London at the time, to see the patient. There was extensive destruction and crusting in the nose, as well as a large perforation in the hard palate. In that case, as in Mr Tawse's, the Wassermann test was negative, and no history of syphilis was obtainable, yet the lesions were very much like those due to syphilis. The patient was treated with "606," but no progress whatever ensued. Dr Lieven felt certain, in spite of the negative Wassermann, that the lesions were those of tertiary syphilis. The patient got worse, small indurated swellings appeared on the muscles of the limbs, and he died. Post-mortem, the *Bacillus mallei* was found, and the case proved to be one of chronic glanders. He (Mr Tilley) had asked Mr Tawse's patient and her husband whether they had had anything to do with horses, but they had not. There were also those types of case which Semon had described as malignant syphilis, *i.e.*, cases of tertiary syphilis, which, however, did not respond to large doses of iodide of potassium or mercury. Mr Bell Tawse had told him (the speaker) that iodide of potassium made his patient's lesion worse. Possibly such cases might improve with inunctions of mercury, but if they did not do so, Zittmann's decoction of sarsaparilla might be tried, because Semon * had recorded two cases which responded to this treatment.

Sir JAMES DUNDAS-GRANT recalled a case he showed † of a young man whose pharyngeal lesions did not respond to antisyphilitic measures. He wondered whether there was some added infection, possibly tuberculous. Dr Lieven, of Aix-la-Chapelle, recommended the intramuscular gluteal injection of a suspension of calomel in liquid paraffin. At the following meeting he showed this man after he had had that treatment, and his throat was practically well. Perhaps Mr Bell Tawse would keep that treatment in mind. A soft rubber cover could be adjusted to the posterior margin of the dental plate she was wearing, as a protection from the food. If it was syphilis, probably the ulceration was more extensive on the upper surface of the palate than on the visible part. In the old days, solid nitrate of silver was applied to such ulcerated surfaces.

Mr T. B. LAYTON said that if the Wassermann test had not been available, all would have felt confident this was a gumma. He submitted that none of the Wassermann tests that had been done in this case were of any value, as on every occasion some antisyphilitic treatment had been given within the previous month. This being so, the only evidence against this being a syphilitic lesion was invalid.

Concerning dosage, twenty years ago if one had trouble with the administration of iodide of potassium, the dose was doubled; and he suggested that in the present case, instead of giving 30 gr. three times a day, 60 or 120 gr. thrice daily should be given. He supported the giving of liquor sarsaparilla co., as advocated in certain cases in the days before salvarsan.‡

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* "Some Unusual Manifestations of Syphilis in the Upper Air Passages," *Brit. Med. Journ.*, 1906, i., p. 61.

† *Proc. Laryng. Soc. Lond.*, 1906, xiii., pp. 33, 44.

‡ Cullingworth, *Brit. Med. Journ.*, 1906, i., p. 791, "First Report on Treatment of Venereal Diseases in the Army," 1904, p. 32.

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Sir WILLIAM MILLIGAN said that recently he saw a very severe case of foot-and-mouth disease in a lady. She lived in Cheshire, and was very fond of animals, and the disease was subsequently found among animals on her property. There was very serious ulceration, which had penetrated to the bone, though it was only superficial on the palate. It was the only case of the disease he had seen in the human being, and he would like to know whether the present patient had been in the way of contracting foot-and-mouth disease. To him, however, it looked like a tertiary syphilitic lesion.

Dr L. POWELL suggested that this lesion was a simple atrophic ulcer. He thought many people were fond of diagnosing syphilis without sufficient cause. He had seen, not long ago, a similar case in an old man, who also had ethmoidal trouble, and a continual discharge on to the floor of the nose, which was sufficient to cause spreading ulceration. He watched the patient for a long time, and there was never any sign of growth, nor anything suggesting gumma; it was simply a clean hole, from which sequestra issued from time to time.

Mr E. D. D. DAVIS suggested that a guinea-pig should be inoculated and the result noted. This case suggested tuberculosis or lupus.

Mr W. IBBOTSON said he thought this was some form of tuberculosis. The undermining ulcer was suggestive of that disease, and there was some connection between the nasal region and this ulcer; therefore it would be well to investigate the bacteriology of the nasal sinuses.

Sir ST CLAIR THOMSON said that for many years he had taught that a perforation of this sort through the hard palate must be due either to syphilis or traumatism. He did not remember having seen a case of lupus which had perforated the hard palate and in which there were no signs of lupus elsewhere.

With regard to the question of the Wassermann test, he asked whether any members had had an experience similar to his own, in which a negative Wassermann reaction was reported twice or three times, and then a colleague emphasised the necessity of having the cerebro-spinal fluid examined. The examination was refused; later, the patient returned with early symptoms of tabes, and then the Wassermann test of the cerebro-spinal fluid was positive. There were cases of the kind which would resist every treatment.

He saw the present case a month ago, and, among other things, he suggested that the patient be put to bed while undergoing her antisyphilitic treatment.

Dr W. H. KELSON (President) said it must be admitted that with long experience one did get a certain number of undiagnosed cases, which he was in the habit of calling those of simple spreading ulceration; cases in which antisyphilitic treatment had completely failed, as well as every other form of treatment. These cases showed destruction up to a certain point, and after that, the patients got well. He thought that by collecting and comparing notes of these, important deductions might be made.

Mr BELL TAWSE (in reply) said he would have the complement-fixation test done for glanders, and he would give Zittmann's sarsaparilla, as suggested. He had already had an obturator made for the patient. There

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was no ulceration in the floor of the nose now, but there was a month ago. He was disinclined to give as much as 120 gr. of potassium iodide three times daily. Nottingham and the county was a prohibited area at the moment for foot-and-mouth disease, but there had been no cases of it there for the past twelve months. This patient lived in the town. He intended to have ultra-violet rays applied direct to the palate, also to the body generally. An examination of the nasal contents showed the predominant organism to be pneumococcus. He would have the Wassermann done on the cerebro-spinal fluid, and report the case later.

Instrument for the Application of Diathermy to the Œsophagus—A. J. WRIGHT, F.R.C.S.—This is a further development of one shown at the meeting in December 1924.* In principle, it consists of a Jackson's bougie with an annular terminal at the proximal end of the bougie portion. This, being slightly larger in diameter than the bougie, enables the diathermy current to be applied to the stricture from below upwards, thus avoiding risk of damage to healthy tissues. A needle or disc terminal can also be fitted.

Sir WILLIAM MILLIGAN said that this was a distinct addition to the laryngologist's armamentarium ; he thought it would enable the operator to surmount many difficulties. A great advantage was the little rubber stilette at the end of the bougie. After locating the lesion, the subsequent movement was a retrograde one, which meant that one had much more control over what one was doing than when a forward movement was required. A further advantage was that it was always in the direct line of vision. Diathermy in the œsophagus he regarded as a risky procedure, but with this instrument the risks were much minimised. He wondered whether it was possible to make the stem of the instrument more rigid.

Mr SOMERVILLE HASTINGS asked whether Mr Wright had watched these cases after the application of diathermy, and if so, whether there had not been a complete fibrosis and occlusion of the œsophagus after the destruction of the growth by this means. He had found this a real difficulty when using radium, and he asked whether it was thought desirable to do a gastrostomy before treatment by diathermy was undertaken.

Mr WRIGHT (in reply) said that he had used this type of electrode in a considerable number of cases, and, so far, without any fatality ; he was pleased with the results he had obtained. Radium was not possessed by his hospital, and getting radio-active tubes was expensive ; at present he was using diathermy in association with other things, such as Souttar's tubes. If one could get through the stricture at all, it was easy, with this type of terminal, to feel the lower end of it and pass it through. Then if the current were turned on and steady traction maintained, the sharp knife-edge would cut through. It was easy to perceive when one had finished the application, and the instrument could be employed without

* *Journ. Laryngol. and Otol.*, 1925, vol. xl., p. 186.

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running unjustifiable risk. It was a great help to use a large tube, and to stop when one had cut through the stricture. In the earlier types he found that the heat of the terminal damaged the bougie, and the makers of this instrument had inserted a disc of a material which would stand the heat. It could be made more rigid, but he did not require it to be so. It had been kept small, and there was quite a light cable.

Nasal Polypus showing the Structure of a Glioma, from a patient suffering from Cerebral Tumour—DOUGLAS GUTHRIE, M.D.—The case will be published *in extenso* in the *Journal of Laryngology and Otology*.

Sir JAMES DUNDAS-GRANT said he had recently had a case which illustrated a point in connection with this specimen, namely, one in which there was a sarcoma extending from the ethmoid region into the brain. There were also polypoid growths in the nose; these he removed time after time, and could get no evidence of malignancy in them. The present case showed the need for caution in assuming that there was no malignancy in these conditions. Grünwald had emphasised, that in malignant disease of the sinuses there might be ordinary polypoid and inflammatory outgrowths into the nose which showed no signs of malignancy.

Swelling in the Pharynx—N. E. KENDALL, F.R.C.S.Ed.—Girl, aged 21, had a swelling on the lateral pharyngeal wall on the left side, which extends into the nasopharynx and down to just above the arytænoids; first seen ten months ago. No pain, no difficulty in swallowing and no perceptible change in size were noted. Suggestions as to diagnosis and treatment were desired.

Mr T. B. LAYTON said he did not suppose any member would know what was the nature of this swelling until it had been cut out. He suggested that it might be a parotid tumour arising from a salivary or other gland in the lateral wall of the pharynx. He had seen one case beneath the tonsil, and another in the soft palate. Apparently it was non-malignant, and it was tense and elastic. He recommended that it be attacked via the mouth, under intratracheal anæsthesia; he expected it would shell out pretty easily, though there was a possibility of the capsule bursting in the process.

Sir JAMES DUNDAS-GRANT said he thought this must be a malignant growth, probably sarcoma. There was a discrete enlarged lymphatic gland behind the angle of the jaw, which was disconnected from the parotid gland, and it was a question whether this ought not to be removed for microscopical examination, or whether radium might be tried.

Mr NORMAN PATTERSON said he considered that the swelling in the pharynx and that in the neck were one and the same thing, and he would be inclined to attack it from the outside, whatever its nature.

Mr F. H. DIGGLE suggested that the tumour be left alone. The patient had noticed it five years ago, when she had her tonsils removed, and it

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was only recently noticed by her doctor, when she had a sore throat. His own view was that it was a lipoma. A number of these cases were seen in which the lateral wall of the pharynx was displaced inwards.

Dr DOUGLAS GUTHRIE said that still another possibility in diagnosis was the rare tumour originating from the tiny ductless gland—the carotid body.* He had seen one case which closely resembled that shown at present; it could be distinguished from the commoner mixed tumour of this region only by microscopic examination. Growth was very slow in his (the speaker's) case; the tumour had hardly altered since coming under notice three years ago, and caused the patient little inconvenience.

ABSTRACTS

THE EAR.

Discussion on Chronic Non-Suppurative Middle-Ear Deafness (excluding Otosclerosis). (*Brit. Med. Journ.*, 12th December 1925.)

Sir William Milligan, said that advanced chronic catarrhal otitis media is incurable. Our aim should be to endeavour (1) to prevent the onset of the disease, (2) to treat it energetically in its early stages so as to prevent, if possible, the advent of incurable fibroid changes. The original cause is a mild sepsis, not sufficient to produce suppuration, but enough to induce submucous changes which lead to atrophic alterations in the mucous glands and to the ultimate formation of fibrous tissue. If any exudate of this non-purulent kind is thought to be present in the middle ear, it should be expelled by paracentesis and inflation. The researches of George and Gladys Dick go to show that a scarlet fever antitoxin administered on the first day the rash appears obviates the onset of ear complications.

The sheet-anchor of treatment is inflation. Bougies are indicated if the Eustachian tube is blocked, but this should be done from above instead of from below, as is usually practised. Paracentesis is performed in the anterior part of the membrane and fine silver bougies passed. These should be retained for an hour or more. Sir William had many years ago tried the effect of the radical mastoid operation but without success. The changes occur mainly on the inner wall of the middle ear, and chiefly in the region of the oval and round windows. If paracusis is present the oval window is chiefly affected; in advanced cases without paracusis, probably the round window. He had tried removal of the stapes in some cases but found it of no value. Where tinnitus is the symptom most complained of it may be necessary to consider ablation of the cochlea. Loss of

* *Journ. Laryngol. and Otol.*, 1924, xxxix., p. 635.

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