SOCIETIES' PROCEEDINGS

ROYAL SOCIETY OF MEDICINE—SECTION OF LARYNGOLOGY

President: MYLES L. FORMBY, F.R.C.S.

December 4th, 1959

Discussion on Post Cricoid Carcinoma, Closed Injuries of the Larynx, and Adenoma of Larynx

PAPERS by J. F. Simpson, D. L. Chadwick and E. F. Stewart, appear on pp.300–330.

Discussion on Mr. Simpson's paper

DR. SIMSON HALL said, with reference to Mr. Simpson's description of his laryngopharyngectomy, he has had an opportunity of carrying out this operation on one occasion shortly after he was privileged to see the film which Mr. Simpson had shown to us. He believes that this operation forms a real advance in the treatment of post-cricoid malignant disease. It is not universally applicable; it seems to be applicable only to a limited group of cases, but where it is applicable it can be carried out with surprising ease, and with very rapid recovery on the part of the patient.

R. L. FLETT said he had performed two of these operations for post-cricoid carcinoma. They were for palliative reasons only as on exposing the trachea secondary glands were found below the thyroid gland on the left side, and down towards the arch of the aorta. It was felt therefore not worth subjecting the patient to a laryngo-pharyngectomy although these glands were excised. The operation was of the Asherson type.

One other patient had the skeleton of the larynx dissected from the mucous lining of trachea and larynx. This was a difficult procedure and required the use of magnification to avoid button-holing the tube of mucous membrane. Above the cricoid it was more easily performed. These patients were kept comfortable as regards their swallowing, but died from secondary deposits about six months later.

MR. ROBERT OWEN said he congratulated Mr. John Simpson on the result of his operation. There is no doubt that what he has described is certainly a step forward in the process of reconstruction after a pharyngo-laryngectomy. Mr. Owen, however, felt that it was a procedure that could be carried out only in a limited number of cases. It does not matter how small the involvement may appear in the post-cricoid area: there is always the possibility that the cricothyroid glands in front can be involved. It must be realized that mobility of the vocal cords is no criterion that these glands are not affected. This meant that

https://doi.org/10.1017/S0022215100056668 Published online by Cambridge University Press

dividing the larynx and the trachea in the posterior half gave the possibility of leaving a residual area of carcinoma.

Mr. Owen felt that the operation as described could be made use of in those cases of the Paterson-Brown-Kelly syndrome that had been dilated previously on many occasions and were found to show early malignant changes. Also those cases where there was a localized malignant ulcer on the posterior wall opposite the cricoid. In his opinion these two forms of pathology made this type of reconstruction appear to be ideal.

MR. HENRY SHAW said he wished to congratulate Mr. Simpson on the operation of one-stage pharyngo-œsophago-laryngectomy he had described and on the beautiful film presented. Mr. Shaw himself had recently had the privilege of discussing the technique with Mr. Asherson of London, and Mr. Max Som of New York, one of whose patients he had seen. He believed it to be a most ingenious and valuable addition to the concept of the one-stage operation.

He felt he would like to amplify Mr. Owen's remarks regarding the indications for such a technique, also believing that it was ideally suited to small tumours limited to the posterior wall of the laryngopharynx or upper end of the œsophagus. But he had some doubts about its real suitability for the more frequently seen extensive tumours in necks which had already received large doses of irradiation, and which might also require bilateral neck dissection. However, this would soon be resolved.

MR. K. G. MALCOMSON said that he could quote experience of one patient with reconstruction of the pharynx from the larynx and trachea. Aged 60, she presented on *27th February, 1959* with a history of increasing dysphagia for three months and hoarseness for one month. Radiologically there was an anterior filling defect at the pharyngo-œsophageal junction, confirmed by endoscopy to be a circular plaque about 3·0 cm. across; histology grade II squamous carcinoma. Sluggish right vocal cord. Radical radiotherapy was given by Cobalt 60 beam.

The dysphagia disappeared as the mucosal reaction settled, but the right cord remained sluggish and a middle deep cervical node became palpable on the right side. A check endoscopy on *14th August, 1959* revealed complete disappearance of the lesion with a perfectly smooth mucosa; a biopsy from the original site of the growth showed normal mucosa but there was active grade II carcinoma in the submucosa.

On *27th August* after a block dissection on the right the laryngeal mucosa was mobilized from the thyroid and cricoid cartilages; the pharynx was excised from the level of the arytenoids to 2·5 cm. below the former site of the growth, and the upper stoma closed by a purse-string suture. An end-tracheostome was established, and the lower end of the upper trachea anastomosed to the œsophagus. She was fed *viâ* a nasogastric tube for ten days; convalescence mainly uneventful and speech recovery was good.

He would like to stress a number of points:

(i) The clinical disappearance of the growth at the second endoscopy but with positive histological evidence of its continued presence.

(ii) The main components of the laryngeal skeleton were excised to avoid radio-necrosis.

(iii) Block dissection is easily combined with the above procedure.

https://doi.org/10.1017/S0022215100056668 Published online by Cambridge University Press

(iv) There was no reflex coughing of any consequence in spite of intact superior laryngeal nerves.

(v) Voice recovery is good is spite of absent laryngeal skeleton or motor innervation.

(vi) No post-operative fistula or stricture formation.

Discussion on Mr. Chadwick's paper

MR. BOWEN-DAVIES said a middle-aged pilot flying a light aircraft crashed on landing. As a result, he was thrown forward and his flying helmet struck the front of the cockpit and was forced backwards over his head. He received several superficial injuries, and while these were being dressed in the Station Sick Quarters, he suddenly developed stridor and became very distressed.

When he saw him there was a wheal across his neck, in the region of the hyoid, caused by the chinstrap of his flying helmet. He expected to find a hæmatoma of the larynx, but much to his surprise the larynx was perfectly normal except that both vocal cords were adducted and there was a very inadequate glottis.

He performed a tracheostomy and saw the man again six days later, when both vocal cords were moving normally and he was able to remove the tracheostomy tube.

It is probable that the chinstrap of the flying helmet had pulled the larynx upwards and stretched both recurrent laryngeal nerves.

MR. ANGELL JAMES said he had seen one case of paralysis of the vocal cords from a closed injury of the neck. The patient was an R.A.F. pilot who was flying a Stirling aircraft fitted with a horizontal bar in front of the pilot's seat. The aircraft crashed and he struck his larynx against the bar. There was severe bruising of the neck and crico-arytenoid region with complete vocal cord paralysis.

Discussion on Mr. Stewart's paper

MR. W. A. MILL said some years ago he removed by direct laryngoscopy a small tumour, red in colour and pedunculated which was attached to the inner margin of the right vocal cord. On microscopical examination it proved to be an adenoma.

MR. E. G. COLLINS said he also had a case of adenoma which differed from those described in that his case was an adenoma of the trachea which showed some malignant change. An attempt was made to remove the malignant tumour and reconstruct the trachea by the method of Robb and Bateman. However, all the tumour could not be removed.

It is hoped to publish this case at some future date.

MR. MAXWELL ELLIS said Mr. President, these four papers have been most enjoyable, and the speakers are to be congratulated.

I have seen a case of adenoma of the larynx which differs from those presented by Mr. Stewart and Mr. Mill. Six years ago a lady of seventy-eight presented with a large and apparently cystic swelling coming from underneath the anterior half of the right vocal cord. Both cords moved quite freely and normally. I excised this apparent cyst by direct laryngoscopy and I have seen the patient at

https://doi.org/10.1017/S0022215100056668 Published online by Cambridge University Press

intervals ever since—she last came early in November. There is no sign of any recurrence of the tumour.

The histological appearance is shown in this slide Fig. 1. There is a collapsed cyst almost underneath the epithelium, and the deep surface consists largely of areolar tissue and some muscle fibres, presumably from the ventricular band. The pathologist (Dr. I. Friedmann) reported the tumour as a capillary cystic adenoma, arising from the acidophilic cells or oncocytes. I had previously considered the condition a so-called prolapse of the ventricle—a hypertrophy of

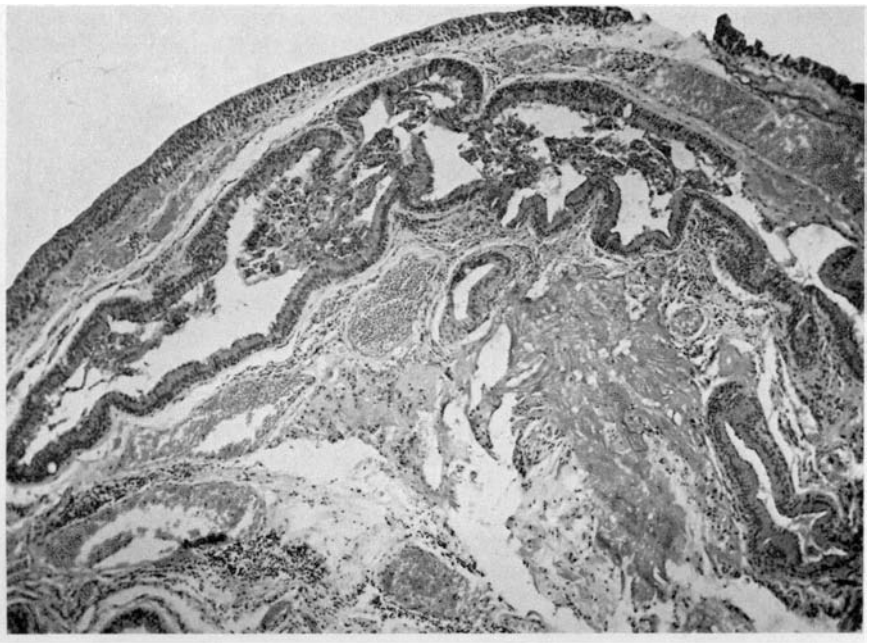


FIG. 1.
Capillary cystic adenoma (Ellis)

the glandular and connective tissue elements of the corium burgeoning into the lumen of the larynx—rather than a neoplasm. However, the localized character of the tumour, and its non-recurrence more suggest benign neoplasm than hyperplasia.

LARYNGEAL SPILL-OVER. CURED BY OPERATION

By H. S. SHARP (London).

MR. SHARP described the case of a lady of 48 who had had a carotid body tumour removed in 1947. This tumour arose in the region of the ganglion nodosum of the vagus nerve on the right side, and during operation this nerve had to be sacrificed. She was referred for laryngological opinion some 18 months after operation. She then complained that for some months she had had difficulty in

https://doi.org/10.1017/S0022215100056668 Published online by Cambridge University Press

swallowing fluids because of spill over into the larynx, and she had a mucopurulent sputum. The cough was bovine, and the voice only a faint whisper. She could not swallow any fluids without choking.

The right vocal cord was fixed in the paramedian position, and on phonation the left cord failed to meet it.

It was considered that inability to close the glottis was the main cause of her symptoms, and an operation was performed to rectify this. The procedure consisted of a preliminary tracheostomy, and an approach *viâ* a laryngofissure exposure, to the anterior ends of both cords. The anterior end of the right cord was mobilized and sewn below the left cord, to the inner aspect of the left ala of the thyroid cartilage, by two separate catgut sutures. The tracheostomy tube was removed 24 hours later.

The patient had an uneventful recovery, and when last seen the voice was stronger, the cough normal, and there was no more overflow on swallowing.

It was suggested that this relatively simple procedure might be found useful in other cases.

This case was published in full by Mr. T. L. Bradbeer in the *Lancet* of Oct. 3rd, 1959, p. 492.

https://doi.org/10.1017/S0022215100056668 Published online by Cambridge University Press