Societies' Proceedings

ROYAL SOCIETY OF MEDICINE—SECTION OF LARYNGOLOGY.

March 1, 1929.

President—H. BELL TAWSE, F.R.C.S.

Cases and Specimens.

Paralysis of Left Vocal Cord, associated with Substernal Goitre, apparently recovering — H. BELL TAWSE, F.R.C.S. (President). Female, aged 56, professional singer.

12th December 1925.—Hoarseness for two months, with swelling left side of neck—indifferent health. *Thyroid Gland*—Left lobe enlarged and rather hard. It can be traced down behind sternum. *Cervical Glands*—A few in anterior and posterior triangles are somewhat enlarged. *Superficial Veins*—Upper part of left chest very prominent. *Larynx*—Subsiding laryngitis—otherwise normal—vocal cords move well. Rest, silence and tonics completely restored voice and health.

17th March 1928.—Hoarseness, dry throat, pain behind sternum for three months. Has been working in a room with a leaking gas radiator. *Thyroid Gland*—Left lobe much enlarged and hard—extends behind sternum. *Cervical Glands*—Enlarged lymph gland, size of tangerine orange, in left anterior triangle adjacent to thyroid—other smaller glands in left anterior and posterior triangles, supra-clavicular space and axilla. *Superficial Veins*—Left chest greatly dilated. *Larynx*—Pushed over to right, giving the epiglottis a twisted appearance, and making a view of the right vocal cord difficult. Left vocal cord is pale and looks swollen and flabby and is in cadaveric position. Left arytænoid immobile—palate normal. Wassermann test—negative.

23rd October 1928.—In excellent health, which she attributes to three months of ultra-violet rays. *Thyroid Gland*—Considerable decrease in size, but still general hardening. *Cervical Glands*—Largest one now size of walnut and others just palpable. *Superficial Veins*—Much less prominent on left chest. *Larynx*—Left vocal cord still looks swollen and flabby, but moves fairly freely. Arytænoid quite mobile. Voice fair—bottom "A" to "E"—three years ago bottom "A" to top "C." Epiglottis still twisted and right vocal cord difficult to see.

Physician's Report (Dr G. A. Robinson), *4th January* 1929—*Heart*—No abnormality or displacement can be detected on palpation, percussion or auscultation. *Lungs*—Well-marked area of dullness

https://doi.org/10.1017/S0022215100033843 Published online by Cambridge University Press

over manubrium sterni. Air entry into both lungs on quiet respiration seems equal, but on exertion it is defective into the left upper lobe.

X-ray Report (Dr Stanley Melville), 10*th January* 1929.—A swelling, dense in character, more or less obscuring the inner ends of clavicles, and more sharply pronounced on the left side, with lessened translucency of apex of left lung. The trachea, which is also somewhat obscured, is displaced to the right side, and definitely narrowed. The arch of the aorta is depressed. The appearances are more in keeping with some thyroid enlargement, with enlargement of the left lobe, and perhaps a middle lobe passing down beneath the manubrium sterni, depressing the aorta and displacing the trachea. 15*th January* 1929—Marked improvement in mobility of left local cord and arytænoid. The deviation of the larynx is not so pronounced. Opinions on the following points are requested: (*a*) Present condition of epiglottis and left vocal cord. (*b*) Coal-gas poisoning as a possible ætiological factor in the paralysis. (*c*) The pathology of the thyroid and cervical gland enlargement. (*d*) A large substernal goitre as the cause of all the symptoms, with an added hyperplasia (now subsided) of the lymphatic glands, in some way associated with the thyroid enlargement. (*e*) Prognosis and treatment.

Dr BROWN KELLY said that in this case the epiglottis was strongly twisted to the right, so that it lay obliquely. He thought that the pressure causing the displacement must be acting on the front part of the larynx, because the posterior part was normally applied against the posterior wall of the pharynx. If the whole larynx were twisted, he would expect other signs, *e.g.* unequal pyriform sinuses. The notes stated that on 17th March the left cord was in the cadaveric position. He thought it might be difficult to judge whether it was in this position or in that of abductor paralysis, the latter being the paralysis commonly caused by goitre. In such cases the voice, as a rule, was normal; if affected the change was usually due to a difference in the level of the vocal processes. To-day the left cord seemed to him to be acting normally, and the case was a good example of recovery from paralysis caused by pressure of a goitre.

It was very important to examine the larynx in cases of thyroid enlargement before performing thyroidectomy, as in a fair percentage abductor paralysis of a cord would be found, although the voice was normal. If both cords were affected the disease was usually malignant, or else was in the central nervous system.

Mr HAROLD KISCH said it was difficult to regard this case as being one of simple goitre; the paralysis of the cord, the pressure on the veins, and the great hardness of the swelling on the left side of the neck had to be explained. He had not seen a simple adenoma or goitre of such stony hardness as this. It was in the supraclavicular fossa, and he did not know whether it was a lymphatic gland or an extension of the thyroid itself. He believed that this was a case of malignant goitre. A curious point was the duration, and the fact that there had been some

https://doi.org/10.1017/S0022215100033843 Published online by Cambridge University Press

diminution of the symptoms. He would, however, try anti-syphilitic treatment in the case.

Mr A. D. SHARP said that he had a female patient of the same age, who had paralysis of the left vocal cord. There was a history of repeated loss of voice, with intervals of recovery. It was thought that there must be some mediastinal cause of the paralysis, but neither physicians nor radiologists had found anything abnormal in the chest. She had had repeated attacks of bronchitis and loss of voice during the last four years. On each occasion as the state of the chest cleared up the vocal cord became mobile. A repeating temporary inflammatory enlargement of a gland pressing upon the nerve might be the explanation of the recurring cord paralysis.

Mr J. S. FRASER said that in the clinic at Cleveland, Ohio, Dr G. W. Crile had all his goitre cases examined beforehand by Dr Waugh, who found paresis of one vocal cord before operation in a certain number of cases.

Mr H. BELL TAWSE (President) in reply said he had shown this case because there was considerable difference of opinion as to whether non-malignant goitre could cause paralysis of the recurrent laryngeal nerve. At Edinburgh, in 1927, Dr Brown Kelly had quoted several authorities who had observed paresis or paralysis in approximately 10 per cent. of cases of enlarged thyroids. A Swiss colleague, at the same meeting, had stated that in Switzerland as a rule a distinct vocal palsy indicated malignant degeneration. At a recent meeting of the American Laryngological Association, one speaker had stated that an enlargement of the thyroid gland, no matter how great, or whether substernal or intrathoracic, did not exert sufficient direct pressure on the recurrent laryngeal nerve to cause paralysis, and that when paralysis occurred the gland should be regarded as malignant. When he (the President) had seen this patient in March 1928 his diagnosis had been malignant thyroid. The cervical lymphatic glands were enlarged, and the patient had lost much weight. He had seen her next in October 1928, after three months' treatment with ultra-violet rays. She was then a different woman, and had remained in perfect health ever since. He, personally, had no doubt that the left vocal cord was mobile.

Adhesion of Soft Palate to Posterior Pharyngeal Wall. Surgical Diathermy followed by Right Hypoglossal Paralysis and Meningitis. Recovery.—DAN MCKENZIE, M.D.—The patient, a woman, aged 32, was operated upon at the Central London Throat and Ear Hospital in July 1928, the adhesion being destroyed by diathermy. The cause of the adhesion was not clear; it dated from infancy; and she had had a radical mastoid operation performed on both ears.

The diathermy interference was immediately succeeded by acute pain in the nape of the neck, but the patient left hospital, and, though still in pain, went abroad.

https://doi.org/10.1017/S0022215100033843 Published online by Cambridge University Press

When next she came under my care at the French Hospital, in September 1928, she was seriously ill with severe, continuous pain on the right side of the head, vomiting and dysphagia. The right side of the face was paretic, and the tongue, when protruded, deviated strongly to the right. There was some rigidity of the muscles of the back of the neck. The diathermised area had healed with the exception of a tough necrotic patch on the right. The finger in the nasopharynx passed into a deep cavity under the petrous leading towards the tympanum, but a probe could not be passed through it into the middle ear. Cerebrospinal fluid withdrawn on several occasions showed leucocytosis but no organisms. For a month the temperature varied between 100° F. and 103° F., and the meningeal symptoms persisted.

Various remedies were tried, including electrargol intravenously, but drainage of the meninges was not adopted.

After some six weeks of varying fortunes, the conditions, local and general, slowly improved and the patient recovered. The tongue still shows hypoglossal paralysis. The nasopharynx has healed.

We may suppose that the diathermy coagulation involved the hypoglossal nerve near to its exit from the anterior condyloid foramen, but the reason for the meningitis is not plain.

The PRESIDENT asked how the raw surfaces were kept from adhering. Many years ago, as a house surgeon, he had to look after a similar case in which the condition was due to congenital syphilis. The adhesion was broken down and a rope of iodoform gauze was passed through each nostril and tied in front of the upper lip. The gauze was replaced each morning by tying a fresh piece to one end and pulling it through. This had caused much pain and after a few weeks had been abandoned. Four weeks later the adhesion had been as bad as ever. In another case a rubber drainage-tube had been used with a similar result.

Dr BROWN KELLY asked whether the opening into the nasopharynx was smaller before the operation than at present. He had had several of these cases, and found that the difficulty was in preventing re-closure. He had had plates made with hooks to retract the palate, but the strong tendency was still towards closure. If diathermy gave a surface without that tendency, it would be a great gain.

Dr DONALD WATSON (Bradford) said he had a case of lupus in which the soft palate was adherent to the posterior pharyngeal wall. He had employed diathermy, and the opening was now $\frac{3}{4}$ in. $\times \frac{1}{2}$ in. It had not contracted during the last year.

Dr MCKENZIE (in reply) said he should have used a hook electrode, but there was not one available. He did not know how the patient had escaped a large hæmorrhage from the internal jugular vein. He had employed diathermy in another case of cicatricial contraction of the posterior pharyngeal wall; but it had completely failed as the contraction had recurred. He believed that in the present case the opening would remain. The peculiar pain felt in the nape of the neck soon after the

https://doi.org/10.1017/S0022215100033843 Published online by Cambridge University Press

operation was like that which frequently followed the operation on tonsils and adenoids, the cause of which seemed to be unknown. The adhesion had been complete before the operation, the patient not having been able to breathe through the nose at all.

Œsophageal Obstruction probably Traumatic, treated by Gastrostomy and Retrograde Dilatation by Multiple Silk Threads. Improvement—W. M. MOLLISON, M.Ch.—C. G., male, aged 30, was referred to Guy's Hospital on account of difficulty in swallowing.

The history was of interest; the patient had been treated by Dr Johnson for an attack of bronchitis, during which he had been given a fluid or semi-fluid diet. On recovery he found he could not swallow solids (previously he swallowed normally) and this disability persisted.

X-ray examination with barium showed a long, tight stricture in the lower half of the œsophagus. Œsophagoscopy confirmed this, and only the smallest bougie could be passed under the anæsthetic. As the passage of bougies was impossible on account of pain, and as the man could only swallow fluids, gastrostomy was performed by Mr Davies-Colley. When this was healed the patient was given a silk thread to swallow, and eventually this was brought out through the gastrostomy wound; successive bundles of silk threads increasing in number were pulled through the gastrostomy opening into the stricture. This proved most satisfactory, and the patient was soon able to swallow semi-solids and finally solids, so that the gastrostomy was allowed to close, except for a small hole through which one silk thread passed, the buccal end of the thread being fastened to a bar attached to the lower front teeth. Bougies were then passed instead of threads. It is found, however, that the stricture tends to close again and a further treatment with threads is necessary. The patient continues to be able to swallow well.

At one stage there was a suspicion that the stricture might be syphilitic and the Wassermann test gave a ± reaction; but after a full course of antisyphilitic treatment no improvement occurred, and the diagnosis of traumatic stricture was made.

The interest of the case lies in the absence of history of any damage of the œsophagus and the success of retrograde dilatation by means of bundles of silk threads: these bundles were left in position for about a week and then renewed.

Sir JAMES DUNDAS-GRANT said that the Seiffert hook was cleverly adapted for catching a thread or a long thin flexible bougie.

The PRESIDENT said that some years ago he had had a case in which multiple strictures had followed the swallowing of ammonia. Gastrostomy was performed and when the ulcerated mucosa of the œsophagus had

https://doi.org/10.1017/S0022215100033843 Published online by Cambridge University Press

healed, dilatation was begun under direct vision and was continued for eighteen months, after which the gastrostomy was allowed to close. The patient became quite well and now swallowed normally.

Mr MOLLISON (in reply) said the history given was all that could be obtained. He had seen one case comparable to this in the medical wards of Guy's, under Dr Hurst. A man was very ill with pneumonia, and when he recovered from that he could not swallow at all, and a gastrostomy had been required. The stricture in the present case was about 6 ins. long : a bougie was passed with difficulty and produced no improvement. He felt despairing about this case when the threads were first used, but his dressers had persevered to such effect that the patient could swallow solids.

Two Cases to show a Method of Laryngectomy by raising a large U-shaped Skin-flap—LIONEL COLLEDGE, F.R.C.S.—(1) Patient, female, aged 47. Loss of voice since July 1928. Epithelioma in anterior part of larynx involving both vocal cords. Portion removed showed an epithelioma with cell nests. No preliminary tracheotomy. Laryngectomy on 25th January 1929.

(2) Patient, male, aged 60. Hoarse for two years. Recently had increasing stridor, for which he attended a hospital and saw Mr A. T. Cunningham, who diagnosed carcinoma and sent him to St George's Hospital. Owing to severe stridor a low tracheotomy was performed through a transverse incision just above the jugulum. On the day of admission, 21st January 1929, the glottis was reduced to a chink by a wide involvement of both vocal cords, which were fixed. No tubercle bacilli in sputum. Wassermann reaction negative. All septic teeth were removed. A specimen taken with Jackson's forceps confirmed the diagnosis of carcinoma.

26th January 1929.—Total laryngectomy with upper two tracheal rings. Excised larynx showed a wide subglottic extension. The transverse tracheotomy did not interfere with the raising of a large flap of skin. This method of exposing the larynx is designed to prevent the formation of a pharyngostome from wound infection arising from the pharynx.

Injury to Larynx—E. COWPER TAMPLIN, M.C., F.R.C.S.Ed. (introduced by Mr C. A. S. RIDOUT).—Patient, male, aged 52, 28th July 1928, was pushing a car with his right shoulder against the radiator, when he slipped and a prong of the lamp bracket hit his throat. There was immediate loss of voice, and within an hour his neck was swollen and blue; for three days, during which he was in a hospital in Folkestone, there was difficulty in breathing and swallowing, and much pain.

The hospital notes are as follows—"*On admission:* the left arytænoid was seen to overlap the right; and it was suggested there was a fracture of the cricoid cartilage. Next day: right cord normal,

https://doi.org/10.1017/S0022215100033843 Published online by Cambridge University Press

left cord not seen, some infiltration of the false cord." Electrical treatment has produced no result. The sinus was in the direction of the thyroid cartilage. A fracture of the hyoid bone was demonstrated by Dr Beverley Bird on the screen when the patient swallowed. There has been a succession of small abscesses which arise from the left side of the thyroid cartilage. He still complains of hoarseness and weakness of voice. On examination, the left side of the larynx has an atrophic appearance and moves feebly. There is a fracture of the hyoid bone.

Mr HERBERT TILLEY said that some of the appearances suggested perichondritis of the neighbouring cartilages. There was some irregular subglottic swelling, and the history of a fracture, followed by suppuration and fistula, bore out the probability of such a diagnosis.

The PRESIDENT said that at a meeting of the Section some years ago he had shown a boy, aged 10, down whose throat his mother had forcibly pushed her finger in an attempt to dislodge a foreign body. In that case the glottis had been narrowed by a swelling in the larynx and tracheotomy had been performed on account of dyspnœa. The boy had never regained his speaking voice.

Dr BROWN KELLY said that if there was a chance of necrosis in the cartilages, he advised that the patient be kept under observation. He had had a somewhat similar case in which the patient was later found dead in her home. A piece of cartilage had been extruded into the larynx and had caused suffocation.

Perforation of the Pharynx by a Safety Pin. (*Specimen and Skiagram.*)—J. ANGELL JAMES, M.D. (introduced by Mr E. WATSON-WILLIAMS).—Female, aged 9 months. Thirteen days before admission the child swallowed a safety pin. A swelling of the neck was noticed seven days before admission, and difficulty in swallowing and breathing four days before admission to the Bristol Royal Infirmary. On admission there was marked respiratory embarrassment, and an inflammatory swelling of the left side of the neck. Direct laryngoscopy showed a cleft palate and great œdema of the pharynx and larynx.

Operation.—Tracheotomy and incision of the swelling in the neck with evacuation of pus. Three days later, direct laryngoscopy showed that the œdema had subsided and that there was a perforation of the left side of the œsophagus. The safety pin was removed through an incision in the neck. A fistula into the pharynx resulted but was healed four weeks later.

I am indebted to Mr E. Watson-Williams for permission to publish this case.

Mr W. S. ADAMS said he knew from experience that perforation of the wall of the pharynx was not always fatal. The case had been that of a woman who had swallowed a flag pin $1\frac{3}{4}$ in. long. This had become impacted transversely just above the entrance to the œsophagus. The

https://doi.org/10.1017/S0022215100033843 Published online by Cambridge University Press

point was towards the left, and, judging from a skiagram, seemed to have perforated the wall of the pharynx. The pin had been removed by endoscopy twelve hours after impaction and the patient closely watched. Twenty-four hours after removal there had been an area of tenderness and induration in the left side of the neck, alongside of the trachea. The temperature was then 101° F. A vertical incision was made over the affected area, and the infrahyoid muscles were separated from the upper part of the trachea by blunt dissection to the level of the pharynx. A small quantity of turbid blood-stained exudate was found. The wound was lightly packed with gauze. The patient had made an uneventful recovery.

Dr J. A. JAMES (in reply) said that when he first saw the patient the pin had passed practically through the wall of the gullet and only the top of the head was visible.

Foreign Body Impacted in Œsophagus; Parœsophageal Abscess. Removal of Foreign Body by Peroral Endoscopy, with Drainage of Abscess; Pneumonia; Death. (*Specimen and Skiagrams.*)—E. WATSON-WILLIAMS, M.C., F.R.C.S.Ed.—Patient, a boy, aged 9, was eating rabbit when something stuck in his throat, on left side; his mother "cleared it" with her finger. Next day he was brought to hospital complaining of pain behind the lower part of the sternum and in the left shoulder; unable to swallow anything. He looked and felt very ill. Skiagram negative. Direct œsophagoscopy under general anæsthesia. Immediately after passing the cricoid a splinter of bone was seen sticking transversely out of the left side of the œsophagus. Removed with Paterson's forceps, it proved to be just over 2 cm. long and sharply pointed at both ends; about 1 cm. had penetrated the wall, which was swollen, and pus welled out of the puncture. The opening was enlarged with punch forceps and about one drachm of pus escaped.

Swallowing for fluids and soft solids was thereafter easy and painless.

The œsophageal abscess continued to drain; the boy had periodic attacks of faintness, followed by gulping up of offensive pus, which relieved him. The skiagrams show the diminution in the shadow thrown by the abscess between the second and fourth days. On the third day broncho-pneumonia supervened and the boy died on the seventh. Autopsy showed a large abscess lying on the left side of the œsophagus and expanding among the roots of the lungs, but with a well-defined wall. There was some mediastinal œdema. The apex of the abscess was the hole punched in the œsophageal wall, through which the pus had been draining. There was generalised broncho-pneumonia of both lungs.

Mr H. TILLEY said that in two of his cases of removal of foreign bodies impacted in the gullet, there had been a gush of pus into the lumen of the gullet. The after-treatment had consisted of nutrient enemata for

https://doi.org/10.1017/S0022215100033843 Published online by Cambridge University Press

three days. He would be afraid of placing any tube in the gullet which might prevent free drainage from outside the gullet wall into its normal lumen. The only liquid taken by the mouth for the first two or three days after the removal of the foreign bodies was a mixture containing bismuth carbonate in suspension.

Mr E. WATSON-WILLIAMS (in reply) said that treatment was restricted by the patient's condition. When first seen he seemed much too ill to accord with the history, and his temperature was 101° F.; two days later he had severe broncho-pneumonia. Had the condition allowed he (the speaker) had intended to enlarge the opening of the abscess with œsophageal scissors. Drainage was fair but not adequate; and it was worth while considering whether nursing in a head-down position would assist in such a case. Guisez had reported two similar cases treated with success by repeated tamponnage with peroxide. There was a great difference from the standpoint of prognosis between perforation of the pharynx and perforation of the œsophagus, the latter condition being serious. If only the mucosa of the œsophagus was penetrated the prospect was somewhat better, but when the whole thickness of the wall was pierced the prognosis was gloomy.

Specimen of Mixed Palatine Tumour Associated with the Tonsil—R. SCOTT STEVENSON, M.D.—A man, aged 45, complained of a swelling in the region of the left tonsil. He had had an attack of acute tonsillitis two weeks previously, and had not noticed the swelling before that.

There was a large, firm tumour attached behind and internal to the left tonsil pushing the tonsil forwards. It was thought that the condition was probably an encysted peritonsillar abscess, but might be a sarcoma.

A week later the left tonsil was dissected out under general anæsthesia, and was found not to be attached to the tumour. By dividing the muscle fibres of the tonsil bed, a rounded, smooth encapsuled tumour was exposed and was shelled out; the only difficulty was at its further end, which was attached to the vertebral column.

On microscopical examination the tumour was found to be a "mixed palatine tumour," epithelial in origin, derived probably from the ducts of a salivary gland. It is suggested that the tumour arose from an aberrant salivary gland, such as is sometimes found in association with the tonsil.

Mr J. S. FRASER said that, whatever might be the pathology of this case, the exhibitor was to be congratulated on having been able to remove so large a tumour from such a dangerous region with so satisfactory a result.

Mr L. COLLEDGE asked how long it was since the operation had been performed. [Dr SCOTT STEVENSON: Four months.] He, personally,

https://doi.org/10.1017/S0022215100033843 Published online by Cambridge University Press

would be afraid that by shelling such a growth out of its capsule one would run the risk of recurrence in the capsule. Three years ago he had treated a similar tumour by radium. The patient was a woman aged 55. After the tumour had shrunk considerably he applied diathermy and the remainder had then sloughed, but no recurrence had ensued.

Mr HAROLD KISCH said he had had a case in a child who had a tumour presenting behind the tonsil and a swelling in the neck. When the patient was under an anæsthetic he saw that these had a common origin. He had removed the swelling through an incision in the neck. The naked-eye appearance was that of lipoma, but microscopically the tumour was classified as a ganglio-neuroma. These occurred more often in the abdomen than in the neck.

Specimen of Carcinoma of the Œsophagus treated with Diathermy. Gastrostomy. Death—W. M. MOLLISON, M.Ch.—A man, aged 64, had had symptoms of œsophageal obstruction for four months. Several septic teeth were removed, and an X-ray examination after the swallowing of bismuth had shown an obstruction about 1½ in. above the cardiac end of the œsophagus. The skiagram presents a picture similar to that seen in achalasia.

Œsophagoscopy had revealed a mass projecting from or into the posterior left and anterior walls. By means of Wright's electrode diathermy was applied. Further obstruction having developed, gastrostomy was performed by Mr Davies-Colley. The patient died two days later.

Post-mortem examination showed a growth of the œsophagus extending from the level of the hilus of the lung to within an inch of the lower end: this growth was in the wall of the œsophagus and had not ulcerated into the lumen.

Sections of the œsophagus, cut by Professor Donaldson, show that there is no degeneration of Auerbach's plexus: the growth is seen spreading in the submucous layer.

Dr T. B. JOBSON said it would be interesting to know what size of lumen was obtained with the diathermy electrode. He had applied diathermy seven or eight times in one case, and he had been able to obtain an opening of about half an inch. On two occasions after the application of diathermy, some kind of spasm had set in and the patient had not been able to swallow anything—not even water—for two days. That condition passed away after forty-eight hours and swallowing became easier. On one or two occasions he had tried, under X-rays, to pass a mercury bougie, but had been unable to get it in.

Specimen: Large Calculus weighing 62 gr. removed from Left Submaxillary Salivary Gland of Male, aged 54—H. BELL TAWSE, F.R.C.S. (President).—Twelve years' history of recurrent obstruction of duct with painful swelling of gland. When seen by exhibitor it was accompanied by cellulitis of the left neck

https://doi.org/10.1017/S0022215100033843 Published online by Cambridge University Press

and face, and the patient was very ill. The tongue was swollen and pushed upwards against the palate; swallowing even of fluids was extremely difficult and breathing was obstructed. A large abscess was evacuated through the mouth by incision, but no calculus was felt. A week later the œdema and swelling had considerably subsided and the calculus was removed from its dense capsule of fibrous tissue.

A skiagram shows two more calculi. The submaxillary gland is still much enlarged and slightly tender; the patient is not conscious of any enlargement of it at meals. This suggests that the duct is patent, but the gland may have ceased to function. Should the calculi be searched for, or is removal of the gland indicated?

Mr H. TILLEY said that he had recently had a case in which an expert radiologist's report was that no calculus could be detected, but afterwards a surgeon removed it. When there was suppuration in the duct or gland it was safer to remove them from the outside. After all sorts of local remedies had been tried, in the case of two members of his (the speaker's) own family, the glands had been removed externally and on section were dark grey in colour and had an extremely foul smell.

Specimen: Tracheo-Œsophageal Fistula—E. O. HARRIS, L.R.C.P., M.R.C.S. (introduced by Mr T. JEFFERSON FAULDER).—A labourer, aged 39, had a sudden attack of dyspnœa while cycling to work twelve days before admission. After this he coughed up everything he ate. He had had slight dysphagia for a period of two months.

On admission his condition was grave, owing to rapid starvation and inhalation pneumonia. The right lobe of the thyroid gland and a cervical lymphatic gland were enlarged and stony hard. The patient died one day after admission.

Mr A. J. WRIGHT said it was strange that a tracheo-œsophageal fistula should be compatible with life for a considerable time. It might be expected that in such cases the patients would acquire aspiration pneumonia within a few hours of the formation of the fistula.

Chronic Inflammation of Right Lachrymal Gland. ? Tuberculous—H. BELL TAWSE, F.R.C.S.—E. T., female, aged 12. Four months' history of repeated attacks of painful swelling involving the right orbit and frontal bone. Some years previously had been treated for congenital syphilis, hence a provisional diagnosis of periostitis. Despite a negative Wassermann test, N.A.B. injections were given but did not influence the attacks. Sent as case of acute frontal sinus suppuration, with swelling and œdema involving right upper and lower eyelids, forehead and cheek. Crying out with pain; temperature 101°, obviously ill. Marked thickening of upper orbital margin spreading into orbit but too tender for careful palpation.

X-ray examination of nasal sinuses negative; no periostitis.

https://doi.org/10.1017/S0022215100033843 Published online by Cambridge University Press

Ophthalmic and intranasal examination negative. Hot fomentations reduced the œdema in a few days, when a tense, tender, ill-defined swelling could be made out, extending from the external angular process to the inner canthus.

Diagnosis.—? Orbital cellulitis, ? suppurating dermoid, ? sarcoma. Through an incision below the line of the eyebrow, a hard firmly adherent mass, the size of a large broad-bean, was removed with difficulty.

Pathological Report.—Fibrous tissue stroma, probably produced by chronic inflammation. In this are groups of glandular acini and ducts with considerable evidence of chronic inflammation, which may be tuberculous, though this is not quite certain.

The structure is no doubt the lachrymal gland. It is not a malignant tumour. The wound healed by first intention. Removal has not affected the eye.

Chronic inflammation of the lachrymal gland is seldom met with, and if, in this case, the suspicions of the pathologist that the gland is tuberculous are confirmed, a very rare condition will have been recorded. Although the case proved to be beyond the confines of rhinology, the clinical signs suggested an acute inflammatory process in the orbit, probably secondary to infection from the nose.

ABSTRACTS

THE Abstracts this month, which are taken principally from the *Zentralblatt f. Hals-, Nasen-, und Ohrenheilkunde*, 1928, Vol. xiii., pp. 34-64, are of the first group of papers read at the First International Congress of Oto-Laryngology at Copenhagen, August 1928.

The "Rapports" are not included in these Abstracts. They have been published in full as a Supplement to the *Acta Oto-Laryngologica*, and abstracts of them will appear in the *Journal*. They are:—

"Septicæmia of Pharyngeal Origin," by W. Uffenorde and G. Ferreri.

"The Conservative Radical Mastoid in Chronic Middle-Ear Suppuration," by H. Neumann.

"The Treatment of Cancer of the Pharynx, Larynx and Œsophagus by Diathermy," by Dan McKenzie.

"The Diathermy Treatment of Malignant Tumours of the Nasal Cavities and of the Naso- and Meso-Pharynx," by G. Holmgren.

https://doi.org/10.1017/S0022215100033843 Published online by Cambridge University Press