the case up for diagnosis. What Dr Logan Turner said was very suggestive, namely, that there was a condition due to yeast superimposed on an underlying epithelioma, and that it had not yet affected the underlying muscles of the vocal cords. The Wassermann reaction was negative, as also was the complement-fixation test for tuberculosis. So far no treatment had been carried out. He thought it was justifiable to take away a piece from the posterior pharyngeal wall, and if the growth was diffuse epithelioma, deep X-ray therapy might give some help. He proposed to try it.

Dr JOBSON HORNE suggested that before this was done Mr Mollison should try firm applications of absolute alcohol daily, rubbing it well in under an anæsthetic.

Epithelioma of Vocal Cords—W. H. JEWELL, M.D.—Male, aged 49, was previously shown in January and March, 1927 (*Journ. of Laryngol. and Otol.*, Vol. xlii., pp. 621-637, 1927). At the first meeting the consensus of opinion was in favour of tuberculosis, and at the second malignant disease. Excision of the larynx had been advised. The left vocal cord was fixed and deeply excavated and the subglottic region involved. The right cord was active and covered with macerated, thickened epithelium. Operation April, 1927. Excision of left cord, and about the anterior fourth of right cord; the cricoid was divided. Growth on each was reported to be epithelioma. The right cord is still active, but appears to be infiltrated.

Mr H. S. BARWELL (President) said that the question now was whether the patient was free from disease in his larynx or not. The other cord did not look altogether normal, and he thought the case would have to be carefully watched for some months to see whether any further growth arose. If it did, probably laryngectomy would be the only possible operative treatment.

SOCIÉTÉ DE LARYNGOLOGIE DES HÔPITAUX DE PARIS.

MARCH 1927.

(*From the Archives Internationales de Laryngologie*, 1927-1928.)

Abstracted by M. E. VLASTO, F.R.C.S.

Retropharyngeal Abscess Consecutive to Caries of the Cervical Spine—A. BLOCH and LEMOINE.—The case was that of a child of six years; the abscess was opened through the mouth and not through the neck as it is classically taught should be the selected route of approach.

In the discussion that followed, the majority of the speakers were

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of opinion that secondary infection of a cold abscess did not take place. They preferred the remote risk of a secondary infection to the difficulty of a "blind" operation through an external incision.

A Voluminous Dental Cyst of the Lower Jaw—ROUGET.—The exhibitor showed a radiograph of a large dental cyst which had developed at the expense of the first lower molar tooth.

He remarked that the dentist had fractured the lower jaw when effecting the removal of the offending tooth. It was observed that the whole of the inner table of the bone had disappeared and that the mylo-hyoid muscles formed the inner supporting layer of the cyst. It was further remarked that the growth of the cyst was quite painless, inasmuch as the presence of the cyst was first noticed at the time of the tooth extraction.

LEMAÎTRE noted the fact that dental cysts of the lower jaw were very rare. He recommended that in all cases these cysts should be operated upon through the mouth and never through the cheek. One might be tempted to choose the latter route in cases where the growth of the cyst had taken place at the expense of the outer table of the jaw. The disadvantages of the external route were two-fold. Firstly, the cosmetic result, and secondly, because the periosteum was destroyed. Removal of the periosteum would destroy any possibility of future bone restoration.

Pulsion Œsophageal Pouch treated by Diverticulopexy—F. LEMAÎTRE and A. AUBIN.—The patient was a man of 68 who for the last ten years had suffered from increasing dysphagia. Latterly regurgitation of food and slight pain were also present.

The diagnosis of œsophageal diverticulitis was confirmed by radiology and endoscopy. The pouch was situated in the mid-cervical region, the size being that of a hen's egg, and its lower limit was 2 cm. below the suprasternal notch.

In view of the man's age, it was decided to carry out the less severe operation of diverticulopexy instead of the more usual and classical operation of pouch excision.

The steps of the operation were as follows:—Incision was made along the anterior border of the sternomastoid. The thyroid gland, trachea and œsophagus were retracted medialwards, and the sternomastoid and carotid sheath lateralwards. The superior thyroid artery was divided between ligatures. By firm retraction on the inner side, the prevertebral region was then exposed. But the œsophageal pouch could not be found. Nor could it be seen along the course of the œsophagus. The pouch was eventually identified with the help of the endoscopic tube, and so thin were its walls that the light could easily be seen shining through. The sac was then dissected up to its neck and turned up behind the pharynx. The blind end of the pouch, now uppermost, was then sutured to the lower fibres of the inferior con-

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strictor. This point of attachment prevents any drag on the œsophagus during the act of deglutition.

Although recovery was uneventful, and the patient left the clinique apparently cured, the exhibitors insist that time alone will show whether or not "pexy" is a justifiable operative procedure.

Cases from the Meeting of July 1927.

Sarcoma of the Upper Jaw—Rouget.—A youth of 17 showed a large swelling involving the left cheek and lower jaw. It was first noticed two months ago. The diagnosis of sarcoma was based on the absence of enlarged glands, the age of the patient and the nature of the swelling.

The exhibitor was of opinion that treatment should be carried out by physical agencies alone.

Bloch questioned if the growth could be dealt with surgically.

Lemaître advised against surgical interference. He recognised a spindle-cell form of sarcoma which evolved in the manner of a lympho-sarcoma except that the glands were not involved, and of which he believed this case to be an example.

The type of case which was amenable to surgery was a growth of periosteal origin with deep prolongations but which was easily enucleated and was not prone to recur.

Pseudo-Tympanic Membranes: a Sequel of Suppurative Otitis Media—Halphen.—The case was that of a young girl who suffered from double chronic otitis media, but whose ears had been dry for the last eight years. Her complaint was that of slight deafness.

Examination showed that on both sides, and at only a distance of 1.5 to 2 cm. from the meatal orifices, there was a supplementary drum-head which completely shut off the meatal canal. The appearance on both sides was identical.

The exhibitor asked whether he should destroy the membranes in order to try and obtain better hearing without knowing the condition medial to them, or, as was his opinion, whether it would not be better to leave well alone.

Bourgeois suggested perforating the membrane with a galvano-cautery in order to test the effect of its removal. If the hearing were improved, the membrane could be destroyed by electro-coagulation or the meatal canal could be restored by autoplasty.

Segura said he would destroy the supplementary drumhead if the otoscope revealed that catheterisation was normal. But as Halphen pointed out, the presence of a normal drumhead medial to the false would not suppress the sound of air through the otoscope.

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MOULONGUET reminded the meeting that in addition to the question of attempting to improve the audition, one had to consider the danger of re-opening the middle ear to the path of infection. He was diffident, therefore, in suggesting interference with the *status quo*.

Bilateral Primary Mastoiditis—PIERRE (of Troyes).—A girl of 15 complained of pain behind the right ear of several months' duration. Both tympanic membranes were normal, and audition perfect. There had never been a history of otorrhea. The only physical sign was acute pain on pressure over the tip of the mastoid on the right side. General health was normal. No constitutional signs were present.

The pain was attributed to neurosis in a spoiled child.

Two months later, the general practitioner himself witnessed an attack of acute otalgia, and feeling that the parents of the child would seek further advice if nothing were done, advised an operation.

A further examination convinced us still more that we were not dealing with an otitic infection, but we decided to make an incision under general anæsthesia in the hope that suggestion would effect a cure. At the operation, it was decided to expose the mastoid cortex to see the condition of the bone. To our great surprise the rugine entered a surface in the friable bone, and a large cell in the tip of the mastoid full of granulation tissue was opened up. The disease extended no higher, and the wound was completely closed. The symptoms entirely disappeared.

Two months later the history repeated itself on the left side. On this occasion it was decided to open the antrum to note whether or not it was infected. It was found to be perfectly healthy.

Here again recovery was uneventful.

Although the exhibitor knew that the existence of primary mastoiditis was generally recognised, he regarded the condition as very exceptional.

The present case was still more remarkable by virtue of it being bilateral.

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