SOCIETIES' PROCEEDINGS

AMERICAN LARYNGOLOGICAL ASSOCIATION

Fifty-fourth Annual Meeting, Atlantic City, N.J., May 19th, 1932

(Abstracted from the official Transactions)

By T. A. CLARKE

Dr. G. E. SHAMBAUGH, the President, in a paper entitled "Clinical Problems of Rhinology", said that restraint in diagnosis and conservatism in treatment are very necessary. This is certainly the case with the nasal septum, the indications for operation on which are two only, discomfort from impairment of nasal respiration, and interference with the ventilation and drainage of an infected ethmoid. Chronic progressive deafness, as it occurs in adults, is no justification for nasal operation.

When active sinusitis was shown to be present he favoured the minimum of surgical interference. He did not admit the existence of a vacuum frontal sinus headache, and he stated of headaches in general that they must be very fully investigated before being accepted as a symptom of sinusitis.

Dr. F. A. FIGI read a paper entitled "Chondroma of the Larynx: Report of Six Cases". The literature is briefly reviewed, and some figures are quoted from Irwin Moore's article in the *Journal of Laryngology* of 1925. The symptoms are often hoarseness, dyspnœa, cough, aphonia and dysphagia, usually occurring in that order. Diagnosis is difficult on clinical data only; on laryngoscopic inspection a smooth sessile mass covered with normal mucous membrane in which the vessels stand out prominently is very suggestive of chondroma. The various possible treatments are discussed; laryngofissure and enucleation of the growth and its capsule is usually the method of choice.

Six cases occurring in the Mayo Clinic were described. In one, a very extensive tumour, laryngectomy was performed, the patient dying five days later from pneumonia. Another case was treated by removing much of the thyroid ala, without opening the cavity of the larynx. Three cases were subjected to laryngofissure, and one case did not submit to operation. Of the four cases surviving operation, satisfactory removal was obtained in three, no recurrence of the tumour taking place. Radium, applied in one case in which

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recurrence after operation occurred, and used in another case in conjunction with operation, did not appear to exercise any favourable influence.

Dr. W. B. CHAMBERLAIN spoke of the difficulties of diagnosis, and mentioned two cases in which he had erred, one proving to be a tuberculoma and the other a cyst.

Dr. T. R. GITTINS read a paper entitled "Laryngitis and Tracheobronchitis in Children: Special Reference to Non-Diphtheritic Infections". He stated that non-diphtheritic tracheobronchitis is a good deal commoner than is supposed; many cases are wrongly diagnosed as being diphtheritic or as pneumonia, attention not being paid to the possibility of tracheobronchial obstruction. He emphasised the usual absence of active struggling dyspnœa, and the frequency of the pale cyanosis of exhaustive dyspnœa with its essentially toxic appearance.

In the treatment of all but mild cases, tracheotomy is necessary followed by tracheal instillation of oil or adrenalin solution. Tracheobronchial aspirations are often necessary and life-saving measures. Dr. Gittins mentioned twenty-four cases which had been under his care during twelve years; the mortality was 37 per cent.

Dr. CHEVALIER JACKSON agreed that the condition was comparatively common; many cases were diagnosed as croup. Good plumbing was essential, proper provision of which would result in recovery in almost all cases. Tracheotomy, intratracheal instillations, and frequent tracheal aspiration were the measures to be adopted.

Dr. C. F. THEISEN stated that the obstruction was due not only to membrane and mucus in the airway but also to œdema of the tracheobronchial walls. Dr. H. P. MOSHER agreed that suction was very important in treatment; he thought that there was a definite group of cases with marked membrane-formation in which the infection was due to the Staphylococcus albus.

Dr. M. F. ARBUCKLE read a paper entitled "The Treatment of Cicatricial Stenosis of the Larynx with especial reference to the Application of Surgical Diathermy". By the author's method one or two diathermy punctures are made, the needle being inserted to reach a position calculated to be level with the floor of the ventricle, and the current being of a strength to produce a very limited white reaction round the needle. Chloroform anæsthesia is used. The treatment is repeated on one or more subsequent occasions. The swelling is reduced, and a fixed arytenoid may recover its mobility. Dr. Arbuckle described fully two cases in which treatment by diathermy puncture was supplemented by dilatation by bougies and bronchoscopes. The laryngeal appearances improved very

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greatly in both, but one case died from " neurotic stenosis " (laryngeal spasm) shortly after the conclusion of laryngeal treatment.

Dr. CHEVALIER JACKSON said that conservative treatment is very necessary in children ; the natural growth of the larynx would overcome much stenosis, but natural function of the larynx is essential if growth is to take place. This could be obtained by partial corking of the tracheotomy tube, allowing just enough obstruction to cause slight suprasternal indrawing.

Dr. J. H. BRYAN read a paper reporting a case of " Papillary Carcinoma of the Maxillary Sinus ". The patient was a woman aged 36, who had had symptoms for twelve months. A radical antrum operation was performed, and later the region was heavily irradiated by X-rays and radium. Six months after starting treatment there was no apparent evidence of any tumour in the antrum.

Dr. T. E. CARMODY spoke of cases of this condition in which he had observed recurrence seven, nine, and ten years after removal. Dr. F. R. SPENCER thought that, in operating, a window should be left in the canine fossa, so that the antrum might be directly inspected for a number of years.

Dr. W. V. MULLIN read a paper entitled " A Review of Sinus-Chest Infections ". He mentioned his earlier papers in which he had described clinical observations and animal experiments on the passage of infection from the sinuses to the mediastinal and peribronchial glands and to the bronchi. He regarded the spread by the lymphatic path as the more important. He described the personal history of the great physician Laennec, and put forward the theory that his death was due to bronchiectasis secondary to sinus infection.

Dr. R. A. FENTON congratulated Dr. Mullin, and said that his earlier papers on the subject could certainly claim priority over any others. Dr. F. R. SPENCER, Dr. E. MCGINNIS and Dr. H. P. MOSHER agreed with Dr. Mullin's theories and estimate of the importance of the subject. Dr. E. R. FAULKNER mentioned two cases of interest which he had seen, and thought that one could be too conservative when considering operation on the sinuses.

Dr. D. C. JARVIS read a paper entitled " The Pale Septum Syndrome ". He stated that pale mucous membrane on the nasal septum indicates a potential alkalosis of the body ; red mucous membrane, a potential acidosis. Administration of acid or alkali changes the colour of the mucous membrane, and appropriate selection of foods has, of course, a similar action. The author gave a list of the acid and alkali ash values of the commoner articles of diet.

He stated that persons with a pale septum present a definite syndrome—continual itching of the skin, often a frontal headache,

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and nasal discharge of a characteristic paper-white colour. This syndrome is complementary to the author's " red septum syndrome ".

Dr. A. M. ALDEN read a paper related to the last: " The Treatment of Allergy based on the conception that it is a Potential Alkalosis." He was not satisfied with the theory that specific hypersensitivity is the sole underlying factor in allergy. He commented on various reasons for his dissatisfaction, amongst others that allergy is very rare in diabetics, and that allergic symptoms disappear in other diseases when the acid-alkali ratio of the body is disturbed to the acid side.

He had treated eighteen consecutive cases of allergy by acidification. Three only had not improved.

A very full discussion of these two papers followed, there being very general agreement with the authors in their suggestions.

Dr. L. M. HURD read a paper on " The Nasal Accessory Sinuses as Foci of Infection in Chronic Arthritis ". This was based upon the examination of 386 patients, of whom 262, or 68 per cent., showed pathological changes to the Röntgen ray. Of these 262 cases, 126 had been examined by a rhinologist, and of these 33, or 26 per cent. of the X-ray positives, were negative clinically, and 93, or 74 per cent. of the X-ray positives, were positive—that is to say, showed the presence of sinusitis clinically.

Of these 93 cases, treatment for the sinusitis was instituted in 46, and of these 36, or 78 per cent., showed more than moderate improvement in the arthritis. For various reasons, 47 cases did not submit to treatment of the sinuses, and of these, those who received general care only, 19, or 45 per cent., showed some improvement.

Dr. R. A. FENTON thought that bacteriological examination was very necessary. One predominating organism in the various foci in each case was usually found, and it was his habit to start the treatment of the patient by giving a vaccine of this organism. Streptococcus viridans was often found. Dr. W. V. MULLIN thought that differentiation of the arthritis was necessary; he mentioned the work of Drs. Pemberton, Osgood and Dickson, considered that the foci of infection were usually multiple in each case, and the results obtained without operation not inferior to those obtained after operation.

Dr. F. R. SPENCER and Dr. F. SUMMERILL read a paper on the " Histopathology of the Larynx; antedating clinical evidence of Laryngeal Tuberculosis ". They described fully the clinical, pathological, anatomical and histological findings in six cases which died of tuberculosis, four with no clinical evidence of laryngeal involvement, two with slight incipient lesions. They found that

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there could be marked histological evidence of tubercular change without any clinical evidence thereof. They illustrated their paper well with micro-photographs.

Dr. A. W. PROETZ gave a motion picture demonstration of "Ciliary Action and other Factors in Nasal Physiology". He regarded ciliary action as by far the most important factor in maintaining and restoring nasal health. Knowledge as to whether or not they are functioning in each case is most important; when the antral cilia are still acting the making of an additional ostium through the inferior meatus is futile and unnecessary.

He demonstrated experiments on the nasal air-currents in inspiration and expiration. By one method small pieces of blue litmus paper were carefully placed in different positions in the nose, and the patient was then allowed to inhale the fumes of hydrochloric acid, changes in the paper then being noted. In another group of experiments, bisected skulls were used, and a sheet of glass was fitted to replace the septum; the passage of smoke blown through them in front and behind was then observed and photographed. His results agreed with those of earlier workers in regard to inspiration, but in expiration he found that there was a completely "dead" area opposite and level with the posterior half of the body of the inferior turbinate; hence the difficulty in blowing out secretion lodged in this position.

He also demonstrated the respiratory pressure changes which occur in the antrum, connecting a manometer to a cannula placed in the antrum. He did not think that this factor was of any importance in emptying the antrum of secretion, but he suggested that this method of investigation would be of clinical value in determining the patency or blockage of the antral ostium.

THE SCOTTISH OTOLOGICAL AND LARYNGOLOGICAL SOCIETY

ROYAL INFIRMARY, EDINBURGH

June 2nd, 1933

President—DR. G. B. BRAND

THE PRESIDENT: Gentlemen, as members of the Scottish Otological and Laryngological Society, you are aware that we have no business meeting this afternoon, the business meeting of the Society having taken place in Glasgow some time ago, when Dr. Logan Turner vacated the Chair.

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