Mr. Jenkins added that, microscopically, it was a mesoblastic tumour, a sarcoma. At first it was regarded as epithelioma, but its fungating feature was against that view. Specimens were exhibited for examination by members, and he would be glad of their opinions.

Mr. Marriage saw the case last December, and took a piece for microscopical examination. The report of that examination was that it was carcinoma. The same view was expressed about the glands which were removed in September. He had not seen the specimens himself, but had looked up the note of the pathologist.

Dr. Gray thought there was nothing inconsistent in both views being correct. Carcinoma transplanted into mice occasionally aroused a sarcomatous reaction in the tissues; and he had known a clinical case in which epithelioma of the lip formed a secondary epitheliomatous deposit in the leg, which subsequently became sarcomatous. In view of our comparative ignorance, and remembering the knowledge which had lately been acquired, it was conceivable that a growth which was at first carcinomatous should, some months later, become a sarcoma. The connective tissue elements sometimes reacted in such a way that the epithelial cells were overpowered, and in that process the connective tissue cells acquired a malignancy of their own. He had not heard of the process being reversed—namely, sarcoma causing carcinoma. He had heard of cases in which the same pathologist reported a case to be carcinoma at one examination and sarcoma at another.

Mr. Jenkins, in reply, said he thought the specimen which he had exhibited could not be epithelioma, though there was room for discussion as to whether it was endothelioma or sarcoma. The two expert opinions he had had were both in favour of the tumour being mesoblastic.

PROCEEDINGS OF THE ROYAL SOCIETY OF MEDICINE—LARYNGOLOGICAL SECTION.

June 6, 1913.

Mr. Herbert Tilley, *President, in the Chair.*

Scars of Operation on the Frontal Sinus obliterated by Time.—Herbert Tilley.—Female, aged sixty, was operated on thirteen years ago for chronic empyema of both frontal sinuses. The usual incision through each eyebrow was made—a vertical incision in the lower half of the mid-frontal region—and these were joined by transverse incisions across the root of the nose, which joined the lower end of median with the inner end of the latter incisions. It was thus possible to turn upwards and outwards on each side a triangular flap which fully exposed the anterior wall of each frontal sinus. The nasal cavities are free from suppuration and the internal surface of one sphenoidal sinus is easily seen.

Adult Male with (?) Early Malignant Disease of Lower Pharynx and Upper End of Gullet.—Herbert Tilley.—Male, aged fifty-three, complained of difficulty in swallowing solids and loss of flesh, but no pain

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on swallowing. He says he had a large lump on the left side of the neck which "had been dispersed."

Laryngoscopic examination reveals a small raised, flat swelling with free edges behind and just above the left arytænoid. Its surface is slightly paler than the surrounding mucosa and is not ulcerated. The growth on the postero-lateral pharyngeal wall bleeds freely on being touched. There is a small, hard, easily movable gland behind the upper end of the left sterno-mastoid. Further, in the left base of the tongue is a smooth, circumscribed slightly raised nodule about the size of an ordinary filbert.

Mr. HARMER thought it would turn out to be malignant. He asked whether pieces of growth had been removed from the upper part of the œsophagus and from the tongue; also whether glands had been removed from the neck, because possibly the patient had more than one malignant growth, and, if so, cure by operation was hardly possible.

Dr. W. HILL said operation would have to be a formidable one, because the larynx and base of the tongue would also have to be removed. Mr. Evans once showed at the Section a case in which he did a very extensive removal, including about one third of the œsophagus, glands, the base of the tongue, pharynx and larynx. The patient not only recovered, but afterwards married. Food was conducted from a hole in the side of the pharynx by a rubber tube down to a gastrostomy opening.

The PRESIDENT replied that a portion of the ulcer would be removed before any radical operation, which had not yet been definitely decided on.

Symmetrical Swellings on Anterior Aspect of Arytænoids just above the Vocal Processes.—Herbert Tilley.—Male, aged thirty, complained that his throat gets dry after using his voice for a few minutes. No other symptoms.

On the anterior and median aspect of each arytænoid and above the level of the vocal process a small, pale, raised prominence can be seen. These come into contact on phonation, but do not interfere with the free movement of the arytænoids, and the voice is not affected. The patient has had syphilis and been treated for the disease, but without any effect on the above appearances, which may be of the nature of pachydermia. Possibly the symptoms have nothing to do with the laryngeal appearances. The patient complained of thirst, but there was no sugar in the urine, and no kidney disease was present.

Dr. H. J. DAVIS said the condition at first sight suggested papillomata, but on careful inspection the growths seemed to be hard; on the left side was a cup-shaped depression into which the elevation on the opposite side fitted. He believed it to be pachydermia, and advised leaving it alone.

Sir STCLAIR THOMSON agreed with the diagnosis of syphilitic pachydermia. He was once deceived by a case somewhat similar, which turned out to be tubercle, but in it there was some abrasion or ulceration of one of the swellings. If he were the patient he would not have them operated on, but a scientific enthusiast might wish to remove a portion and examine it under the microscope.

Dr. JOBSON HORNE also considered that the excrescences might be of the nature of pachydermia laryngis and that syphilis was a causative factor. He would be in favour of reducing the excrescences and of insisting upon absolute silence during treatment. The man's occupation permitted of this. The throat symptoms complained of could be accounted for by the nasal obstruction of which he complained, and

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attention to the latter would doubtless be beneficial both to the throat and to the larynx.

Dr. DONELAN said that viewed externally, in the absence of a speculum, the appearance of the nose suggested a deviated septum. The patient said that one of the reasons his throat was so dry was that he had much difficulty in breathing through his nose. Dr. Donelan would be glad to know how far this might be correct.

The PRESIDENT replied that the question of nasal obstruction was gone into, and it was concluded that there was not enough to indicate that it was a probable factor in the laryngeal condition.

Osteoma of the Nose.—H. Lambert Lack.—Woman, aged thirty-one, shown at the Laryngological Society in 1904. She had a large growth in the left nostril, completely distending it, pressing the septum over to the right side, and occluding the ostium of the left antrum. The growth was removed by curetting, and she has remained well until the last three months or so. Now there are signs of a return of the growth in the position of the left inferior turbinate and on the outer wall of the nose above the turbinate. During the last three months she has had some neuralgia on the left side of the face and some swelling of the left cheek. The left antrum is completely dark on transillumination. There is no discharge from the nose. The case is a rare one, and any suggestions for treatment would be welcome.

Dr. JOBSON HORNE said the pathology of these cases had not been worked out. The disease, according to his own observations, was usually bilateral. Speaking generally, he thought the lesions were due to an infective process.

Dr. KELSON some years ago had shown a case resembling the present one, and they seemed to be allied in some respects to cases which occurred on the West Coast of Africa. The bone must have been quite soft, as Mr Lack spoke of removing it with a curette. In his own case, though the bone appeared to be hard, it crumpled up when touched with a sharp instrument. The section showed simply thin bone, and there appeared to be no growth.

Dr. BOND said the history seemed to point to a growth beginning on the inner wall of the antrum, and if the antrum were opened up, either by cutting alongside the nose and through the upper lip, or lifting up the nose and cheek, one could see what should be done. He thought it would be necessary to make a cut to the internal angle of the orbit. Possibly the whole upper jaw would have to be removed.

Mr. E. D. DAVIS said there had been eight cases of hyperostosis cranii shown in which there was enlargement of other bones, including the maxilla, the nasal processes, both sides of the nose, the temporal bone, mastoid, and exostosis of the ear. Dr. Lack's case appeared to be localised to the nose, and was not hyperostosis cranii.

Sir STCLAIR THOMSON said it had been suggested that the upper jaw should be removed, but if a radical operation were contemplated, why remove the upper jaw? It would mean removal of the alveolar border, and result in disfigurement, and it did not bring the operator very near the site of disease. He asked that Moure's operation (lateral rhinotomy) should be considered. He had introduced it to one or two general surgeons, one of whom, Mr. Burghard, said he did not think he would ever again remove the upper jaw. By entering below the eye and cutting through the ascending process of the superior maxilla, there

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was free access to the antrum, nose and sphenoid without disfigurement of the patient. It also preserved the teeth, and there was not much bleeding caused.

Mr. LACK, in reply, said his idea was to turn up the upper lip and reach the outer wall of the nose in that way, as it was the lower part of the nose which was affected.

Fatal Cavernous Sinus Thrombosis following Left Tonsillitis.—**H. J. Davis.**—The patient, a healthy boy, aged ten, developed on December 27 a unilateral parenchymatous tonsillitis. His two brothers had previously been laid up in the same house with follicular tonsillitis. This had run its usual course. On January 3 the temperature was 104° F., with rigors, and these continued in spite of all treatment until he died on January 13, the temperature being 107° F. January 5: Anti-streptococcus serum was injected, and the next day the palate and tonsil were incised and on January 7 incision was made in the neck, but no pus was found. January 8: Swab taken from the wound and blood taken from elbow vein; swab was sterile, but after prolonged cultivation *Staphylococcus albus* was found in the blood. On January 9 the diagnosis of cavernous sinus thrombosis was obvious. The eyelids were œdematous and tightly closed over the eye, which was bulging, there was ecchymosis of the conjunctiva, and œdema had spread to the forehead and face from blocking of the facial vein and extended down the neck. There was little to be seen in the throat except that the left tonsil was red and slightly enlarged. Incisions were made in the palate, face, neck and eyelids, and the conjunctiva was also incised and 5 minims of liq. ammon. fort. administered every two hours in water. January 10: Twitchings and paresis of the leg supervened; lumbar puncture fluid clear; 4 c.c. drawn off apparently not under pressure. Fluid sterile and did not reduce Fehling's solution. Child died on January 13.

In the only other two cases of cavernous sinus thrombosis following tonsillitis which he had seen, in one the patient recovered, but was blind, and the other, a soldier, died on the fifth day. In each case the affection was unilateral.

Mr. O'MALLEY asked the route of spread of the infection from the tonsil to the cavernous sinus. He knew of a case in which the cavernous sinus became involved three weeks after the removal of tonsils and adenoids. The patient died and the *post-mortem* showed the tonsillar and adenoid regions fully healed, and the presence of an osteomyelitis of the body of the sphenoid, which involved the sinus by direct spread along the optic nerve on one side. In the present case there might have been another focus of infection besides the tonsil, which would account for rigors and high temperature, even before invasion of the sinus.

Sir STCLAIR THOMSON said he had seen only three cases of thrombosis of the cavernous sinus. In two the spread was from the sphenoid, and the third was an ear case. It was difficult to trace the route from the tonsil. The histories seemed to suggest that the same infection which attacked the tonsil got located in the sphenoidal sinus, and that even in so-called tonsil cases the thrombosis was really of sphenoidal origin.

Dr. JOBSON HORNE recalled a case in which there was no external indication of infection, but *post-mortem* the sphenoidal sinus was found to be infected, and that fully explained the condition.

Dr. W. HILL asked what line of surgical treatment should be adopted in cases of cavernous sinus disease if one were asked to do something more when vaccines failed. The sinus was awkwardly situated, but it

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could be got at either through the skull or through the orbit or through the sphenoidal sinus. He wondered whether it had been found useful to turn out the clot and drain.

Dr. FitzGerald said that thromboses of the pterygoid plexus of veins are usually responsible for cavernous sinus thrombosis in infection from throat. He believed the sinus had in some cases been approached through the pterygo-maxillary fossa.

Dr. Dan McKenzie said the question of operation would be found dealt with in a recent number of the *Lancet* in an article by Mr. Ballance, in a paper read by him at the International Congress of Otology, Boston, last year.

Mr. H. J. Davis believed the infection of the cavernous sinus travelled through the facial vein, as it communicated by the angular vein with the ophthalmic vein in the orbit. The œdema of the face was due to plugging of the facial vein. He did not know whether there was trouble in the sphenoidal sinus, but there was nothing to suggest it. Strong ammonia certainly reduced the liability of the infection to spread; that was seen also in jugular sinus thrombosis in which the jugular was not tied, and in femoral thrombosis and thrombosis elsewhere in the body. It lessened the tendency to coagulation.

Unilateral Paralysis of Left Cord, Tongue and Palate.—H. J. Davis.—The patient, a healthy-looking man, aged forty-nine, had a history of three weeks' increasing difficulty in swallowing, and the case was supposed to be one of early œsophageal growth. The left side of the tongue was atrophied and paralysed; the same applies to the palate and the same to the left side of the larynx. The dysphagia is probably, therefore, due to muscular weakness. Probably the implication of the cranial nerves is due to a specific meningitis.

The President some years ago had shown two cases: (1) A patient suffering from syringomyelia in which there was paralysis of the right vocal cord, of the right half of palate and pharynx, the right sterno-mastoid and upper third of trapezius. (2) A male, with paralysis of left vocal cord, left sterno-mastoid and upper third of trapezius. This was probably due to a basal pachymeningitis. Similar cases had been previously recorded by Hughlings Jackson and Morell Mackenzie.

Perforating Ulcer of the Palate.—W. H. Kelson.—Patient (a clerk), aged sixty-three, who denies syphilis, says he first noticed a small sore on the roof of his mouth eighteen months ago. Six months ago he went into hospital and had three doses of neo-salvarsan, 2·4 grm. in all, and on leaving the Wassermann test was negative. He then gave up treatment for some months. The ulceration, however, still went on, and he became much troubled with food passing up into his nose. He then became a patient at the London Throat Hospital, and is now taking perchloride of mercury and iodide of potassium. A large funnel-shaped ulcer of the hard palate is present, which passes up into the cavity of the nose.

The President said that two or three years ago there was a similar case at University Hospital. The man was medically treated with anti-syphilitic remedies, as well as calomel inhalations. The Wassermann test, however, was always negative; and yet the appearance was so much like that of syphilis that the treatment mentioned was continued. The patient died, and the disease was proved to have been chronic glanders.

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In this case the whole soft palate was eaten away so that one looked up into a dome in the nasopharynx.

Dr. JOBSON HORNE said the localised nature of the growth and its duration were against it being glanders. The appearance of the ulceration was unusual in that situation and reminded one of so-called "rodent ulcer." However, the enlarged and hard lymphatic gland beneath the angle of the jaw on the right side suggested malignancy.

Lupus of the Gums and Pharynx.—W. H. Kelson.—Patient, a man, aged forty, who denies syphilis, states that his throat first felt sore about seven months ago, but says he now has no pain on swallowing. On examination ulceration and a nodular condition is seen on the gums, right tonsils, palate and pharyngeal wall. Marked improvement has taken place since he has been put on arsenic, and incidentally a very irritating skin eruption from which he had suffered for several years has disappeared.

The PRESIDENT noted that the gums were most diseased where the pyorrhœa was most marked. The teeth certainly needed attention.

Dr. JOBSON HORNE had detected a similar lesion in the inter-arytænoid region of the larynx of the patient.

Dr. KELSON replied that the patient could now swallow in comfort, whereas previously he had been in considerable pain. He believed it was lupus.

Laryngeal Disease.—W. Jobson Horne.—The patient, a male, aged thirty-six. The left vocal cord was hidden by the left ventricular band. The movement of the cords had been irregular: the left appeared to move with a greater effort than the right cord. The nature of the laryngeal lesion was doubtful.

A sister had died from consumption. The examination of the thorax and the sputum was negative.

Sir STCLAIR THOMSON said he looked carefully for the atypical feature, but he could not see it. He saw one ventricular band more prominent and slightly overlapping one vocal cord, but he did not regard that as more than a physiological abnormality.

The PRESIDENT said that the day before he was consulted about a similar case. The patient had been speaking in public a good deal, and his physician saw the left ventricular band rather overlapping the corresponding cord. He (the speaker) gave the opinion that the appearances were within normal physiological limits.

Dr. JOBSON HORNE did not consider that the appearances which the larynx presented should be passed over as being within the normal physiological limits.

Double Paralysis of the Superior Laryngeal Nerves in the Course of Disseminated Sclerosis from Lead Poisoning.—James Donelan.—This man, aged twenty-five, was first seen on June 19, 1912. He gave a history of pleurisy at the end of the previous October, since when he had been losing weight. He had a husky voice and a small, white lenticular swelling, about 3 mm. in diameter, at the junction of the right vocal cord and vocal process. He had some soft *râles* over both upper lobes. The case was regarded as probably one of tuberculosis. He went to a sanatorium on September 14, remaining there until November 9, when it was decided that the case was not one of tuberculosis. The patient on January 8 was seen by Dr. Head, who regarded the case as

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disseminated sclerosis. On March 5 it was found that both crico-thyroid muscles were paralysed, but there was no paralysis of the recurrents. Abduction and adduction are unimpaired, and the patient possesses a loud, rough voice, being able to shout, but the tone and ring of the normal voice are absent. The wavy outline of the glottis is very characteristic. There appears to be some slackness of the arytæno-epiglottidean folds. There is scarcely any movement of the cricoid cartilage towards the thyroid during phonation.

He was a printer's labourer, occasionally employed on small jobs of type-setting, such as the titles of books. He had also a good deal to do with the handling, cleaning and forwarding of frames of type. His attack of pleurisy in 1911 seems to have diminished his resistance to lead-poisoning.

Tonsil Forceps.—James Donelan.—This instrument is on the principle of the Krause wool-holder and permits the passage of any snare or tonsillotome after the grasp has been secured. It is made to grasp the tonsil in a vertical direction as suggested by Ballenger some years ago. Instead of teeth, which are so often apt to tear the tonsil, it has two grooved rings like a tongue forceps. It has proved useful in the removal of stumps and embedded tonsils.

Sinusitis Exulcerans of the Frontal Sinus; operative Trauma of the Dura; Recovery.—Dan McKenzie.—The patient, a female, aged sixty-six, was seen in August, 1912, on account of a small, painless swelling under the left supra-orbital margin of a few days' duration. There was no history of any discharge from the nose, and no pus could be seen in any part of the nasal cavities. Nevertheless, the swelling, which had now spread to involve the whole supra-orbital region and upper eyelid, was obviously due to frontal sinus suppuration.

The first operation was to have been limited to simple opening and drainage of the sinus. But early in the proceeding the dura was wounded in a curious manner. After making the first incision through the eyebrow down to the periosteum, whereby a quantity of pus was evacuated, in elevating the pericranium the end of the elevator plunged through the soft anterior wall of the sinus, and through a sinus full of pus, through its posterior wall, which was thin but healthy, and through the dura!

After removing all the walls of the sinus (save the posterior) the fractured posterior wall lay exposed to view. This wall was removed with cutting bone-forceps and a tear in the dura revealed about 3 mm. in length. The dural tear was then enlarged until the cerebro-spinal fluid began to flow freely. Finally, a gauze drain was inserted between the lips of the dural wound, and the sinus, etc., was lightly packed with iodoform gauze.

Save for a violent headache next day the patient showed no sign of intra-cranial damage, and fears of trouble from the accident soon subsided. After a prolonged course the sinus finally healed. The deformity is great, but so was the bony destruction.

Attention was drawn again to the accident to the dura (and doubtless to the brain), and to the advisability of exposing and enlarging such wounds so as to institute a free flow of cerebro-spinal fluid.

The PRESIDENT had lately seen a similar case, in which there was an acute exacerbation of chronic frontal sinus empyema. He made the usual incision through the eyebrow, and inserted an elevator to raise the

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periosteum from the front wall of the sinus, but the bone composing that wall was so soft and infiltrated by inflammatory products that it broke away with the periosteum, and thus the sinus cavity was at once exposed in its whole anterior extent. The patient had recovered. The posterior wall of the sinus was healthy.

Mr. H. J. Davis said he did not see the object of always removing the floor of the sinus. The best way of making an infundibulum larger was with a drill, and he did not think such a cavity ever closed up. It left a hole large enough for the house-surgeon to pass in a catheter and wash it out. Patients got well without the floor of the sinus being removed, and there was less risk of injury to the eye.

Major Moore said the patient had made an excellent recovery from her very serious illness. It would seem a pity that so large a degree of deformity should remain. Did Dr. McKenzie at a later date propose, by paraffin injection or other means, to lessen this?

Dr. McKenzie replied that the patient was aged sixty-six, and he had no intention of operating any further.

Death after Tonsillotomy.—Dan McKenzie.—The patient, a boy aged nine, was brought to the Central London Throat and Ear Hospital on March 6, 1913, for the removal of enlarged tonsils and adenoids. The presence of subacute middle-ear catarrh, with some fever (temperature 101° F.), led to the postponement of the operation on the throat for five weeks. At the end of that time the ear was dry and he was considered to be sufficiently well. Tonsils and adenoids were, therefore, removed in the out-patient department under ethyl chloride anæsthesia on April 16, 1913, the simple tonsillotomy operation being performed.

Three days after operation he returned to hospital with a temperature of 103° F.; great œdema and swelling of the left side of the neck below the left angle of the jaw, together with redness, swelling, and a sloughy condition of the left side of the palate and pharynx. An incision was at once made under chloroform into the œdematous cervical swelling, and a great quantity of fœtid pus delivered. Next day the boy looked better. The cervical oœdema had disappeared, the faucial inflammation had subsided, and the patient could phonate, swallow and breathe without difficulty. The temperature was lower, oscillating between 99·2° and 102° F. On the following morning, however, he was suddenly seized with violent pain in the left side of the chest, the respirations rose to 30 in the minute, friction could be heard, and his strength began to fail. Eighteen hours later he died. *Post-mortem*: Double pneumonia and pleurisy, with double empyema; pericarditis and pericardial effusion. The organisms obtained both from the cervical abscess and from the pleural cavity were of the same type as those which normally inhabit the mouth and pharynx —*Spirochæta dentium*, etc. The patient's teeth were all sound. The death was ascribed to oral sepsis.

Dr. Jobson Horne considered that the presence of the *Spirochæta dentium* was a coincidence and not the cause of the death. The latter he considered was probably a pneumococcus infection and associated with the middle-ear disease.

Dr. Donelan agreed that death was probably due to pneumococcal infection.

Mr. H. J. Davis said that two years ago an out-patient, aged seven, died after such an operation eight days afterwards, of septic pneumonia, and with enlarged glands on each side of the neck. It was not unusual for out-patient operation cases to be laid up with bronchitis, and the condi-

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tion of the throat became septic if they did not receive careful subsequent attention at home. His practice was to order them to be kept three days in bed and another three days indoors.

Dr. McKenzie stood by his contention that the infection from the mouth was the probable cause of the death.

Goitre with Severe Pressure Symptoms; (?) Malignant.—Dan McKenzie.—The patient is a woman, aged seventy-three. The goitre has appeared within the last three years. It is nodular and rather hard. There is tracheal stridor and some difficulty in swallowing. The left cord is paralysed; the trachea can be seen to be narrowed; the external jugular vein is greatly enlarged; and there are some enlarged glands in the left supra-clavicular region.

Mr. Harmer did not think it malignant. The difficulty of breathing and swallowing might be caused by the fact that it travelled down into the thorax behind the sternum, and if she were well enough he would take out a piece of the growth and ascertain its nature.

The President said he had seen a patient who had paralysis of the left recurrent nerve, with difficulty in swallowing; the case was transferred to Mr. Berry, who operated upon her, and removed a large dermoid cyst from behind the manubrium sterni. In the patient shown to-day the thyroid was rather soft, whereas the malignant tumours of this gland which he had seen had usually been extremely hard.

Dr. McKenzie replied that some years ago he had a case of what appeared to be a goitre, which was pulsating, and hæmorrhage was expected; but it turned out to be a mediastinal dermoid presenting in the neck. It did not permit of removal, and a sinus was left open in the neck, discharging dermoid material.

Endothelioma of the Soft Palate.—Dan McKenzie.—Girl, aged seventeen. The growth appeared in the nasopharynx in clusters of polypoid-looking masses. Three operations have been performed. In the last, a fortnight ago, the external carotid was tied, and the soft palate removed. But it was found impossible to remove the whole of the growth as it had extended to involve the lateral wall of the nasopharynx.

The President said he had seen seven such cases early, when there was only a little deafness or a little anæsthesia over the lower division of the fifth, and a little immobility of the levator palate. Extensive and complete operations on some of his cases had been done, but no case had been cured.

Mr. H. J. Davis said treatment by diathermy might be used.

Mr. Harmer said ten cases of malignant growth of the palate had been treated at St. Bartholomew's Hospital by diathermy. One was still well, eighteen months afterwards, and had been exhibited. There was not much difficulty in the operation, and not much soreness afterwards.

Mr. W. Hill had seen two bad cases in which the tumour temporarily disappeared when treated with radium. In one case the tumour was so large that the palate was pushed forward nearly to the teeth, and the patient could neither hear, swallow nor breathe. Five tubes totalling 250 mg. were used for about forty hours, and the whole soft mass disappeared, though the invasion of the bone in the region of the pterygoid process remained, as evidenced by ulceration and some pain. Hearing became normal in one ear, and greatly improved in the other; swallowing

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became normal; the patient was able to dispense with his tracheotomy tube at the end of a week. The patient lived six months, but there was eventually marked involvement of the maxilla, etc.

Mr. KISCH suggested that Coley's fluid might be tried.

Dr. MCKENZIE replied that he did not think any of the remedies suggested would make much difference in this case, because when he tied the external carotid he had removed some glands which were found to contain growth. The patient came complaining simply of nasal obstruction, and he saw what looked like polypi in the naso-pharynx. On putting his finger in he found they sprang from the upper surface of the soft palate. The pathologist reported at first that they were simple nasal polypi, but further investigation revealed their true nature.

Large Polyp growing from the Tonsil.—E. D. Davis.—The patient, a man aged twenty-one, said that he could see something growing from his tonsil, but there were no symptoms. The pedicle of the polyp was crushed with artery forceps and the polyp cut off.

The PRESIDENT said these growths nearly always grew from the region of the intratonsillar fossa.

Web in the Nasopharynx.—J. H. Connolly.—Patient, a woman, aged thirty-two, under treatment for suppurative otitis media believed to have begun about three years ago. No complaint directly referable to nasopharynx now. Passing upwards and backwards from Eustachian cushion on either side and meeting across vault of nasopharynx is a fringe of mucous membrane, which might be compared to the peripheral remains of a diaphragm. It presents two small perforations, one on either side. There is a distinct interval between posterior edge of septum nasi and the fringe.

Dr. JOBSON HORNE said that when the condition was unilateral the question of traumatism had been raised.

Mr. H. J. DAVIS considered it was scar-tissue from a gumma in the post-nasal space.

Mr. CONOLLY expressed the opinion that the structure was congenital in origin.

Malignant Disease of the Œsophagus; complete Paralysis of the Left Recurrent Nerve.—E. A. Peters.—H. W. F—, aged forty-three, carpenter, had severe influenza eight weeks ago. Twenty days ago the voice suddenly became hoarse. For eight days there has been inability to swallow solid food. The left cord is completely paralysed; it is curved and lies in the cadaveric position. The left arytænoid is slightly pushed forward and rotated, so that the vocal process is prominent and gives the sickle-shaped appearance to the cord. A bougie passes only $8\frac{1}{2}$ inches from the teeth, and an enlarged gland can be felt above the left clavicle. Nothing abnormal was found on examining the heart and lungs.

Dr. W. HILL said he had seen a number of malignant cases in which the dysphagia was of quite sudden onset. The revealing signs of cancer of the œsophagus were very late. Sometimes even with considerable stricture the patient could swallow well, and in most instances the disease was quite advanced before anything was suspected of being wrong, especially when the disease was too low to cause laryngeal paralysis. His diagnosis of advanced malignant stricture based on endoscopy had often been received with scepticism in cases where patients were brought for

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the relief of a sudden impaction of a large portion of meat or vegetable in the gullet where there had been no previous symptoms whatever of dysphagia.

The PRESIDENT mentioned a case in which the dysphagia seemed determined by a hearty laugh, and next day the patient was found to be unable to swallow solid food. Until this symptom arose he did not think he was in anything but perfect health.

Syphilitic Ulcer of the Pharynx.—H. A. Kisch.—Patient has had a sore throat for two months. The glands in the neck have been enlarged about the same time, but both sides are said to have been involved at first. The throat gets better at times, but has never become quite well. A small elongated ulcer is seen on the lateral wall of the pharynx, on the left side just behind the posterior pillar of the fauces. The base and edges are firm to the touch, but not everted or indurated. There is a chain of glands in the left posterior triangle, the upper glands being the larger, and they appear to be inflammatory in nature. A section of the wall of the ulcer simply shows an inflammatory condition. The patient is aged twenty-four, has had two children and no miscarriages. The Wassermann reaction is positive. The ulcer is healing and the glands diminishing in size with antisyphilitic treatment.

Laryngeal Perichondritis with Stenosis.—William Hill.—The man was first shown as a case of escharotic stricture of the deep pharynx and gullet after swallowing glacial acetic acid; later as a laryngeal case with impaired abduction, probably due to myopathic injury; and now he showed it as laryngeal stenosis, obviously associated with perichondritis. The latter had come a month ago. Intubation of the gullet had been discontinued for a considerable time previously. The patient was now wearing a tracheotomy tube and taking iodide of potassium. There had not been more than a slight nocturnal elevation of temperature, for a few days at the most, and he did not suspect it as being streptococcal, but it might be latent chronic pneumococcal disease. There were no tubercle bacilli or any other pathogenic organisms found in the discharges, and the Wassermann reaction was negative. As there was evidence of much external thickening of cartilages as well as internal stenosis it was possible that an abscess might appear later and clear up the diagnosis.

Brain with Large Pituitary Tumour in situ.—William Hill.—The case was described at the March meeting of the Section.[1] The specimen was now shown mounted on gelatine by the Kaiserling process.

A slice has been removed from the surface of the right half of the tumour to show extravasation of blood into the substance of the tumour from operative perforation. This led to the formation of a large hæmatoma beneath the capsule and caused death by increased intra-cranial pressure.

Tumour of Superior Maxilla.—Walter Howarth.—The patient has noticed a swelling of the right side of the face for six months. There has been no discharge from the nose and only bleeding on one occasion three weeks ago. There is no pain. There is no pus in the antrum. On transillumination there is a dark shadow on the right side, whilst the X-ray plate shows the region to be more opaque than the left side. There are no unerupted teeth. An exploratory incision was made in the

[1] See *Proceedings*, p. 103 *et seq.*

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labio-gingival fold and the periosteum raised over the swelling. The surface of the tumour was smooth and gradually shaded off into the maxilla, so that it was impossible to say which was tumour and which maxilla. Considerable portions were chiselled away and presented the appearance of rapidly growing bone. Microscopic sections show a condition of chronic osteitis with considerable rarefaction.

? Malignant Ulceration of Hard Palate.—W. M. Mollison.—Male, aged seventy-one. He has noticed a small lump under the left side of the tongue for some twelve months; it has slowly increased in size and is painless, though bleeding now and then. There is a hard, movable mass under the tongue on the left side scarcely painful to touch; not ulcerated. The tongue can be well protruded. There is superficial ulceration on the right side of the hard palate extending on to the posterior extremity of the alveolus; the palate is freely movable. There is a single hard gland beneath the angle of the jaw on the right side.

Mr. H. J. Davis said epithelioma of the palate often began in this way. One instance was shown at the Section three and a half years ago. Some thought it was herpes and others that it was lupus. He first thought it was lupus, and then tuberculosis, but the patient developed later a fungating mass which was malignant.

The President said Mr. Charters Symonds had drawn attention to the point mentioned by Mr. H. J. Davis.

Dr. Kelson was struck by the resemblance of the case to Mr. Lack's, sections of which proved to be papilloma. He suspected the present case was malignant, but possibly it might be papilloma.

Mr. Mollison said that he recently saw a man with a superficial ulcer on his soft palate, creeping into the right tonsillar fossa. There was a strong tubercular history—almost all his relatives had died from it. The ulcer was superficial and movable. He removed the growth, thinking it was a localised tuberculous ulcer; section, however, showed it to be epithelioma. With regard to his case he replied that he took the ulceration on the palate to be syphilitic, and thought the mass under the tongue was a chronic inflammatory condition becoming epitheliomatous.

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(*Continued from vol. xxviii, p.* 605.)

The Surgical Management of Diseases of the Frontal Sinus.—Robert Cunningham Myles (New York City).—The following rules for the surgical management of the diseases of the frontal sinus were proposed:

(1) When the acute cases have unbearable, severe and continuous pain in the sinus and above the eyes, attended with profound constitutional symptoms—fever, chills, and depression—one should proceed in a definite manner to relieve the pressure, if necessary by doing a submucous operation on an obstructive deflected septum and by removal of the anterior end of the middle turbinal, a part of the anterior ethmoidal

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