SOCIETIES' PROCEEDINGS

ROYAL SOCIETY OF MEDICINE—SECTION OF LARYNGOLOGY.

May 6, 1932.

President—MR. WALTER HOWARTH, F.R.C.S.

Left Recurrent Laryngeal Nerve Paralysis.—JOHN F. O'MALLEY.

Male, aged 33. Two months ago some loss of voice set in, following a cough. Patient then noticed a tendency to coughing from liquids, as they got into his air-passages.

The left vocal cord is in the cadaveric position and the left arytenoid sticks up prominently during respiration, but is overridden by the right on phonation.

Examination of the chest is negative.

P. WATSON-WILLIAMS said that the precise causation of some of these cases was puzzling. In this case it was important to note the crossing of the normal arytenoid in front of that of the paralysed side, on phonation. This excluded a local lesion or a fixation of the arytenoid joint. If he suspected a chronic nerve or bulbar degeneration he always took the pulse-rate, as one often found increased pulse frequency, which was not only a diagnostic but also a useful prognostic point, as it showed involvement of the vagus nucleus. A central nerve lesion seemed to be negatived in this case, so he thought there was some peripheral lesion, possibly in the chest.

HERBERT TILLEY said that about four years ago Dr. Brown Kelly and he (the speaker) had introduced, at a meeting of the British Medical Association in Edinburgh, a discussion on paralysis of the vocal cords. His own part of the contribution was the mechanical aspect of immobility, and he based his remarks on twenty-four cases seen in private practice during the preceding seven years, at the end of which period seven were re-examined and showed completely recovered cords. As a student he had been taught that if paralysis of a vocal cord was present, the patient should be told to lead a quiet life because the prognosis was very bad. Yet in some of the cases the patients recovered the use of the cord, but one did not know what was the initial cause of the immobility. Possibly it was a transient arthritis, but since the left vocal cord was nearly always affected, the lesion was probably a neuritis. Six of the cases referred to had an aneurysm, or malignant disease of the gullet, or some other serious condition.

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E. D. D. DAVIS said that in some cases of recurrent laryngeal paralysis, as the result of enlarged mediastinal glands secondary to pulmonary tuberculosis, the patients recovered with the improvement in the condition of the chest.

HAROLD BARWELL said that in some cases paralysis of the vocal cord of unknown origin was the first sign of serious disease, but in others the condition remained unchanged for many years and then one could only suppose that the left recurrent laryngeal nerve was being pressed upon by a small fibrotic gland. Sir Felix Semon once showed a patient who had had paralysis of the left cord for thirty years.

J. F. O'MALLEY (in reply) said that he could not find any lesion to account for the paralysis ; the chest proved to be in every way normal, and no enlarged glands or vessels were evident, such as would cause pressure on the nerve. The Wassermann test proved negative. There was nothing in the case to suggest early œsophageal carcinoma, though the latter might be present in so early a stage as not to cause symptoms. He was glad to hear of Mr. Tilley's cases, as a passing laryngeal affection might suffice to cause paralysis, something akin to Bell's palsy.

Primary Lupus of Larynx.—F. C. W. CAPPS.

Child, aged 12. First seen 10th February 1932, complaining of hoarseness for three months. The whole of the epiglottis, the aryepiglottic folds, the ventricular bands and, to some extent, the cords, were covered with pale granulations. No lesion on face, nose, in post-nasal space, or on fauces. Examination of chest negative. No tubercle bacilli found in sputum. Wassermann reaction negative. No family history of tubercle. A piece taken for section, by direct laryngoscopy, showed granulation tissue.

Tentative diagnosis: Primary lupus of larynx.

Lupoid Ulceration of Pharynx. — WALTER HOWARTH (President).

Emily V., aged 65. Lupoid ulceration of pharynx in November 1929. This patient had a spreading, painful ulcer on the pharyngeal wall. Wassermann reaction negative. The larynx was normal and microscopical examination of the tissue revealed nothing more than chronic inflammation. The ulcer was destroyed by diathermy but has recurred from time to time, in spite of similar treatment. At no time has the ulcer presented the features of true lupus.

Lupus of Palate, Pharynx and Larynx.—J. F. O'MALLEY.

C. J., aged 41, first seen 11th November 1931.

History of sore throat, three months. Swelling on left side of neck and pain on swallowing for two months. Palate, fauces and pharynx showed small shallow ulcers with white scars. Epiglottis much swollen and ulcerated. Arytenoids and larynx above cords looked greyish and slightly œdematous.

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Wassermann reaction, chest examination, and sputum all negative.

Treatment.—Potassium iodide internally, 15 gr. thrice daily, and locally hydrogen peroxide during December and January. Showed iodide intolerance at beginning of February, and has had nux vomica instead since then.

HAROLD BARWELL said that he regarded the condition in Mr. Capps' and Mr. O'Malley's cases as lupus of the larynx, and Mr. Capps' case was unusual in showing no lupus of the upper air-passages. It was more common for lupus to appear first in the nose, then to extend to the pillars of the fauces, and later to attack the larynx. In Mr. O'Malley's case there was no obvious sign of lupus in the nose; and in Mr. Capps' case there was no lupus in the fauces, while this case also exemplified the tendency of lupus of the larynx to recover. The patient said that her voice was now much better than before, and the vocal cords showed nothing more than a smooth pink swelling which did not look like lupus, though there was much destruction of the epiglottis. In skin hospitals one could see many cases of healed lupus of the larynx. The treatment was open air, on sanatorium lines, combined with large doses of arsenic.

It would be agreed that Mr. Howarth's case was not one of lupus, though he (the speaker) did not know what it was. There was more pain than one would expect from lupus. The superficial ulceration on the posterior wall of the pharynx looked like syphilis, though it did not behave like that disease; it had not responded to anti-syphilitic measures, and the Wassermann reaction was negative.

H. V. FORSTER said that some years ago he saw a case—similar to Mr. Howarth's—of painful ulceration in exactly this position; it was under the care of Mr. Thomas Guthrie. A good deal of trouble was taken, yet the cause was never discovered. There was a history of ulceration of the vulva, but there was no proved evidence of syphilis. At the present time he was interested in a case of ulceration of the nasal septum and pre-maxillary area of the palate. Though possibly of congenital syphilitic origin, it was most resistant to anti-syphilitic treatment.

J. F. O'MALLEY (in reply) said there had not been the progress under treatment by potassium iodide which he had hoped to see. He wondered whether touching with the cautery would be of benefit, but the area was extensive, and the treatment would have to be graduated.

The PRESIDENT (in reply) said that the diagnosis was a difficulty. The pathologist always reported a chronic inflammatory condition, and no treatment hitherto adopted had had a completely successful effect. Light diathermy had been applied at intervals, and the scarring on the pharynx was due to the diathermy applications. There was no necessity to do anything in regard to the nasopharyngeal stenosis, as treatment of that condition was very unfavourable.

Previous Tuberculosis of Larynx.—WALTER HOWARTH (President).

Alice T., aged 50, had ulceration of both vocal cords and involvement of the inter-arytenoid space with pulmonary tuberculosis on the right side in 1910. Was treated by silence for seven months at Ramsgate,

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plus the use of a collar to produce venous congestion. She has remained well for the last twenty-two years, but her voice is rough as there is still some thickening in the inter-arytenoid space.

The PRESIDENT said that he had shown the case in order to bring home the fact that laryngeal tuberculosis could be cured, and remain so, even in working-class people, for a long period. The patient had been given Biers' congestion treatment, with the rubber band in the xiphisternal notch, for four hours a day.

Hypertrophic Carcinoma of Epiglottis, treated by Radium.—SOMERVILLE HASTINGS.

Patient, male, aged 54, admitted to hospital in November 1931, with a large growth surrounding the epiglottis. The larynx, which could be seen only by direct laryngoscopy, was not involved. There were enlarged glands on both sides of the neck, and much dental sepsis.

Tracheotomy was performed under local anæsthesia. Total dental extraction ten days later. In December, eight radium needles, each containing 1·75 mgrm. (length 4 cm., screen 0·5 mm. platinum) were inserted vertically downwards across the base of the tongue, so that they lay just anterior to the growth and epiglottis.

Two needles came out after four days, and the remainder were removed on the fifth day. Dose 1512 mgrm.hrs. = 11·3 mc.d. There was a very marked improvement by the end of the month.

In January 1932, twelve needles each containing 1·25 mgrm. radium (3 cm. long, screen 0·5 mm. platinum) were inserted deep to the glands, six on each side of the neck for six days. Dose 2160 mgrm.hrs. = 16·2 mc.d. Four days later, surface application of radium to left side of neck on Columbia paste 5·25 cm. thick. Charge 351 mgrms., surface 117 sq. cm., filtration 1·0 mm. platinum, duration six days, dose 31239 mgrm.hrs. = 234·5 mc.d. Three days later, application to right side. Charge 351 mgrms., surface 106 sq. cm., distance 5·5 cm., filtration 1·0 mm. platinum, dose 28782 mgrm.hrs. = 215·9 mc.d.

In April there was slight irregularity of epiglottis but no sign of growth, and the glands had subsided. Section of growth showed a squamous carcinoma with much necrosis and secondary infection.

J. F. O'MALLEY said that the patient had made satisfactory progress up to the present, and now the epiglottis could be seen well. One could not see what was between the tongue and the epiglottis, but there was no large neoplasm. The left arytenoid moved badly, and that raised the suspicion that there was some extension of the growth in that region, and in the pyriform fossa.

Melanotic Tumour of Right Ethmoid.—J. F. O'MALLEY.

H. J., female, aged 65.

History.—Right nasal obstruction of three weeks' duration.

On examination.—Large coloured mass filling right nasal passage;

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slight swelling of right cheek. Transillumination: Good crescent on left; right quite opaque. X-ray examination: Left antrum clear; right opaque; no erosion of bone.

Report on microscopic section of growth.—"Large cells in active mitosis. Melanin granules: a melanoma."

E. D. D. DAVIS said that cases of melanotic sarcoma of the nose must be very rare. The only other case he had seen was a similar one shown by Mr. G. Wilkinson at a meeting of this Section twenty-one years ago.[1] It was difficult to say in which part of the nose the growth originated, but he believed that in Mr. Wilkinson's case the growth began in the vestibule of the nose.

J. F. O'MALLEY (in reply) said that during twenty years he had seen one only other such case, that to which Mr. Davis had referred, shown by Mr. Wilkinson. Where were the pigmented cells from which this tumour was growing? A case was on record in which it grew from the olfactory region, where some pigmented epithelium existed, but he had not gone beyond the ethmoid region in his examination.

Specimen of Sphenoid showing Suppuration.—E. WATSON-WILLIAMS.

Specimen from boy, aged 8, shows suppuration in the right sphenoidal sinus which had led to meningitis; the condition simulated mastoiditis, in so far as the only localising sign was pain referred to the right ear; the mastoid was found to be quite healthy, but suction exploration of the sphenoidal sinus showed it to be full of pus; the child died two days later.

Intractable Pain following Sinusitis.—A. LOWNDES YATES.

S. G., male, aged 40, seen June 1930. Antra previously opened intranasally, 1927.

Pus washed from sphenoidal, posterior ethmoidal, and frontal sinuses on both sides. Frontal sinus opened by Howarth route, November 1930. Suppuration in all sinuses ceased. Pain continues. Injection of sphenopalatine ganglion and frontal branches of fifth nerve with alcohol without relief of pain. Wassermann reaction negative.

HERBERT TILLEY said that direct access to the sphenoidal sinus ganglion through the nasal cavity was comparatively simple, and he had proved this on post-mortem subjects with the help of Dr. H. A. Harris, Assistant Professor of Anatomy in University College. He removed the middle turbinal and waited from ten to fourteen days until the parts were healed, and then found a little stump, which was the remains of the posterior end of the middle turbinal. Taking a trocar and cannula, one applied the point in the angle made by the junction with the outer wall, when a little pressure enabled one to pierce the thin bone and so enter the spheno-maxillary fossa. A solution of phenol 2 per cent. and spirit 85 per cent. was used for

[1] *Proceedings*, 1911, v. (Laryng. Sect., p. 11).

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injection. This was immediately followed by acute pain in the branches of Meckel's ganglion, which passed off in about three minutes, to be followed by numbness in the regions where the neuralgic pain had been felt, *e.g.*, inner regions of the orbit, supra-orbital nerve distribution, the lip, and over the mastoid region of the same side.

A. LOWNDES YATES (in reply) said that cocaine had relieved the pain, though only temporarily. Injection of the spheno-palatine ganglion was simple. One need not remove the middle turbinal, but could go over it. In some cases there was a palsy of the levator palati, which was thought by some to be supplied by the spheno-palatine ganglion. All those cases were relieved. It was possible to inject alcohol round the ganglion, and not into it; he did not think any technique would ensure that the solution injected would enter the ganglion; when it did so, palsy of the palate sometimes occurred. In the present case there was no such palsy and it might be that the spheno-palatine ganglion itself had not been entered.

Concretion in Nose.—SOMERVILLE HASTINGS.

Patient, male, aged 44, first admitted to Middlesex Hospital in 1902 with an osteoma growing from the inner margin of the right orbit. The growth was removed by an external operation. Readmitted 1908 with right-sided nasal obstruction. Nose turned aside and a large bony tumour, which arose chiefly from the maxilla, was removed with a chisel.

Readmitted 1909 with discharging sinus on cheek; antrum opened, and necrotic material removed. An osteoma growing from the inner wall of the antrum was found, but attempt at removal failed. Readmitted 1910. Examination under anæsthetic. Large mass of necrotic bone was felt post-nasally, but considered too large for removal. Since then small pieces of bone have been coming away. In September 1930, a large concretion was found loose in the nose, the septum being pushed over to the left. Behind, it filled the whole of the post-nasal space.

9th *December* 1931.—Moure's incision: anterior wall of antrum removed, and concretion extracted.

20th *April* 1932.—Bony projection found growing into nasal cavity from region of right infra-orbital plate, and nasal process of maxilla. Removed with chisel. Scar on lip excised and resutured.

A Series of Patients illustrating the results of Bronchoscopic Treatment.—V. E. NEGUS.

(1) *Vegetable Foreign Body in situ for six weeks with almost complete absence of Signs or Symptoms: Cured.*—On 24th August 1931, patient, a girl aged 4½, tried to unfasten a gate while eating roasted and salted peanuts. She was annoyed because the gate would not open, and choked. She was seen by her mother to become blue in the face

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for a few minutes. She was sick and brought up some nut and much sputum, and subsequently wheezed and gasped for a short time. In less than two hours she was happy again, and had no signs of fever or difficulty in breathing.

Next morning she appeared to be quite well except for slight wheezing when out walking; later in the day she felt cold and shivery. Later in the evening she was found to have a temperature of 101°, and weakened breath sounds in the whole of the left lung. There was no urgent dyspnœa.

The temperature dropped to normal the next day and remained so during the next three weeks. The breath sounds in the left lung became almost as good as those on the right side, but there was still occasional wheezing and a few rhonchi and sibili.

Her mother subsequently thought that the child looked ill and noticed that she wheezed at night; therefore she was taken to St. George's Hospital and was admitted 21st September, under Dr. J. A. Torrens, who found signs of partial deflation of the entire left lung, with very little air entry all over the base behind. X-ray examination showed the left lung to be more translucent than the right. Two days later there was much better air entry on the left side.

By the kindness of Dr. Torrens and Mr. Colledge the child was transferred to King's College Hospital on 25th September. On 26th September she had no radiological signs of foreign body. Examination by Dr. Wilfred Sheldon on 28th September showed air entry to be less good into the left lung than into the right. There were some coarse crepitations over the left lung, with a curious twanging sound. The temperature rose in the evening to 99·2 but the child appeared to be quite well and had no cough.

On 4th October Dr. Sheldon reported that air entry was equal in both lungs, and that no adventitious sounds were present. In spite of the negative reports the evening rises of temperature were disturbing, and, on 5th October, bronchoscopic examination was made with avertin anæsthesia. The complete half of a peanut, quite unchanged, was found in the left main bronchus opposite the upper lobe branch.

There were only slight signs of inflammation in the bronchi, and there was no collection of pus. The main bronchus and the mouths of the upper and lower lobe branches were red and somewhat swollen in the site of impaction of the nut, and there was slight formation of granulations on the medial and lateral walls, just above the division of the main bronchus. The after-progress was uneventful.

I am indebted to Dr. Dawe and Dr. Torrens for permission to publish the notes of the case, and to Mr. Colledge for the opportunity of dealing with it.

(2) *Lung Abscess caused by an Unsuspected Foreign Body.*—Male,

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aged 54, cured by the removal of a vertebra of a rabbit from the right lower lobe bronchus, with nine subsequent bronchoscopic aspirations.

(3), (4), (5), (6) *Lung Abscesses following Dental Extraction.*—Cured by bronchoscopy and aspiration.

(7) *Lung Abscess following Pneumonia.*—Cured by bronchoscopy and aspiration repeated six times.

(8) *Lung Abscess following Influenza and Quinsy.*—Cured by bronchoscopy and aspiration repeated eight times.

(9), (10) *Unilateral Multiple Bronchiectasis.*—Improved by repeated bronchoscopy and aspiration.

(11) *Adeno-carcinoma limited to Bronchus. Patient well, after Three Years.*—Male, aged 29, when first seen in April 1929, at the request of Dr. L. D. Burrell, had cough with much sputum and hæmoptysis, and complete absence of air entry into the right lung. Bronchoscopy showed foul pus in the right main bronchus in which a round tumour was seen on the postero-lateral wall just proximal to the mouth of the upper lobe bronchus. The pus was aspirated and the tumour was painted with silver nitrate 10 per cent.

A second bronchoscopy enabled a soft tumour the size of a large pea to be removed complete with its pedicle, cupped forceps being used. The site of attachment was clearly seen and was painted with silver nitrate. Subsequent bronchoscopic examination showed the bronchus to be perfectly clear. The patient gained 10 lb. in fourteen days after operation and the lung returned to a normal condition.

The tumour was an adeno-carcinoma invading muscle, the cells suggesting an origin from bronchial glands.

The PRESIDENT congratulated Mr. Negus on the series of cases, which showed what could be done by bronchoscopy in the treatment of lung abscess.

He was particularly interested in the second case, because some years ago he had had, at Victoria Park Hospital, a similar case, in which there was collapse of the lung, and a marked purulent expectoration during six months. The X-rays did not reveal anything, but when he examined with the bronchoscope he found a foreign body, which proved to be the vertebra of a rabbit.

These cases showed that dental extraction was responsible for a number of lung conditions which had hitherto been unexplained. They also showed that lung abscess following influenza or tonsillitis could be cleared up by this method. The least satisfactory cases were those of diffuse bronchiectasis. It was very difficult to cure them, but they were much relieved by repeated aspiration and touching the granulations with silver nitrate as they became visible.

A. LOWNDES YATES said that Mr. Negus had at his (the speaker's) request, made this selection from 100 cases of the kind. This series emphasised the fact that lung abscesses could be relieved by aspiration. A large number of early lung abscesses were being missed and remained

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too long before aspiration was performed. He did not think the full effects of a lung abscess were shown at once; it caused trouble and damage at a later period, when contraction of fibrous tissue took place. One was apt to say that because an abscess condition was emptying, the patient would get well. His (the speaker's) view was that if the emptying did not take place at a certain rate there would be trouble in the future. In one of his own cases aspiration was followed by collapse of the other lung, which was expanded again by means of oxygen. Some cases of abscess in the upper bronchus were difficult to treat, as there was apt to be a valving of the bronchus.

V. E. NEGUS (in reply), said that it was necessary for the patients to be brought, in order that they could themselves testify whether they were well or not.

The case of carcinoma of the bronchus was exceptional. The patient was perfectly well three years after having had carcinoma of the bronchus, and it was difficult to treat such a case in a way different from that adopted.

One of the patients shown was able to continue his work; he returned at fortnightly intervals for bronchoscopy, and left happily after it. Phrenic division had helped him, but some thought that procedure harmful rather than good.

In cases operated upon when the patients had septic teeth, it was the entrance of a clot containing bacteria into the bronchus, and the resulting inflammation with blockage, which caused the trouble. Removal of the thick secretion and dilatation of the granulation tissue, followed by aspiration, cured some cases.

In upper lobe cases he did not try to see the abscess, but passed a flexible tube into the bronchus. Most of his acute cases had had medical treatment when he saw them, but they had not responded to it. Any patient with pulmonary suppuration, which did not yield in a short time, ought to be examined with the bronchoscope and, if necessary, treated; there should be no period of waiting.

Perforating Foreign Body causing Rupture of Common Carotid Artery.—V. E. NEGUS.

Male, aged 53, admitted to King's College Hospital, 25th November 1931. While eating cake containing almonds, ten days before admission, he choked and coughed. He had temporary pain in the throat but no further symptoms of dysphagia until three days before admission. He then had difficulty in swallowing, but this had passed off before he came to hospital. He had had a cough continuously since the choking attack, increasing in degree, and with a moderate amount of sputum, becoming blood-stained. Indirect examination showed slight swelling of the aryepiglottic folds, but no froth in the hypopharynx and no sign of foreign body.

On admission.—Temperature 103·2°F.; pulse 96; respiration 36. No physical signs in chest except slight dullness and diminished breath sounds over the upper part of the right lung. Bronchoscopy was performed under local anæsthesia, but no foreign body was seen.

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Sudden hæmoptysis of several ounces occurred through the bronchoscope ; the blood was aspirated and the instrument withdrawn without delay. Next day there was a slight hæmoptysis; on the following day another (22 oz.), and again on 30th November (12 oz.).

On 4th December, there suddenly appeared a tense swelling on the right side of the neck, pushing the trachea far to the left. Violent bleeding, stopped by packing, occurred on opening the swelling. The patient died twenty-four hours later.

Post-mortem examination showed a small perforation on the lateral wall of the right pyriform fossa, with a track leading into a space around the common carotid artery which had sloughed for one and a half inches. No foreign body was found.

Pansinusitis with Orbital Cellulitis. Pyæmic Infection. Osteomyelitis of Frontal Bone. Operation. Recovery.—L. GRAHAM BROWN.

Female, aged 27. First seen 5th June 1931, suffering from pansinusitis, left orbital cellulitis, and superficial abscess over the left temporo-malar region. Operation the same day. Left frontal sinus opened externally and right frontal sinus opened through necrosed septum dividing the two sinuses. Both drained into left nasal fossa by a rubber tube. Both ethmoids were exenterated intranasally with removal of middle turbinates. Fluctuating area over temporo-malar region was incised and drained. Neither antrum was drained. 19th June 1931—Acute synovitis of the right knee appeared and also two small foci of fluctuation in the scalp covering the left fronto-parietal region. About 3 oz. of sterile turbid fluid were subsequently aspirated from the knee-joint, and an incision was made over the scalp abscess and pus evacuated. On 24th July a small, tender swelling appeared just below the anterior tubercle of the right tibia. From this a blood-stained fluid was evacuated. 3rd August—An epileptiform convulsion occurred, the onset beginning in the right arm. The following week two more fits occurred, but further progress was satisfactory. 31st October—There was a small discharging sinus in the scalp over the left fronto-parietal region. A skiagram showed necrosis of the frontal bone. On 18th November the necrosed bone was removed by gouge and bone forceps. The necrosis affected chiefly the outer table and diploë, though at one small point the dura was exposed. A month later the wound was completely healed.

Endothelioma of the Tonsil: Addendum to Case Exhibited Previously. *Proc. Roy. Soc. Med.*, Vol. xxiv., p. 1645 (Sect. Laryng.) —N. ASHERSON.

A recrudescence of glands in the neck was dispersed with radium, but recently the patient has developed a limp. A skiagram revealed

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a lesion in the head of the femur, and Mr. J. R. M. Love explored the hip-joint, discovering a fungating growth inside its capsule. This is being treated with radium.

Retro-pharyngeal Abscess with unusual symptoms.—N. ASHERSON.

The patient, a child, was admitted to hospital gravely ill from infection and lack of sleep, and with a history of respiratory embarrassment for a few days. When the child fell asleep the jaw fell back and respiration ceased. Holding the jaw forward re-established respiration and, to enable the patient to sleep, recourse was had to this method. The condition was analogous to that observed during deep anæsthesia. Laryngeal diphtheritic paralysis was assumed and serum administered. Direct laryngoscopy, without an anæsthetic, revealed a central globular swelling in the posterior pharyngeal wall opposite the larynx. This swelling obstructed the glottis when the tongue fell back during slumber. There was no œdema of the glottis.

The respiration immediately improved after the abscess was incised.

Lymphangioma Circumscriptum.—C. P. WILSON.

Patient, a girl, aged 13. Pain in roof of mouth for two years which became worse after measles last year. Septic tonsil remnants were removed in August 1931.

The lesion is situated on the right half of the palate, and consists of small vesicles, some of which are clear, while others contain blood-stained fluid. There are acute exacerbations during which the vesicles become purulent, and deglutition painful.

Carcinoma of Tonsil.—C. P. WILSON.

Patient, male, aged 54. Admitted to hospital, September 1931, with an ulcer of the right tonsil and the lateral pharyngeal wall below. There was an enlarged gland beneath the sterno-mastoid. Eight needles (3 cm. long, screen 0·5 platinum) containing in all 18·4 mc. radon were inserted around and deep to the growth. At the same time ten similar needles, containing in all 23 mc. radon, were placed deep to the cervical gland. All needles removed after seven days. Section shows undifferentiated squamous carcinoma. Three weeks later, surface application of radium to right side of neck for six days. Charge 241·5 mgrms., surface 116·5 sq. cm., distance 5·5 cm., filtration 1·0 mm. platinum, dose 30912 mgrm. hrs. = 231·9 mc.d.

Surface application of radium to left side for eight days. Charge 241·5 mgrms., surface 118 sq. cm., distance 5·75 cm., filtration 1·0 mm. platinum, dose 35259 mgrm. hrs. 264·5 mc.d. April 1932, no sign of growth either local or distant.

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Ear

Acute Œsophagitis in Infant.—E. WATSON-WILLIAMS.

A baby three weeks old (born four weeks prematurely) had been quite normal until it suddenly began to have difficulty in swallowing. Although it sucked vigorously, it regurgitated each mouthful at once. There was somewhat rapid, but not severe, wasting, and forty hours after the onset of symptoms œsophagoscopy was carried out. The whole œsophagus was bright red, without ulceration, and bled very slightly on introduction of the tube. The child died next day, apparently from water starvation.

Autopsy.—The only lesion was an acute inflammation of the whole length of the œsophagus; no signs of syphilis in child or in mother.

ABSTRACTS

EAR.

Correlations of Histological Observations and the Acuity of Hearing. STACY R. GUILD (Baltimore). (*Acta Oto-Laryngologica*, Vol. xvii., fasc. 2-3.)

An attempt was made to apply the numerical results by examining the ganglion cells of the spiral ganglion (following the method described last year at the reunion at Frankfurt by Guild, Crowe, Bunch and Polvogt) in each of the 48 ears whose acuity of hearing for sounds had been audiometrically examined during life.

From the correlations which exist between these results and the observations which it was possible to make by the usual methods in other essential parts of the cochlea and middle-ear cavities, it was shown that our knowledge of the rôle which each of the parts of the organ of hearing plays has not yet arrived at the stage at which it is possible to diagnose with certainty, even with the aid of the excellent audiometer curves, what are the pathological changes taking place in various individuals. The numerous combinations of different lesions which present themselves, and which could be present, hinder the satisfactory evaluation of the effect of each distinct lesion.

The work of Wever and Bray has inaugurated a new method for finding out by experiment the effect produced by distinct ear lesions on the acuity of hearing.

The preliminary results which have been obtained in the author's laboratory, after examining the lesions of the middle ear in animals by this method, indicate that we can thus obtain information which will be very important in finding out the correlation between some of the functional and structural changes observed in man.

Translation of author's abstract.

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