relaxation in spasmodic cases. The triangular space behind the œsophagus as it turns forward and to the left to enter on the diaphragmatic part of its course should be particularly noted — in malignant cases this space is often obliterated, while in spasmodic cases it is clear.

Dr A. BROWN-KELLY (Glasgow) said that in cardiospasm the œsophagoscope reveals the normal opening and closing of the hiatal œsophagus as long as the tube is kept at least 3 cm. above the hiatus, but when it is pushed 1 or 2 cm. further, the wall of the hiatal œsophagus gathers itself together so that the mucous membrane forms a closed rosette. This closure becomes firmer when the tube is pressed down more firmly. If moderate pressure is maintained for about a minute the closed œsophagus usually yields and the tube glides into the stomach. Hypertrophy of the sphincter does not as a rule occur, because the spasm is intermittent. His conclusions are :—

1. That the obstruction at the lower end of the gullet in the affection, commonly termed cardiospasm, is due to spasm.
2. That the spasm is predisposed to by a state of irritability of the muscle fibres, or of the nervous mechanism controlling them.
3. That all the endoscopic appearances are against the theory of achalasia.

Sir St Clair Thomson, Dr W. S. Syme, and the President, Dr Macintyre, also took part in the discussion. T. RITCHIE RODGER.

THE SCOTTISH SOCIETY OF OTOLOGY AND LARYNGOLOGY.

EXTRAORDINARY MEETING HELD IN THE WESTERN INFIRMARY, GLASGOW.

July 28, 1922.

President.—DR J. G. CONNAL.

Demonstration upon Analysis of Sound by Resonance.—Mr GEORGE WILKINSON—(See *Journ. of Laryngology*, September 1922).

The Relations of the Optic and Vidian Nerves to the Sphenoidal Sinus.—Dr GAVIN YOUNG—(See *Journ. of Laryngology*, December 1922.)

Two patients with Malignant Disease of the Nose. Lateral Rhinotomy—Dr J. G. CONNAL.

1. Female, aged 45, with right nasal obstruction of one year's duration, associated with discharge and bleeding. Pain and swelling over right side of nose and cheek; vascular growth in right nostril; squamous epithelioma on section. Lateral rhinotomy on 6.11.19.

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2. Female, aged 72, with nasal obstruction of a few months' duration; absence of pain and bleeding. A hard gristly growth in left nostril was extensively invaded by squamous epithelioma.

Dr WRIGHT (Bristol), congratulated Dr Connal on the first case, and directed attention to the fact that the patient had shown evidence of chronic infection in her accessory sinuses for some years before the malignant disease was recognised. He believed that malignant disease was a not very uncommon result of prolonged infection in the nasal accessory sinuses, as it was in the middle ear.

Web (Congenital?) in Larynx of Boy, aged 6—Dr J. G. CONNAL.

Dr CONNAL was inclined to delay interference, for the reason that the boy had only a slight disability in the way of a little roughness in the voice. The chest development was good.

Sir WILLIAM MILLIGAN (Manchester), thought it would be very much better to leave the patient alone. The web was in the anterior commissure and was very concave posteriorly, and would probably not give him much trouble; if divided, it would be extremely difficult to prevent re-adhesion.

Dr ANDREW WYLIE (London), agreed that the condition should be left alone, and that on no account should the galvanic cautery be used. He had used it with terrible results—great cicatrisation afterwards—and the patient was made three times worse than before.

Multiple Telangiectases of Skin and Mucous Membranes—Dr A. BROWN KELLY.—Woman, aged 55, had been subject to epistaxis since girlhood, the attacks becoming more frequent and severe. Telangiectases were noticed on the cheeks years ago. Others were present on the lower lip and right ear and several on the right side of the septum anteriorly, which were the sole source of bleeding. Small ones existed on anterior ends of right middle and inferior turbinates and a few on the dorsum of tongue, and faint traces on the palmar surfaces of the finger tips. Patient's mother, and a brother of the latter, died in consequence of nasal hæmorrhage. Other relatives have suffered from epistaxis, including her mother's father, an uncle, a brother, and a son.

Dr W. S. SYME wished to issue a word of warning. He had a similar case where the telangiectases appeared more on the septum than elsewhere. He performed submucous resection, thinking that the cicatricial tissue formed afterwards would help to obliterate the veins. The condition had become aggravated.

Sir WILLIAM MILLIGAN thought radium should be used. It would be a troublesome case, and there were a good many places where it would have to be applied. The action of radium upon the inner coat of a blood vessel was such that it would crumple it up and prevent hæmorrhage. Where the hæmorrhage was serious it would be worth while trying it, beginning at those places where it was most troublesome and using a fairly stiff dose.

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Dr BROWN KELLY said the usual tendency in such cases was for the telangiectases to increase in number and size and for the hæmorrhages to become worse. He was obliged to Sir William Milligan for his suggestions, but years ago, in a worse case, he had tried radium; although it helped somewhat, the patient died from loss of blood.

Prolapse of Left Laryngeal Ventricle — Dr A. BROWN KELLY.—Woman, aged 45, has been husky for six years and slightly breathless of late; there is no history of colds, overuse or abuse of voice, or injury. An ovoid, smooth, red growth emerges from the left ventricle, concealing the whole of the left true cord and about the anterior half of the right. On suspension laryngoscopy, the upper surface of the growth is found to be continuous with the upper surface of the ventricular band, the two being demarcated by a shallow furrow. The growth, when raised, is seen to be separate from the underlying true cord, and from the floor of the ventricle. Its consistence is that of a polypoid hypertrophy. It can be pushed outwards into the ventricle, but immediately escapes again when pressure is relaxed. The appearance closely resembles that of prolapse of the left ventricle shown in Fig. 10, illustrating Irwin Moore's paper (*Journal of Laryngology and Otology*, July 1922).

Sir ST CLAIR THOMSON suggested that the case should be entitled "So-called" prolapse of left laryngeal ventricle.

Dr BROWN KELLY said it could be easily removed. The condition was merely a continuation downwards of the edge of the false cord and was not coming from the inside of the ventricle.

Accessory Thyroid (Cystic) at Base of Tongue—Dr W. S. SYME.—Female, aged 61. The swelling was first noticed about ten years ago. The only disability is some thickness of speech. The growth is spherical, about the size of a hen's egg, pinkish in colour, and there are some fair-sized veins coursing over it. In some places it is of firm consistence, in others it appears cystic. The patient has suffered for thirty years from recurring attacks of hæmatemesis, without any gastric or other cause. It is suggested that the hæmorrhage arises from the enlarged veins on the surface of the swelling. The question of removal is at present held in abeyance.

Dr P. M'BRIDE asked Dr Syme if he was quite sure that this was a thyroid tumour. The only case of similar appearance in a man, which he had seen, turned out to be a lipoma. There was at first the feeling of a foreign body in the throat, but little real trouble. An attempt to remove it with a cold snare failed to cut through the base, so that it had to be detached by means of scissors. It recurred, and was then completely removed with the electric cautery. He had seen a second case of lipoma in the same year, and, at that time, there were only three other cases previously reported.

Dr LOGAN TURNER had shown at the June Meeting of the Society a case exactly similar to that now exhibited by Dr Syme. A piece of tissue

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removed for microscopic examination revealed thyroid gland structure. It seemed unnecessary to remove the tumour as there was no troublesome symptoms.

Mr WILKINSON (Sheffield) said he had had a case of accessory lingual thyroid with a second accessory thyroid in front of the hyoid bone: the patient was anxious to have something done. It became a question of removing one or other of the accessory thyroids, because he was not sure if there was any real thyroid. He removed the one which he thought was capable of causing the symptoms.

Dr W. S. SYME was much interested in Dr M'Bride's remarks. He thought that the tumour was too pink or red in colour to be a lipoma. He could demonstrate no thyroid mass in the neck. If it were a lipoma it should be removed, but if thyroid tissue, the question of its removal required more consideration.

Cerebellar-pontine Tumour. Removal by way of the Mastoid and Labyrinth. Death four days later—Dr W. S. SYME.—Female, aged 27. She was first seen on 7th March 1921, complaining of deafness in the right ear. Occasional tinnitus was also present. The hearing in the right ear was—Watch, 6/40. Bone conduction was good; there was no giddiness, no nystagmus, and the tympanic membrane was normal. There was no history nor sign of present or former suppuration. The Eustachian tube was patent, and inflation led to no appreciable improvement. The throat and nose showed no marked abnormality. A diagnosis of early otosclerosis was made.

On 15th March 1922, she consulted Dr Lewis M'Millan because of increasing blindness. He found optic neuritis on both sides, the left being the more advanced, and passing into atrophy. There were erratic blind-spot fields. Diplopia was present. On 16th March, Dr T. K. Monro reported that she had suffered for eight months from headaches and sickness; the headaches, usually severe, awakened her from sleep and might last from twelve to twenty-four hours; they were associated with throbbing. Diplopia had been present for a week. She has never had convulsions. All the organs are healthy; reflexes normal; smell and taste not defective; pupils equal. On 27th March 1922, again examined by Dr Syme. The deafness in the right ear had increased. About every four weeks she had a bad attack of giddiness and vomiting. The tinnitus is now masked by the throbbing. Right ear, Watch, 0/40, but bone conduction reduced. Hearing in left ear normal. With noise apparatus in left ear, loud conversation voice is heard by right at 2 feet. There is no contraction of the hearing field in the right ear as tested with the monochord. Nystagmus when eyes are turned to the right, and sometimes when turned to the left; rotatory nystagmus on looking up. The eyes are rotated, following the finger, in a jerky manner. There is paresis

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of the right sixth nerve. Vestibular reactions—Rotation, stimulating each ear in turn, gives good response. Caloric reaction (cold), almost no response in either ear. Dysdiadokokinesia of right forearm. There is a very slight right facial paresis. No sensory paresis could be detected. 28th March, lumbar puncture. Fluid clear but under greatly increased pressure (subsequently found to be sterile). A diagnosis of tumour in the region of the right internal auditory meatus or of the right cerebellar-pontine angle was made. Operation, 3rd April, the mastoid was opened, the lateral sinus exposed, the posterior wall of the mastoid and the labyrinth removed up to the internal auditory meatus, no attempt being made to save the facial nerve. On reaching the internal auditory meatus, there was a very free flow of cerebrospinal fluid. Free bleeding occurred from the superior petrosal sinus. The dura was now opened, and with the finger through the opening a firm growth, of the size of a walnut, was felt deep in towards the apex of the petrous bone. Owing to patient's collapsed state further interference postponed. 6th April, cerebellum retracted and tumour enucleated. Firm, smooth, and the size of a walnut, in structure it proved to be a cellular and very vascular glioma. Though the post-operative condition of the patient was very satisfactory, she died somewhat suddenly on 10th April.

Sir WILLIAM MILLIGAN thought that the appearance of this case at such a meeting was an extraordinary indication of the progress of the aural surgeon. As aurists, we saw a fair number of these cases, but we did not diagnose them as such. The patient, complaining of very slight deafness, or possibly of some form of tinnitus, first consulted the aurist. An exact diagnosis at the moment was of course quite impossible. In the course of about a year and a half the patient next consulted the eye specialist, as by that time there was probably some definite sign of loss of vision and possibly some atrophy. Even then it was not at all easy to say what the actual lesion was. Another period elapsed in which there was a steady reduction of vision and hearing, and then slight evidence of intracranial pressure, and the patient really became ill, but, unfortunately, at this stage it was very seldom that the aural surgeon saw the case. One of the most important nerve symptoms was the effect of the growing tumour upon the fifth nerve. When a diagnosis of tumour has been made, either cerebello-pontine or an auditory nerve tumour, the question arose as to how it should be dealt with. He believed that they should be removed by the trans-cerebellar method, because in that way only had the surgeon sufficient access, seeing that the growth encroached into the "porus acusticus." It was of great importance too that in the earlier stages of the operation the lateral ventricle should be drained in order to relieve intracranial pressure. He wished to emphasise one other point. On account of the peculiar pathological course of events, and the invasion of the "porus acusticus," it was probably, from a surgical point of view, inadvisable to try to remove the growth entirely. In that case, as much of the growth as possible should be removed. The serious thing in a situation such as this

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was the hæmorrhage. It was a very severe and grave complication from the point of view of the patient.

Dr SYME thought it possible, if another case occurred, he would prefer the trans-cerebellar route, if he was quite sure he was dealing with a tumour of the cerebellar-pontine angle.

Two Cases of Simple Stricture of the Œsophagus to emphasise the value of the Œsophagoscope in the Treatment—Dr W. S. SYME.—Two boys, aged 6 and 12 respectively, suffered from stricture, 8 to 9 inches from the upper incisors, as the result of swallowing caustic soda, sixteen and eight months previously. In the first case, a second stricture existed one inch below the first. In both cases the œsophagoscope revealed the upper end of the stricture as a small pit on the top of a pyramid, the œsophagus being dilated all round. Before it was possible to pass a fine bougie into the stricture it was necessary to anchor the pyramidal projection by passing the inner tube of the œsophagoscope. The strictures had been dilated.

Dr SYME wished to know how long it would be necessary to continue the use of bougies, and what hope he could hold out to these patients. At first he bougied once a week and then every four weeks; then he delayed for a month, and now he operated every six weeks. The second case had a fair passage way.

Sir ST CLAIR THOMSON said that we did not have the experience which they had in America in this connection, as it seemed to be a very common occurrence for the children there to drink lye. He got the impression in making a short visit to Chevalier Jackson's clinic that he passed the bougie once or twice a week. Perhaps Dr Hall Forbes could tell them more about this.

Dr HALL FORBES (New York) said that in reference to the actual technique followed, it was on the lines which Sir St Clair Thomson had already mentioned. They did not hesitate, in the early stages, to pass the instruments twice a week for probably six or seven weeks, depending on the amount of dilatation; after that, from intervals of ten days or two weeks, increasing the intervals—once in six months and once a year in very long cases. The idea was to work them up rather rapidly and then keep them open. He thought there was some irritation in the strictures of the nature of small ulcers. They had found a great deal of benefit at the time of bougieing in making an application of nitrate of silver in rather strong doses. This helped to prevent contraction.

Cases were also shown by Mr James Russell, Drs John W. Leitch, W. Charles Macartney, and G. B. Brand.

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