infections commencing over both infra-orbital areas; the appearance was one of acute infection of the antra of Highmore and the frontal sinuses; these were, however, quite healthy. During the second anæsthetic the antra were punctured and no evidence of sepsis found; the nasal cavities were healthy throughout. It is difficult to conjecture what was the path of infection to the two infra-orbital areas.

It is also curious that the tonsillar and nasopharyngeal areas healed in a perfectly normal manner despite the secondary sepsis.

SOCIETIES' PROCEEDINGS

ROYAL SOCIETY OF MEDICINE—SECTION OF LARYNGOLOGY.

SUMMER MEETING.

June 9, 10, 1927.

President.—ANDREW WYLIE, M.D.

Chronic Hyperplasia of the Upper Jaw—F. BRAYSHAW GILHESPY, M.R.C.S.

The paper is published in the *Journal of Laryngology and Otology*, Vol. xlii., p. 721, November 1927.

DISCUSSION.

Mr WALTER HOWARTH said he had recently shown two or three cases of this kind which he had followed up for several years. In one of these he had removed the swelling seven years previously and in another three years, and the condition afterwards had remained stationary up to the present time. He did not suppose that he had removed all the disease. In both these cases the original site was the alveolus, and most probably dental sepsis was the real cause.

Dr W. H. KELSON said that he had only had two such cases under his care, and in neither was there any dental sepsis; clearly, extensive removal of teeth was not warranted. Sir Victor Horsley had had considerable experience of these cases, and was inclined to operate freely; but after free operation the patients seemed to go from bad to worse. There was need for a closer study of the pathology of this rare condition.

Dr T. RITCHIE RODGER said he had read a paper before the Scottish Society of Otology and Laryngology describing a case of the kind, which he had entitled leontiasis osseum. There had been large bosses on the left maxilla, and one on the right mandible. He had lost sight

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of the patient for three or four years; then she had returned and several bony rhinoliths had to be removed. The Wassermann reaction, which had previously been negative, was then positive. He (the speaker) advised that this test should be carried out repeatedly in these cases.

Mr DOUGLAS GUTHRIE said that in the Museum of the Royal College of Surgeons of England there were two specimens of hyperplastic upper jaws which had been removed, presumably because the operator thought he was dealing with malignant growth. He (the speaker) showed slides of these bones illustrating how the antrum became compressed and small. One of the specimens had been removed by Lord Lister; in no case was there associated dental sepsis or decay.

He also showed the photograph of a small boy whom he saw six years ago, the condition having been verified microscopically. He saw the boy again recently, and the size of the swelling of the jaw had not increased. The condition apparently caused no inconvenience.

Another case, that of a girl aged 15, he had followed for several years. Recently tuberculosis had developed and the patient was now in a sanatorium. In this case there was definite dental sepsis.

Mr J. HARPER said he now had three cases of the kind under his care; one in a girl, aged 15, with extensive enlargement of the right upper jaw. He first saw her four years ago, when he chiselled away as much of the bone as he thought necessary in order to improve the contour of the face. A month ago she returned with a projection upwards of the floor of the orbit. Microscopic sections showed the usual fibrous changes, but no malignancy. It had now become necessary to remove the jaw in order to save the sight.

Dr J. S. FRASER said that the appearances shown in Mr Gilhespy's lantern slides were much like those seen in the labyrinth capsule in otosclerosis, and pointed to both conditions being of a chronic inflammatory nature. There was some support for his view that otosclerosis was a chronic inflammatory process. The bony inner wall of the middle ear was covered by mucous membrane, and the inflammatory process might spread from the deep layer of the mucous membrane into the bone in the region of the anterior margin of the oval window. There were special circumstances in this region which rendered infection liable to occur, such as the anastomosis between the vessels of the labyrinth capsule and those of the periosteal bone, as described by Politzer. Another factor was the presence of the tensor tympani tendon.

Dr LOGAN TURNER asked that this subject might be taken up as a collective investigation in connection with the general pathologist, and that a small committee might be appointed.

Mr GILHESPY (in reply) said interesting cases of osteitis deformans had been shown recently by Mr Jenkins, and these cases bore an analogy to those of otosclerosis, as Dr Fraser had pointed out.

Some Points in the Technique of Laryngofissure—WALTER HOWARTH, F.R.C.S.

The paper is published in the *Journal of Laryngology and Otology*, Vol. xlii., p. 725, November 1927.

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DISCUSSION.

Dr ANDREW WYLIE (President) said that in two cases in which he had performed laryngofissure without preliminary tracheotomy, he had had difficulty with the hæmorrhage, and after the operations the patients had coughed so severely that he was obliged to open the trachea immediately.

Professor G. PORTMANN (Bordeaux) said that in his clinic the custom was to do this operation without preliminary tracheotomy. If there was severe hæmorrhage, but that was exceptional, one was not in a good position to deal with it, but one could then do tracheotomy. The rule was to perform the operation under local anæsthesia, and usually there was no trouble.

Mr N. S. CARRUTHERS said he questioned whether no blood at all passed down the trachea when ether was administered through the trachea.

The tube lay in the posterior part of the trachea, and at the point of contact the upward pressure of air was insufficient to prevent blood flowing downwards. This fact could be easily demonstrated in the laboratory. The small quantity of blood so passing might account for the severe bronchitis or pneumonia which occurred afterwards in some of the cases.

Sir ST CLAIR THOMSON said that, having himself performed some eighty laryngofissures, he had naturally arrived at certain opinions. But while holding certain opinions, it was very important for the surgeon's outlook that his opinions should not hold him. He therefore tried to rid his mind of prejudice—a very difficult matter.

With regard to the question of the removal of the thyroid ala: He had seen the beginning of laryngofissure in this country, as he had helped Sir Henry Butlin and Sir Felix Semon in that operation, and they did not remove the cartilage in question. Its removal, he thought, was first suggested by Broeckaert, of Ghent, at a congress in Paris, some time before Dr Lack suggested it. Besides, Dr Lack did not suggest it as a step in the median laryngofissure operation, but as a window resection from the side. He (Sir St Clair) first tried it on Broeckaert's suggestion. Before employing it he had had two or three cases in which there was some necrosis, and small portions of the cartilage were coughed up during convalescence. Since he made a practice of removing the ala that had not happened. That the ala might form a barrier was a very wise suggestion, and in the study of malignant disease this question of Nature's barriers and how they could be conserved was one which merited careful study. In one of his early cases, in which he had not removed the cartilage, the patient had returned seven years later with an epithelioma on the opposite side, and a second laryngofissure was done; he had shown that patient recently (four years after the second operation) to the American surgeons who were visiting this country. There had been no recurrence, a fact that might be due to his having left the cartilage, which had formed a barrier. He had, however, had another case, that of a female, aged 33, on whom he was doubtful whether the laryngofissure would be successful, as the whole extent of the cord was involved and it did not move very freely. However, he had performed the operation and removed the ala. Within five months there was a recurrence, but the patient deferred

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coming for another three months, and when she returned the whole side of the larynx was so fixed and infiltrated with the growth that he had handed her over to Mr Wilfred Trotter, who had operated successfully and turned in a flap. That was seven years ago, and the patient was still well and earning her own living. She wore a tracheotomy tube because of the stenosis. Removal of the ala gave a larger field. It was a mistake to talk of the alæ being forced apart. They could be fairly well separated, and if one ala was taken away and only soft tissue was left, there was a freer approach, and one could study the extent of the trouble. In the cases in which the ala was removed the glottis was larger than in those in which it was left, and the bare cartilage on one side was more slowly covered over with granulations than were soft tissues. The longer the covering process took the greater was the contraction, and in the cases in which he had left the bare ala to cicatrise over there was a smaller glottis than when he had removed it. He could show four cases of laryngofissure in which the patients were medical men who were now using their voices, the most recent operation being two years ago. The barrier did not consist in the cartilage, but in the perichondrium, and he was always careful to preserve the external perichondrium.

With regard to preliminary tracheotomy, his (Sir St Clair's) principle was "safety first." Tracheotomy added no danger to the operation, and it caused no shock. He had operated on a patient aged 80, whose blood-pressure was 200 mm., and had had occasional attacks of angina pectoris. That patient had been sitting up and playing cards within twenty-four hours of the operation, and was alive and well three years afterwards. Another patient, with a blood-pressure of 200, was out of bed reading on the evening after the operation. The injection of cocain, and other precautions, prevented coughing, splashing, loss of blood and shock. He could not understand how a fairly large ether tube in the interior of the glottis could facilitate the view of the extent of the disease. Blood could be cut off absolutely by tracheotomy and the careful packing with gauze above it.

Reports of successes along various lines were published from time to time, but little was heard—except indirectly—of failures and of the accidents which occurred owing to the non-insertion of a tracheotomy tube —three of these had come to his notice during the previous winter. He (Sir St Clair) was anxious that the high reputation which laryngologists in this country had obtained with regard to this operation should be maintained. In his eighty cases of laryngofissure there had been, as everyone knew, three deaths ; one of those was due to rupture of the œsophagus, and the other two followed mistaken doses of heroin and morphia.

Mr W. M. MOLLISON said he had performed laryngofissure on two or three occasions with intratracheal ether, and the tube had not been in his way ; it lay in the posterior commissure, out of the line of vision.

Mr HOWARTH (in reply) said that in his later cases he had had better results and an easier passage than in earlier ones in which he had first performed tracheotomy. In his early laryngofissure cases he had had three deaths, and those were caused by blood getting into the trachea. He had

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not found the objection which Mr Carruthers mentioned. There was always a return current of air which blew anything upwards, even from the upper end of the trachea. He thought that if the ala was removed there might be a more diffuse recurrence in the neck tissues. He did not think the ala greatly limited the view.

The Relation of Nasal Polypi to Inflammation of the Accessory Sinuses of the Nose—T. B. LAYTON, D.S.O., M.S.

The paper is published in the *Journal of Laryngology and Otology*, Vol. xlii., p. 729, November 1927.

DISCUSSION.

Dr W. S. SYME said he had taught for years that in all cases of multiple polypi in the nose there was antral as well as ethmoidal disease. He opened the antrum in these cases, and had never regretted doing so, for the same changes were there as in the membrane of the nose. He did not agree with Mr Layton's rigid demarcation of catarrhal from purulent sinus disease, though the catarrhal element might be more evident in one case than in another. Even if there was a negative result from washing out the antrum he was not deterred from opening it. He had so far lacked the courage to do an external operation on the ethmoid, because it might result in some subsequent disfigurement. With careful precautions he thought one could radically operate on the ethmoid from inside the nose.

Mr C. A. S. RIDOUT said he did not consider that the catarrhal and suppurative types were separate entities, though one case might be more catarrhal, another more suppurative. He agreed with Dr Syme's remarks about the antrum ; in severe nasal polypi the antrum seldom escaped. He thought the external operation was not done often enough. In one case of his own, after two or three fairly thorough curettings of the ethmoid region, the patient had remained incapacitated. He then carried out a double external operation on the ethmoid, and the patient had now returned to her work.

Dr J. S. FRASER said that last year he had discussed the recurrence of nasal polypi with Dr Otto Hirsch of Vienna. Dr Hirsch maintained that these recurring polypi came from the maxillary sinus through an accessory or even through the normal ostium. He (Dr Fraser), acting on that view, had opened the maxillary antrum in a number of such cases. In several of these the antral mucosa had been polypoid, and polypi could be seen passing into the middle meatus through the accessory ostium. But in one or two of the cases the mucosa of the maxillary sinus was healthy and certainly not polypoid. He therefore felt doubtful about performing the Caldwell-Luc operation in all cases of recurring nasal polypi.

Many years ago he (Dr Fraser) had published a paper on chronic inflammatory œdema of the submucous tissues of the nose,* *i.e.*, polypoid middle turbinals and so-called "hypertrophy" of the inferior turbinal which did not subside on applying cocain and adrenalin. The inflammatory change was really the same in the two conditions. It was a chronic inflammatory œdema, spreading in the deeper layers of the submucosa,

* *Journ. Laryngol. Rhinol. and Otol.*, 1908, xxiii, 402.

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between the superficial layers of epithelium on the one hand, and the glands and blood spaces on the other.

He agreed with Dr Syme that there was no essential difference between chronic catarrh and chronic suppuration. In the suppurative form leucocytes were present in the discharge in large numbers, while in the catarrhal they were comparatively few. It was a question of the virulence of the infection and of the resistance of the patient—not a real difference in the pathological process.

As to radical operation in these cases, radiograms could not always be depended on; a better criterion was furnished by proof-puncturing the antrum and washing it out. If the infected fluid returned easily, the antrum was not filled with polypi; but if one had to exert pressure with the Higginson's syringe the mucosa was probably polypoid and the radical operation was required.

Mr JAMES ADAM said that not enough emphasis was laid upon the effect of pressure in causing polypi. If the uvula was caught between the two enlarged tonsils, it became polypoid. If there were inflammatory swellings about the middle turbinal, and the mucosa was compressed between the septum and outer wall, polypi formed, and they continued to form until the pressure was relieved by dealing with the septum, or the outer wall, or both.

Mr F. B. GILHESPY said he was interested in hearing that it was possible to perform an external operation in such a case through a small incision. He had always used a longer incision than Mr Kisch did, and turned the eye outwards, so as to get back to the sphenoid. Patients required a guarantee that there would not be a recurrence of polypi, therefore the operation must be a thorough one. He would like to hear statistics relating to the Sluder operation, which would give an indication of its dangers.

Professor PORTMANN said that in most cases polypi of the nose had a connection with the ethmoid, especially when they were multiple. Sometimes when the nasal polypus had been removed it was necessary to operate on the antrum. In diagnosing maxillary sinusitis one could begin by puncturing and washing out the sinus, and with the sinuscope one could see the condition of affairs. Removal of ethmoidal cells could be carried out by intranasal operation. This operation did not destroy the sense of smell, and was not dangerous at all when performed with the aid of Moure's curette.

The Occurrence of Brain-tissue within the Nose: the so-called Nasal Glioma—DOUGLAS GUTHRIE, M.D., and NORMAN DOTT, M.B.

The paper is published in the *Journal of Laryngology and Otology*, Vol. xlii., p. 733, November 1927.

DISCUSSION.

Dr LOGAN TURNER said he had removed the polypi in the second case some years previously. They had the appearance of ordinary nasal polypi. Was it not possible that in this case there might be a large congenital gap in the cribriform plate, and that there might originally have been an encephalocele projecting through it?

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Professor PORTMANN said that such cases were seldom seen in Bordeaux, but one or two had been observed, the patients being infants. Mr Guthrie's were particularly interesting because the patients were adults. The question was whether the condition was one of simple glioma or of glio-sarcoma. In the present case there seemed to be evidence of malignancy.

Dr J. S. FRASER asked whether in such cases there was anything in the appearance in the nose which would warn the observer that he was dealing with something beyond ordinary nasal polypi.

Mr DOUGLAS GUTHRIE (in reply) said that the paper described two different conditions. The first was a glioma of the frontal lobe, which invaded the nose. The second he did not regard as glioma, but as an encephalocele which developed in the nose, probably in embryonic life, and later became involved in a nasal polypus. To find such a condition in an adult was very unusual. Possibly the patient had "ordinary" nasal polypi previously. Clinically, the polypus could not be distinguished from the common type, though it was rather tough and fibrous. The microscope alone gave a clue to the unusual nature of the tissue.

Meningitis of Sphenoidal Sinus Origin—M. VLASTO, F.R.C.S.

The paper is published in the *Journal of Laryngology and Otology*, Vol. xlii., p. 746, November 1927.

DISCUSSION.

Dr P. WATSON-WILLIAMS said that probably there were few who could always diagnose in time the source of infection in these cases. In children, especially, one was apt not to think of the question of sphenoidal sinus infection in such circumstances, and there was a belief that in childhood sphenoidal sinus infections were extremely difficult to deal with. He, himself, explored the sinuses in practically all mastoid cases, and often he found conclusive evidence of previously unsuspected suppuration. Exploration of the sphenoidal sinus did not involve removal of any part of the middle turbinate. It was easy, with the blunt cannula, to enter the sinus and to suck up any contained discharge, first from one side and then the other side. In a child, especially, he usually began with the maxillary antrum, and if this was uninfected and there was reason to suspect the sphenoidal sinus, that would be explored, when the presence of infective discharge would be revealed.

As to the route of infection, at first he thought it was through the bony wall, but he now doubted it. Few pathologists appeared to look upon the sinuses as worthy of careful routine examination. In such cases it was important to know the exact route taken by the infection, and therefore the sphenoidal sinuses and ethmoid labyrinth should be removed *en bloc* and submitted to careful investigation. He thought many cases of coccal meningitis were of nasal origin.

Mr NORMAN PATTERSON asked whether the ethmoidal cells were opened and whether they were suppurating.

Dr LOGAN TURNER thought it very unfortunate that the sphenoidal cavities should be opened at the time the post-mortem examination was

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made. One could not tell by naked-eye observation the route of infection. Much information could be obtained from the examination of the accessory sinuses if the block containing the ethmoid and sphenoidal sinuses were removed, and the diagnosis postponed until a complete microscopical examination could be made.

In this case there did not appear to have been cavernous sinus thrombosis. But many cases of leptomeningitis associated with sphenoidal sinus suppuration were secondary to septic thrombosis of the cavernous sinus, due to a retrograde septic thrombosis of the veins which threw their blood into the cavernous sinus, many of these veins being meningeal. It was not always necessary that there should be clinical signs of cavernous sinus thrombosis.

What was the direct route of infection from the sphenoidal sinus to the leptomeninges? One would naturally say by the lymphatics, but so far as he knew no direct lymphatic route had been traced anatomically from the sphenoidal mucous membrane to the pia-arachnoid meshes. It was a point needing further inquiry.

Sir JAMES DUNDAS-GRANT said that in many cases, if the sphenoidal sinus was opened post-mortem, a muco-purulent fluid would be found, which was not generated there as a result of inflammation of the sinus, but had entered post-mortem when the cadaver was on its back. A little muco-pus in the sphenoidal sinus was therefore not of the same significance as it was when in the ethmoidal cells.

Sir ST CLAIR THOMSON said that in a paper, written twenty-two years ago, he had reported two cases with cerebral complications and death—not traumatic or surgical—from sphenoidal sinusitis, which had been diagnosed in life and fully proved by post-mortem examination. He was disappointed to hear that examination of the sinuses was not a systematic part of every post-mortem ; he hoped those engaged in active practice would persuade their colleagues not to omit this routine. It could be readily done without disfiguring the face of the cadaver. After the skull-cap was taken off, by sawing down the bone to the root of the nose and behind to the foramen magnum, the two halves of the skull fell away from each other, the sphenoidal block could be removed, and the skull could be put together again and the skin stitched.

He asked whether Mr Vlasto said he removed the middle turbinal to give drainage? The speaker questioned whether it was wise, in acute sphenoid conditions, to produce any traumatism in the nose beyond a proof-puncture of the antrum, as it had been shown that in acute sinus disease this tended to open the blood- and lymph-channels.

Mr VLASTO (in reply) said he regretted that, for reasons stated in the paper, no steps had been taken to preserve the specimen of his case *en bloc*. He could not state whether or not the ethmoidal sinuses were infected, because they had not been specifically investigated. The cavernous sinuses were incised, and they had contained liquid blood. He would not care to say definitely that there was not a mural thrombosis. The statement that the meningitis was of sphenoidal sinus origin was based on the facts that the sphenoidal sinuses were filled with pus, that the meningitis was basal in position and extended from the region of the optic chiasma to

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the pons, and that no other cause of the meningitis was found. He agreed that ante-mortem diagnosis would probably not have saved the patient's life, but this was no excuse for the fact that a diagnosis had not been made. Of the very few cases in which an ante-mortem diagnosis had been made, two of these were reported by Sir St Clair Thomson, and in both cases the patients had died. He noted the fact that Dr Watson-Williams would have proof-punctured the sphenoidal sinuses in a case such as had been reported, but he, personally, had not found sphenoidal sinus puncture in the case of a child either so reliable or so easy to perform as one might be led to believe.

Three Bronchoscopic Cases—W. S. SYME, M.D.

The paper is published in the *Journal of Laryngology and Otology*, Vol. xlii., p. 751, November 1927.

DISCUSSION.

Sir JAMES DUNDAS-GRANT said that he had had a case resembling one of Dr Syme's. The patient had had dyspnœa and stridor, chiefly inspiratory. With the bronchoscope a fimbriated body which moved with the breathing was seen at the bifurcation. He (Sir James) had removed this and the breathing had afterwards been perfect. One passage of the bronchoscope relieved the patient during a subsequent attack of dyspnœa. There was a syphilitic stricture of the trachea. The patient had improved greatly under appropriate treatment, and was allowed to go home, with the injunction to return if he had serious symptoms again. He did not return, however, until the dyspnœa was extreme, and on the night after his arrival he died.

Mr RITCHIE RODGER said the moral of Dr Syme's second case was that when laryngologists were asked for an opinion by their physician colleagues they should be careful to say they could not see anything with the laryngoscope, but that they would like to make a bronchoscopic examination. Two years ago he (the speaker) was asked to see a man suffering from what appeared to be an attack of asthma. He could not find anything unusual in the larynx. A bronchoscopic examination was not made, and after death a papilloma just above the bifurcation was found, similar to that occurring in Dr Syme's case.

Dr SYME (in reply) said that at the Scottish Society, a year ago, he had pressed the point, as Mr Fraser had done, that bronchoscopic examinations should be much more frequently carried out.

CLINICAL MEETING.

June 10, 1927.

FURTHER REPORT OF CASE PREVIOUSLY SHOWN.*

Laryngeal Lesion Associated with Apparent Miliary Tuberculosis of the Lung—WALTER G. HOWARTH, F.R.C.S.

Mr HOWARTH said that this patient was not now appreciably worse than when last shown, but the point of interest was the associated lung

* *Journ. of Laryng. and Otol.*, Vol. xlii., p. 392, June 1927.

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condition, and the analogy to the other case, the skiagram from which he had shown—that of the patient who had died from miliary tuberculosis in the lung. It was suggested that a blood-infection had already taken place, and that it was merely a matter of time for it to progress through the lung and for the tubercles to break down.

Tumour of Nasopharynx: Case for Diagnosis—WILLIAM IBBOTSON, F.R.C.S.—Boy, aged 7, made noises when breathing during sleep; had persistent nasal discharge. He was treated daily at the local hospital since August 1926; has recently received an external application of radium.

Examination, 21st March 1927.—Nose: both nasal passages blocked with a hard suppurating mass. Nasopharynx: also filled by the above. Mouth: downward bulging of soft palate. Transillumination: frontal sinuses clear; right maxillary sinus clear; left maxillary sinus dim.

Operation.—The tumour was found to be very firmly fixed to the tissues forming the choanæ, and though the nasopharynx was completely cleared, it was found impracticable at this operation to attempt to remove the above fixed portion owing to the unsatisfactory condition of the patient.

Unfortunately the patient died from shock a few hours later.

Diagnosis.—It has been suggested that the tumour is of the nature of (*a*) an odontoma, (*b*) a teratoma.

Mr BROUGHTON BARNES said he had had a case in a baby in which there was a skin-covered tumour in the nasopharynx, growing from the basisphenoid. It was readily removed with a diathermy snare and there was no hæmorrhage.

Mr HAROLD BARWELL said that splitting the palate was not always the best way to reach these sessile nasopharyngeal tumours. Better access was to be obtained by lateral rhinoscopy.

Mr IBBOTSON said that Mr Layton had suggested to him that the tumour should be called epignathic teratoma.

Intralaryngeal Tumour in a Baby aged Fourteen Days—WILLIAM IBBOTSON, F.R.C.S.—Infant, first seen on 5th November 1926, with crowing inspiratory stridor since birth; now increasing, with cyanosis. Tracheotomy performed two hours after admission.

7th November 1926.—Patient had progressed fairly well until this morning when he became deeply cyanotic and died.

Post-mortem examination revealed the heart, healthy. Lungs with patches of atelectasis in both organs. Thymus, extremely large. Larynx with upper aperture very narrow, with marked lateral incurving of both ary-epiglottic folds. A sprouting growth on each cord. Trachea healthy everywhere; no clot; no evidence of obstruction present.

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Mr IBBOTSON said it would be interesting to know if any member had met with such a case at an earlier age.

Tumour of Frontal Bone—WILLIAM IBBOTSON, F.R.C.S.—Male, aged 29, about eighteen months ago was admitted to hospital in the following condition: completely unconscious; a large Pott's puffy tumour over the nasion; history of recent fits; history of an operation on the frontal bone in 1918.

Operation: immediate. A large ivory exostosis was removed from the diploic tissue of the frontal bone; there was suppuration and definite pressure on the dura mater, which was not itself apparently traumatised in any way.

Patient recovered consciousness within twenty-four hours and made an excellent recovery.

19th May 1927.—For several months past patient has consistently complained of "pressure" headaches, which occur with slowly increasing severity and frequency: there is also slight vertigo. General health good; he is able to perform his work.

Clinical examination and radiography suggest that a further exostosis is present.

Mr RITCHIE RODGER said he was showing the skiagram and specimen of a recent case of his own. It was that of a woman aged 26, who had first come to hospital seven years ago, with a round, hard tumour in the ethmoid region, in the midline, obviously an osteoma. He had removed this growth by means of a horizontal incision, and after making preparations in anticipation of hæmorrhage, he found that one blow with the mallet dislocated the tumour, so that it was easily lifted out. He could see into the frontal sinuses, and both were normal. The wound healed by first intention, and the deformity disappeared. Two weeks ago she had returned with a complaint of considerable pain in the left temporal region, and some displacement of the left eye downwards with œdema of the upper eyelid. The temperature was 101° F. X-ray examination showed a dense, bony growth occupying the whole left frontal sinus, involving the left ethmoid, and projecting into the left antrum. He operated by making an incision as for the radical frontal sinus operation, and found that the tumour had filled the frontal sinus and eroded the inner table of the bone. The roof of the sinus was eroded to the extent of a square inch with the dura mater exposed, the whole tumour lying in pus. He then had to remove the inner wall of the orbit, which was involved in a dense, rounded, bony tumour mass extending downwards into the upper part of the antrum. The wound had healed by first intention, but there was considerable flattening of the left frontal region.

Mr GRAHAM BROWN thought that this was a condition similar to ivory exostosis growing from the frontal sinus. The treatment was radical removal. He himself had had a case in which the tumour grew from the cavity of the frontal sinus, and appeared clinically to be an ethmoiditis, as there was a red swelling in the region of the inner canthus. A skiagram

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had shown the usual dense appearance. At operation an ivory exostosis was found protruding into the orbit, into the frontal sinus which was much enlarged, and also back towards the sphenoid through the ethmoid cells. It had come away fairly easily, piecemeal. The muco-purulent discharge was confined to the frontal sinus; there was no evidence of discharge in the nose. The mucous membrane of the ethmoid region had not to be removed.

Cure of Chronic Empyema of the Antrum after Operation on the Frontal Sinus—HAROLD KISCH, F.R.C.S.—Female presented herself at hospital with a left-sided purulent discharge from the nose. On examination both antrum and frontal sinus contained foul pus, and the X-ray plate showed dense shadows. Operation on the frontal sinus was carried out by the method recently described by the author, and lavage of the antrum was subsequently performed. After three washings the antrum remained clear, and the patient is now quite well. The scar of the operation is practically invisible.

Mr HERBERT TILLEY said that in many cases the antrum was merely the receptacle of pus, and its mucous membrane was not itself diseased. Some members might remember a case he (the speaker) had shown many years ago, in which both frontal sinuses had been opened externally for chronic empyemata, but the antra had not been washed out after the operation, although beforehand they were filled with pus. He had seen the patient about once a year since and had never observed any signs of antral suppuration. If the discharge from the upper sinuses was checked, the antra in many cases would take care of themselves.

Mr T. B. LAYTON said he thought that this condition should be called pyosinus* to distinguish it from inflammation of the maxillary sinus. It was true that he did not know how to tell the one from the other, but the nomenclature was needed in order that the difference might be borne in mind. Thereby we might learn to make the diagnosis in the future.

Dr W. S. SYME asked whether Mr Tilley deliberately used the word "many." He hoped not, as his own view was that there were not many cases in which the antrum was merely filled with pus from the frontal sinus.

Mr TILLEY (answering Dr Syme) said that perhaps he had used the term "many" somewhat loosely, but during thirty years he had seen a number of such cases, in which the purulent discharge in the antrum cleared up after the frontal sinus suppuration had been cured. The cases were parallel with those in which pus was passed with the urine. This might come either from the kidney or the bladder, or from both, but if only from the former the "purulent cystitis" might cease when the renal lesion was cured and without any direct treatment of the bladder.

Mr SOMERVILLE HASTINGS said Mr Kisch was to be congratulated on the result in this case, as it was an open question whether this was a justifiable operation. Many years ago he had seen two cases in which the

* After Hajek (*vide* "Nasal Accessory Sinuses," 1926, i. 230).

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ethmoidal region was operated upon in the presence of an antrum containing foul pus. Both the patients had died from meningitis, and the fact made a profound impression upon him (the speaker). In his opinion it was very doubtful whether one was justified in doing anything operative to the upper region of the nose when there was a definite reservoir of pus in the antrum. He did not think a cavity like the antrum could contain pus without having some infection of its mucous membrane. His practice was to abstain from any operative procedures in the upper regions of the nose when the antrum was full of pus. In the present case he would have dealt with the antrum first, leaving the frontal sinus until later.

Mr KISCH (in reply) said he agreed with most of the remarks that had been made. The difficulty was to determine beforehand whether the antrum was acting merely as a cistern, or whether it was actively diseased. Before doing an antrum operation he made it a practice to try to ascertain whether the frontal sinus was diseased. For that reason he had all the sinuses examined by X-rays. If the frontal sinus was implicated, he operated upon that first; he did not see how one could expect to get a successful antrum result if the frontal sinus was diseased. He washed out the antrum beforehand. During the operation he was careful to avoid unnecessary damage to the bone, therefore he did not use burrs or rasps. Then, he thought, there was no extraordinary risk to the patient.

Enlargement of the Frontal Bone, Maxilla and Mandible—T. JEFFERSON FAULDER, F.R.C.S.—Female, aged 26, had enlargement (unilateral right) of the frontal bone, maxilla and mandible, with right nasal obstruction.

The growth had ceased when the patient was aged 21.

Mr W. M. MOLLISON said that the skiagram was much like that seen in Paget's disease.

Mr NORMAN PATTERSON said he had seen the patient seven years previously, and the growth had not altered since then.

Three Cases of Epithelioma treated successfully by Deep X-rays—W. M. MOLLISON, F.R.C.S. CASE I—Male, aged 54, was seen in September 1926, on account of "sore throat" of twelve weeks' standing. There was a large epitheliomatous ulcer on the left side of the back of the tongue extending as far as the epiglottis.

The ulcer had the typical hard raised edge of epithelioma. The patient had been advised to have his tongue removed.

Diathermy was carried out in October 1926, but on account of the position of the ulcer great difficulty was experienced; indeed it is doubtful whether any good was done, as on 15th December the ulcer had become larger.

Dr Watt gave a series of doses of deep X-rays in November 1926, and again in December 1926.

It will be seen that the tongue now presents a smooth, almost normal, surface over the site of the previous ulcer; has gained $5\frac{1}{2}$ lb. in weight.

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CASE II.—Male, aged 54, was seen in January 1923. There was a large epithelioma involving the posterior part of the tongue and epiglottis; it was so extensive as to overhang the larynx. Diathermy was applied. Dr Watt then gave two series of doses of deep X-rays, October 1923 and January 1924. Last dose, a single one, in July 1924.

Examination now shows a smooth, supple scar at the back of the tongue. Patient has put on 2 st. in weight.

CASE III.—Male, aged 52, was operated upon three years ago at Guy's Hospital for growth of the right antrum and ethmoid; section showed squamous epithelioma.

A further operation for recurrence was performed and finally sixteen months ago the right eye was removed on account of extensive orbital involvement. Dr Watt gave five series of doses of X-rays—the last fifteen months ago. The patient has put on 2½ st. in weight and is back at work.

Sarcoma of the Tonsil treated by X-ray Therapy and Excision—C. GILL CAREY, F.R.C.S.E. — Female, seen on 31st March 1926, complained of swelling in the throat of six weeks' duration.

Examination showed a large, firm mass, without ulceration on its surface, occupying the right tonsillar fossa. There were no palpable glands in the neck.

As the patient was then eight months pregnant, it was decided to postpone operation until the child had been born. The growth increased so rapidly in size, however, that dyspnœa occurred, and the patient was shown to Dr W. L. Watt, who treated her with deep X-ray therapy on three occasions between 9th and 13th April. This treatment reduced the size of the tumour sufficiently to allow her to have a normal labour on 15th April.

Five days later the tumour was removed through the mouth. Sections cut from it were reported on as sarcoma.

Following the operation a second series of three radiations was given.

Dr ANDREW WYLIE (President) said that Mr Mollison's cases were so successful that it appeared as if in the future surgery in this region would be replaced by the use of irradiation.

Mr NORMAN PATTERSON said he was much impressed with these results, and asked whether in each case a specimen had been taken for microscopical verification. It would be interesting to know whether or not there was a tendency to differentiation of cells.

Mr A. R. TWEEDIE asked for further details as to the treatment.

Dr JOBSON HORNE asked how many attendances on the part of the patient the deep X-ray course necessitated.

Mr MOLLISON (in reply) said that the first case which drew his attention to the enormous value of deep X-ray therapy was that of a

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woman whom he had seen four years ago, because she was suffering from a postcricoid carcinoma; ulceration could be seen above the arytænoids, and she was only able to swallow water. Dr Finzi applied X-rays deeply; three weeks later she could swallow fluids comfortably, and six weeks later she was able to swallow almost anything. She was still alive and well. He then decided to employ this method in all cases in which recurrence was probable and the approach to the region was very difficult. Dr Watt, of Guy's Hospital, was an enthusiast in this matter, and at his own cost he had supplied to the hospital a deep X-ray apparatus. He (the speaker) had asked Dr Watt to treat his cases of this kind. Members of the Section knew the brilliant results obtained by Mr Norman Patterson by diathermy, but, in his own hands, diathermy had not been a success for growths in difficult situations.

In only two of the cases were microscopical sections taken. In the first case it seemed so obvious that the growth was carcinoma, it did not seem necessary to take a section. In the second case, growth of the epiglottis and the deep pharynx, a section was taken, and showed squamous-celled carcinoma, which was the nature of the growth in the case of the man whose orbit had been exenterated.

He could not give Mr Tweedie the details as to the tubes used; he hoped Dr Watt would read a paper on the subject before the Section during next Session. Dr Watt usually gave the treatment from forty to sixty minutes three times in the first week, aiming the rays at different portions of the neck. If the result seemed to be good, an interval of a month or two months was allowed, then another series of doses was given, of much the same duration. He (the speaker) thought that the results in cases of sarcoma were more striking than those in cases of carcinoma. For example, he had seen, fifteen months ago, a patient who appeared to be in the last stages of sarcoma of the nasopharynx. He had suggested treatment by deep X-rays, which was given by Dr Carter Braine, Dr Watt's assistant, and in a week that patient was practically well. Dr Braine, however, thought there would be recurrence in a short time, and sent the patient back to his home in South Africa, whence letters later arrived from his friends stating that no disease could be seen, and indeed doubting the previous presence of growth. The man had remained free from disease for a year.

Papilloma of Stenson's Duct followed by great enlargement of Parotid Gland: Case for Diagnosis—H. NORMAN BARNETT, F.R.C.S.—Male, aged 71, was first seen last year suffering from rheumatism and complaining of pain in the throat of a year's duration.

On Examination.—Tonsils unhealthy; papilloma of Stenson's duct (left); throat and mouth were treated and patient rapidly improved. He returned later with ulcerated surface of the hard palate. Ultra-violet rays now used for the throat and surface of the palate; condition temporarily improved but subsequently became worse. Patient underwent radium treatment which had the effect of improving ulcerated surface. Some months later his doctor reported that he had acute

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illness, the nature of which he did not know. Symptoms pointed to mumps. When seen again there was found to be a papilloma of Stenson's duct on right side with great enlargement of the parotid gland, the bony outlines of the jaw being completely obliterated with enlargement of the cervical glands on the same side. Under treatment the condition greatly improved, the parotid became normal and the glands smaller. The ulcer in the mouth, however, began to increase and radium treatment was again given but there was no improvement. Subsequently the glands on the right side again became very much enlarged and those on the left began to increase in size. A short time afterwards a gland on the right side suddenly broke down and operation was performed, when a large pus cavity was found and drained, and the broken-down gland removed. Pathologist's report: "Pus contained streptococcus; a scraping from the ulcer of the palate showed streptococcus in short chains and degenerate epithelial cells, no tumour cells in the spreading margin. Blood count normal; urine normal; Wassermann reaction negative."

Dr W. HILL asked whether the treatment had been by ultra-violet rays only.

Sir JAMES DUNDAS-GRANT asked whether examination had been made of the piece from the ulcer of the hard palate. It looked like epithelioma, with secondary involvement of glands on both sides.

Mr NORMAN BARNETT (in reply) said that the papilloma had been removed, and ultra-violet rays and radium applied. No tumour cells were found in the growth nor at the spreading edge. He did not think the case was so simple a one as suggested. There was especial difficulty in explaining the extreme swelling of the parotid gland, which subsequently subsided, and the presence of a large amount of pus in the neck containing streptococci.

Suspected Papilloma of the Larynx: Case for Diagnosis —N. STUART CARRUTHERS, F.R.C.S.—Patient, aged 27, was first seen in July 1926. Patient complained of hoarseness of seven months' duration. Examination revealed what appeared to be a papilloma in the anterior commissure and growing from the right cord.

6th August 1926.—The growth was removed through a laryngoscope and the base cauterised.

23rd March 1927.—Patient re-admitted to hospital; the papilloma, which was as large as on the previous occasion, was removed and the base again cauterised.

Pathological Report.—"This tissue is of an epitheliomatous nature."

Present Condition.—There is a large papillomatous mass in the anterior commissure growing from the right cord, but there is also some infiltration of the left.

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Societies' Proceedings

Paralysis of Right Vocal Cord: Case for Diagnosis—J. A. GIBB, M.D.—Female, aged 23, for two years had greatly enlarged glands in her neck; was treated in a sanatorium. Glands incised; discharged for twelve months. On healing, voice became husky. There was never any cough and no sputum: no pulmonary signs.

Examination of larynx showed the right vocal cord paralysed in position of extreme abduction.

Case for Diagnosis—C. HAMBLEN THOMAS, F.R.C.S.—Male, aged 60. Occupation, instrument-maker. Six months ago he began to have attacks of coughing, worse at night, with associated swelling at root of neck (? emphysematous); lately huskiness of voice; no dyspnœa; no dysphagia; not losing weight; no symptoms referred to chest.

Examination.—Pharynx: chronic tonsillitis; papilloma on uvula. Larynx: left vocal cord showed a pale limited smooth swelling anteriorly; no ulceration; cord somewhat limited in movement. Neck: fullness above clavicles; no definite glandular enlargement. Chest: nothing abnormal seen by X-rays or found clinically. Sputum and blood not examined.

Treatment.—Vapours and sedative cough mixture. Slight improvement.

DISCUSSION ON THE THREE PRECEDING CASES.

Sir ST CLAIR THOMSON said that Mr Carruthers' case might possibly be one of malignant disease. These growths were more common on the anterior third of the cord than on the posterior. His (the speaker's) youngest female patient was aged 33, and the disease in her case was of very malignant type. Recurrence had been treated by hemilaryngectomy, and the patient was still well seven years after the operation. He suggested that a further piece of growth should be removed and examined. If it were found to be epitheliomatous, the case should be dealt with by laryngofissure. The greater part of the right cord might have to be removed, and half the left. In some cases, if there was stenosis, the patients managed very well with a tracheotomy tube. The idea of laryngectomy should not be entertained.

With regard to Mr Gibb's case, it was difficult to say whether there was anything subglottic.

Mr HERBERT TILLEY said he did not think it was correct to speak of Mr Gibb's case as one in which the "right vocal cord was paralysed in a position of extreme abduction." The cord was not paralysed, the arytænoid moved with comparative freedom. There was some ulcerative condition of the cord which in parts gave it a congested granular appearance.

Professor GEORGES PORTMANN (Bordeaux) said he did not regard Mr Gibb's case as one of paralysis of the vocal cord. He thought the patient had tuberculous trouble, and that the vocal cord and the false cord were pulled out by cicatricial tissue.

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Mr H. SMURTHWAITE said that there was scar tissue in this case (Mr Gibb's) which he was sure was one of tuberculous disease of the cord. There was hoarseness, but patients with one cord paralysed could always produce some voice. One could only see a thin streak of the right cord, and it was partially fixed.

Sir JAMES DUNDAS-GRANT said that a paralysis starting in the right vocal cord was comparatively rare, while paralysis of the cord in extreme abduction was almost unknown. The cord was in the position of extreme abduction and was immobile, but in his opinion the immobility was due to local cicatricial contraction, not to involvement of the laryngeal nerve. There was probably a mitigated form of tuberculosis, which had arrived at a stationary condition.

Dr J. S. FRASER considered that Mr Carruthers' case was one of malignant disease of vocal cords. Not only was the right cord affected, but the condition had spread round the anterior commissure to the anterior part of the left cord. He agreed that in young people the malignancy of these growths was high. Therefore he was surprised to hear Sir St Clair Thomson recommend laryngofissure in this case; he would have thought it more suitable for laryngectomy.

Dr ANDREW WYLIE (President) said that with regard to Mr Carruthers' case, a piece of the growth should be removed and examined under the microscope. The condition in Mr Hamblen Thomas' case had a tuberculous appearance.

Mr CARRUTHERS (in reply) said that on the first occasion the growth in this case was completely removed, and its base touched with the cautery. After two months it began to grow again. The second removal was by the same method—direct laryngoscopy. The growth had a broad base and he removed it as far as possible. It rapidly recurred. The pathologist reported it as an epithelioma, but would not be definite on this point.

Mr GIBB (in reply) said that in his case there had never been any sputum or evidence of active tuberculosis. She had entered a sanatorium because of a large number of diseased and discharging cervical glands. She had been in the sanatorium two years. Her voice was unaffected during that time and while the glands were discharging, but as soon as healing took place loss of voice had occurred. Consequently, it occurred to him that the laryngeal nerve had been caught up in scar tissue. He was willing to accept the opinion of more experienced members with regard to the cord. No reaction had been obtained on stimulating the laryngeal nerve. He proposed to tell the patient that nothing further could be done for her.

Sinusitis with Complications: Phlegmon of Orbit—J. A. GIBB, M.D.—Patient, aged 2, on 12th November 1926, was admitted to hospital with redness and œdema of both upper eyelids and profuse discharge of pus from both nares.

Operation.—Right and left maxillary antra opened. Right ethmoid region freely opened.

Temperature between 100° and 102° F. developed, and on 22nd

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November 1926 a fluctuant swelling at the right inner canthus was opened and pus evacuated.

24th November 1926.—As there was evidence of pus in the orbit an incision was made through the lower lid and a good deal of pus was evacuated. The wound was gently scraped and drained by a wisp of gauze.

26th November 1926.—Discharged to the out-patient department.

Frontal Sinusitis—J. A. GIBB, M.D.—Patient, aged 22, consulted me on 22nd March 1927, complaining of frontal headaches. Headaches were marked on rising in morning and usually lasted until 11 or 12 o'clock. Pressure over right supra-orbital nerve and at inner angle of orbit caused pain; pus in middle meatus.

Transillumination.—Right frontal sinus dark, and maxillary antrum dark.

24th March 1927.—Operation: Small incision was made at inner angle of orbit and anterior wall of frontal sinus removed; sinus full of pus; carefully swabbed out. Anterior half of the middle turbinate was removed and frontonasal duct enlarged by burring; tube inserted into nose.

29th March 1927.—Tube removed and nares douched.

8th April 1927.—Owing to swollen condition of wound and rise of temperature to 104.8° F. the original incision was carried to the full extent of eyebrow, and anterior wall of sinus completely removed as well as part of floor. Direct communication with the nasal cavity was made by burring; wound sutured with exception of outer portion, which was drained.

10th April 1927.—Definite attack of erysipelas developed. Twenty c.c. antistreptococcus serum were given at twelve-hour intervals for three days, when calcium chloride and iron and quinine were administered.

15th April 1927.—Temperature normal.

29th April 1927.—Left nursing home quite well.

Case is shown with a view to elicit discussion as to the value of the small external incision.

Dr WYLLIE (President) said that in the second case the patient seemed to be quite cured; he could not detect any pus.

Sir JAMES DUNDAS-GRANT said that Mr Gibb was to be congratulated on his result in this difficult case.

Mr GIBB (in reply) said he had two patients in hospital, one a boy, aged 10, the other a younger child, both suffering from ethmoiditis. He performed an external operation on the first of these, and healing occurred without complications. In the second case he operated by the external route; pus appeared at a later stage. He thought that in these cases the operation should be performed externally.

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Royal Society of Medicine

Cases Illustrating Mr Layton's Paper on "Nasal Polypi." *

I. Girl, aged 15, had polypi in both sides of nose, often removed without effect. Much pus on each side of nose, but after repeated examinations I could not persuade myself that she had suppurative sinusitis anywhere. *X-ray examination:* Ethmoids and perhaps sphenoids foggy. *Operation*, 7th January 1927, under intratracheal ether: removal of ascending process of superior maxilla and lacrymal bone. Anterior ethmoidal cells contained gelatinous material. All anterior ethmoidal cells removed lateral to mid-turbinal. One posterior ethmoidal cell was cleared out.

II. Elderly man, after extraction of all teeth, had "a full feeling" on right side of head; single polyp on right side, no pus. Antrum opened 14th January 1927 under local anæsthesia. No secretion, no discoloration, no general swelling of mucous membrane, some rather large vessels. At first I thought it was normal, then I noticed certain areas whiter than the rest. I touched one of these and it burst, exuding a bead of pus. I then realised that the mucous membrane was studded with twenty or thirty such areas, each the size of a sago grain. From swab from pustule nothing was grown except what were thought to be organisms of an air-borne contamination. Polyp removed, ethmoid explored through antrum, apparently normal, all mucous membrane curetted away and radical maxillary operation (Denker) completed. Patient still complains of "full" feeling.

III. Male, aged 54, had been advised to have tonsils removed for rheumatoid arthritis.

13*th December* 1926.—Polyp, left side was removed; both antra washed out; nothing found.

31*st December* 1926.—Suspicion of mucopus over inferior turbinal below orifice of antrum on each side.

3*rd January* 1927.—Posterior rhinoscopy (poor view); suspicion of pus above middle turbinal on right side. Maxillary sinus washed out, right *nil;* left *nil*, but on suction with syringe a few flakes; on blowing air through cavity some pus appears in meatus. X-ray, each side opaque. Operation on left side, polypoid condition especially on the floor with flaky purulent secretion; most of mucous membrane scraped off. Right side—upper part apparently normal; lower part, commencing polypoid condition. This scraped away, the rest left.

IV. Female, middle-aged, had polypi on each side of nose; pus in each antrum.

First operation: Local anæsthesia; bilateral radical operation on maxillary sinus with pus in cavity; mucous membrane inflamed, not swollen; tooth removed; cultivation gave a mixed growth of *Staphy-*

* See p. 729.

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lococcus albus, *Streptococcus longus* and torulæ; swab from antrum, *Staphylococcus aureus*.

Second operation: Intratracheal ether; all ethmoid on each side removed lateral to middle turbinal through external incision. All cells full of polypoid mucous membrane, but *no* pus.

Aneurysm of Internal Carotid—E. BROUGHTON BARNES, F.R.C.S.E. — Male, aged 71, was first seen on 5th April 1927, complaining of slight dysphagia of two years' duration; internal carotid aneurysm, best seen with laryngeal mirror.

No abnormal physical signs in the chest.

Professor GEORGES PORTMANN said that four years ago he saw a similar case, which he published in the *Archives Médicales Belges*. He had seen very few cases of aneurysm of the carotid artery. Differential diagnosis was sometimes difficult in cases of aneurysm of the pharyngeal artery.

Mr HAMBLEN THOMAS did not think this was aneurysm of the internal carotid. Often the large vessel seen in that situation was the ascending pharyngeal. The carotid tended in that direction when the head was flexed, and it was the bend which caused visible pulsation and led to the mistaken diagnosis of aneurysm.

Dr W. HILL asked what was the objection to trying ligature?

Mr H. TILLEY said the objections to ligaturing the artery were the man's age, and the fact that he had had the condition a long time and was fairly comfortable.

Dr ANDREW WYLIE (President) said he did not consider that the swelling was an aneurysm; it was probably a dilatation of the vessel.

Mr BROUGHTON BARNES (in reply) said he did not follow Mr Hamblen Thomas as to the reason of the curve. This was not a saccular aneurysm. He considered there was a fusiform expansion. He agreed that tying the vessels should not be done, because of the patient's age and the probable condition of the fellow vessel, which might not give an adequate blood-supply to the brain.

Fracture of Larynx—T. B. JOBSON, M.D.—Female, aged 26, was injured in motor accident on 30th May 1927; struck on left side of neck; she coughed up some blood during next twenty-four hours. There was pain in the throat, with dysphagia and dysphonia; surgical emphysema over larynx, 10th June 1927. Crepitus could still be felt; outline of cords was irregular and larynx still showed evidence of trauma; there was no paresis present.

Dr SALISBURY SHARPE said there was stiffness in the crico-arytænoid joint. A somewhat similar effect had ensued in a case which he had had thirty-nine years ago, of comminuted fracture of the thyroid cartilage. Two

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years after the accident the patient had had a very good voice, and the only abnormality was a slightly lessened amplitude of the cricothyroid movement on one side; this would probably follow in the present case.

Sir JAMES DUNDAS-GRANT said this was a remarkable recovery from a dangerous accident. Sir Felix Semon had once shown a case in which a man almost lost his life after such an accident which had occurred during a game of football.

Mr JOBSON said that he had seen the patient for the first time on the previous day. Such cases were more frequently seen in the days when garotting was a common crime. The patient's symptoms were now steadily subsiding. He wondered whether he ought to strap the larynx, as it was still crepitating. He proposed to enjoin silence on the patient.

Chronic Enlargement of the Upper Jaw—G. W. BADGEROW, C.M.G., F.R.C.S.E., and F. C. ORMEROD, M.D.—Female, aged 65, for six years has noticed an enlargement of the left side of the face. The extent of the swelling has varied from time to time, but latterly has been fairly constant.

A number of carious teeth had been removed shortly before the onset of the swelling; others had been falling out since she was 17. (Evident history of pyorrhœa). Attacks of pain in face from time to time.

The points of special interest are: (1) The massive enlargement of the maxilla including the alveolar margin and its extension on to the nasal process and to the opposite side of the nose; and (2) the encroachment on the cavity of maxillary antrum by thickened walls.

Fibromata (or? Papilloma) of Larynx—W. H. JEWELL, M.D.—Male, aged 37, had been "losing voice" for five months. There is a rounded tumour about the size of a pea attached to the anterior margin of the right vocal cord. Below and in front of this nodule there is another one which is not so definitely circumscribed.

Postscript.—The tumours were removed by means of Haslinger's directoscope, and the patient has recovered his voice and is able to sing.

The pathologist reported the growth attached to the vocal cord was a soft fibroma and the other one was suggestive of an epithelioma, but admitted it might have been due to the way the section was cut. No recurrence two months later.

Section of Laryngology Research Committee—Mr BELL TAWSE's case of "Perforation of the Palate," * shown at Meetings of the Section on 4th December 1925, 4th June 1926, and 5th November 1926, was considered by the Research Committee on 12th May 1927.

The microscopical section of a portion of the growth removed was

* *Journ. Laryng. and Otol.*, xli., pp. 249, 762; xlii., p. 51.

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submitted to Mr T. W. P. Lawrence, F.R.C.S., and Dr G. W. Nicholson, as Referees, and they report as follows :—

The section examined shows downgrowths of columns and tubes—lined with a single layer of cubical cells—into the deeper tissues. These can be traced to the surface epithelium, which is ulcerating and granulating. It is a basal-celled carcinoma (rodent ulcer).

T. W. P. LAWRENCE, F.R.C.S.

The tumour is more tubular in structure than the average rodent ulcer of squamous epithelium. Parts of it bear a close resemblance to salivary gland tumour. It is therefore possible that the tumour arose in connection with mucous glands. This does not, however, alter the fact that it is a basal-celled carcinoma.

G. W. NICHOLSON, M.D.

ABSTRACTS

THE EAR.

Aural Microscope Magnifying 10 *to* 50 *Times.* LÜSCHER, ERG., Berne. (*Zeitschrift für Hals-, Nasen-, und Ohrenheilkunde*, Band xvii., Heft 3, p. 403.)

The speculum is mounted on an upright with facility for movement in any direction. The microscope is attached to the outer end and the light is directed down from a powerful electric lamp at the top of a vertical tube. The ray of light is reflected through the speculum by a perforated mirror at an angle of 45 degrees. The patient is recumbent on a narrow table, the observer sits on a chair at the side. Under higher magnifying power the shape of the membrane as a funnel with convex sides is very evident and many fine blood-vessels, as well as minute dendritic cicatrices, when present, can be detected. Red-free light makes clear features which are obscured by congestion, and the blood-vessels with their moving contents are made plain in black colour. The apparatus can be adapted for binocular vision and for two observers. Measurement in three directions can be made, the relative depth being determined by means of the fine adjustment. The description is enhanced by two beautiful coloured views magnified eight times. The instrument is supplied by Messrs Haag-Streit of Berne. JAMES DUNDAS-GRANT.

Paracentesis Tympani—A Practitioner's Operation. W. STUART-LOW, F.R.C.S. (*Practitioner*, July 1927.)

The author thinks that paracentesis is not likely to be generally performed as early as it ought to be unless practitioners are prepared to do the operation themselves. He gives details of his own method,

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