developed some days later. Both lateral and cavernous sinuses contained suppurating blood clot.

Aspergillus from the Ear—Mr ARTHUR CHEATLE and Mr W. D'ESTE EMERY.—The material was removed from an old operation cavity and was causing pain and discharge. The material was washed in sterile water, and a black nodule was picked out and planted on maltose agar (1 per cent.). I had seven of these cases in private practice in ten months. In one case I was able to prove that the source was the bath water. During the war there had been neglect in cleaning out cisterns.

Columnar-celled Carcinoma arising in Sebaceous Glands or Hair Follicle Ducts—Mr H. J. BANKS-DAVIS.—Man, aged 35, two years ago had a "tumour removed from behind the ear." Intense pain ever since. Tragus red and tender and meatus occluded. Hard swelling over the parotid. Tumour removed along with cartilaginous meatus. Cessation of pain. X-ray treatment.

THE SCOTTISH OTOLOGICAL AND LARYNGOLOGICAL SOCIETY

NINTH MEETING, ROYAL INFIRMARY, EDINBURGH.

June 14, 1919.

President—Dr WALKER DOWNIE.

Discussion on the Prevention of Chronic Ear Disease was opened by Dr LOGAN TURNER. The following conclusions were arrived at:—

1. That an otologist should be attached to each of the large fever hospitals in Scotland.
2. That the medical examination of school children should include a report upon the state of the hearing.
3. That the nurses attached to the various Child Welfare Centres should receive special instruction in the treatment of middle ear suppuration.
4. That each Educational Authority should organise the treatment of adenoids and tonsils in school children, instead of utilising the voluntary hospitals for that purpose.

Epistaxis due to a Leech in the Nasal Cavity—Dr W. T. GARDINER.—Two soldiers were treated by him in Palestine.

Malignant Disease of the Post-cricoid Area—Dr A. LOGAN TURNER (*Journal of Laryngology*, February 1920).

Amyo-trophic Lateral Sclerosis with Bulbar Involvement—Dr A. LOGAN TURNER.—Woman, aged 46, with impaired mobility

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of right half of soft palate and both vocal cords; diminished sensation of pharyngeal mucosa.

Four Cases of Epithelioma of the Larynx—Dr J. S. FRASER.—Three were cases of cancer of one vocal cord, treated by laryngofissure. Recurrence in one case, necessitating laryngectomy. Fourth case, woman aged 60, with extensive epithelioma; laryngectomy; no recurrence two years later.

Acute Infection of Nasal Accessory Sinuses and Middle Ear Cleft on Right Side, associated with Pachymeningitis Interna Hæmorrhagica—Dr J. S. FRASER.—Male, aged 55, with a history of acute frontal sinus inflammation, followed later by severe headache, drowsiness, and occasional vomiting. Removal of the posterior wall of the right frontal sinus exposed an intensely blue dura mater, and on puncture 5 c.c. of blood were withdrawn. Recovery.

Malignant Disease of Middle and External Ear (Right)—Dr J. S. FRASER.—Woman, aged 36. Otorrhœa since childhood. The disease involved the middle ear cleft and the skin of the meatus. Operation followed by radium application.

Epithelioma of External Auditory Meatus (Left)—Dr J. S. FRASER.—Male, aged 45. No history of otorrhœa. When examined, the growth was small, but the patient refused radical measures.

Orbital Complication of Ethmoidal Suppuration and Ethmoidal Mucocele—Dr J. S. FRASER.—1st case: girl, aged 10, with a fistulous opening above the left inner canthus communicating with the ethmoid cells; cured by establishing intra-nasal drainage. 2nd case: female, aged 21: history of injury four years before. Contents of mucocele drained by intra-nasal opening.

Left Recurrent Laryngeal Paralysis—Dr J. D. LITHGOW.—Male, aged 17. Pleural thickening at left apex. When first seen the abductors only were affected.

Note on the Anatomy of the Membranous Labyrinth—Dr J. K. DICKIE.

TENTH MEETING, AT THE WESTERN INFIRMARY, GLASGOW.

December 18, 1919.

President—Dr W. T. GARDINER.

Stenosis of Trachea following Bullet Wound—Dr R. P. MATHERS.—Male, aged 21. Bullet passed through neck at lower border of thyroid cartilage; tracheotomy necessary: attempted dilatation with T-shaped trachea tube not successful.

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Societies' Proceedings

Three Cases of Squamous Epithelioma of Larynx—Dr W. S. SYME. — Male, aged 47. Growth extensive in larynx; laryngectomy in February 1918. Male, aged 69, tumour of anterior part of right vocal cord; thyrotomy, August 1916: no recurrence. Male, aged 72, tumour on anterior part of right cord; thyrotomy, August 1917; no recurrence.

Malignant Mixed Parotid Tumour of Palate—Dr W. S. SYME.—Female, aged 50. An encapsulated tumour involving the soft palate was dissected out. It contained no cartilage. No recurrence.

Carcinoma of Naso-pharynx—Dr W. S. SYME.—Female, aged 20. The patient worked under exposure to fumes of naphtha.

Malignant (?) Growth in Hypo-pharynx—Dr JAMES ADAM.—Female, aged 51. During six years she had been repeatedly treated with radium, cautery, and diathermy, the growth recurring at intervals. The complete duration of the condition was 13 years.

Two Patients with Menière's Symptoms—*Dr JAMES ADAM* and *Dr W. T.* GARDINER.—Female, aged 33, and male, aged 30. It was thought that these were cases of toxic neuro-labyrinthitis.

A Series of Cases illustrating the Thesis that Atrophic Rhinitis is the End Stage of a Process commencing with Hyperplasia, and that it is not due to Specific Microbes—Dr JAMES ADAM.—The chief features in the cases were the frequency of associated sinus suppuration and the great thickness of the nasal osseous wall of the antra. Neither the Perez bacillus nor Koch's bacillus was found in any of them.

Electrical Aids to Hearing—Dr J. KERR LOVE.—A series of careful tests made with the Acousticon led to the opinion that it would prove of most value to those who had become partially deaf in adult life from middle ear deafness, and who had not the intricacies of language to deal with as the deaf child had.

Cerebrospinal Rhinorrhœa — Dr J. L. HOWIE. — Female, aged 42. Profuse watery discharge from right nostril preceded by headache and giddiness. Drip continued night and day over considerable periods. No objective evidence of organic or functional nervous disease.

Lupus of Fauces and Pharynx—Dr J. W. LEITCH.—Male, aged 60. Extensive scarring of faucial pillars which were adherent to pharynx. Superficial scarring of right upper arm following a skin affection in childhood.

Pemphigus of the Mouth and Pharynx—Dr A. BROWN-KELLY.—Male, aged 69. Blisters occasionally seen, but more usually

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irregular white patches of membrane and red raw areas; various areas of mucosa became affected. The eyes became affected and the patient is now blind: eyeballs shrivelled: closure of nostrils. Duration five years.

Demonstration of Specimens showing Comparative Anatomy of the Membranous Labyrinth—Dr A. A. GRAY.

Model to Demonstrate Movements of Endolymph in the Semicircular Canals during Rotation Tests—Dr J. D. LITHGOW.

ABSTRACTS

EAR.

The Innervation of the Tensor Veli Palati and Levator Veli Palati Muscles. A. R. RICH. (*Johns Hopkins Hospital Bulletin*, Sept. 1920.)

While studying the physiological relation of the palatal muscles to the Eustachian tube (see abstract in *Journal of Laryngology and Otology* last month), the author discovered in the literature dealing with the nerve supplies of those muscles so great a variety of conflicting opinions that he proceeded to investigate the matter by experiments on dogs.

The tensor veli palati and levator veli palati muscles having been exposed, with their nerve supplies intact, by dissection in the living animal, the various cranial nerves were stimulated within the skull while the naked muscles were observed, and it was determined that:—

1. The fifth nerve is the only cranial nerve which supplies motor fibres to the tensor veli palati muscle. The failure of most clinical observers to detect paralysis of the palate in cases of disease of the fifth nerve arises from the fact that the tensor veli palati exerts, ordinarily, no effect upon the soft palate that can be detected by oral examination.

2. The method of intracranial stimulation, combined with experimental paralysis of the muscle produced by nerve section, places the motor supply of the levator veli palati muscle in the so-called bulbar portion of the eleventh nerve, or rather, in the inferior rootlets of the tenth nerve, since the bulbar portion of the eleventh nerve has been shown to be really an integral part of the vagus.

DOUGLAS GUTHRIE.

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