MR. CAPPS replied that a big dose must be given if any good was to be done at all.

DR. I. FRIEDMANN thought that there was a great deal of confusion in the field of benign laryngeal tumours, perhaps, entirely due to the nomenclature and vague definitions.

He was in agreement with Mr. Capps' views and has always excluded the so-called vocal cord polypi from neoplastic conditions. In consequence he could not accept Mr. J. P. Stewart's theory that vocal cord polypi were in fact neoplasms or precursors of some tumours of the vocal cord, such as fibroma and angeioma.

He has also been concerned about the confusion which such divergent views, as expressed in this discussion, caused among students. He would, therefore, like to emphasize that vocal cord polypi are not neoplasms but arise as a consequence of a reaction of the stroma to trivial, traumatic or infectious factors. Of true benign neoplasms, the simple squamous-celled papilloma is common. One may encounter an occasional fibroma, angeioma, chondroma and simple adenoma, but these benign tumours of the vocal cord are rare. Keratosis of the vocal cord should, however, not be considered under this heading.

Fibrotic vocal cord polypi have been mistaken for fibromata. Equally, *vascular* vocal cord polypi have been described as true angeiomata which they are not.

He was, therefore, not at all surprised to hear that the pathological diagnosis had not always confirmed the clinical diagnosis. If, as in his hospital, definitions were clarified, then discrepancies need not be great.

THE SCOTTISH OTOLARYNGOLOGICAL SOCIETY

THE seventy-third meeting of the Society was held in the Ear, Nose and Throat Hospital, Glasgow, on Saturday, November 24th, 1956, with the President, Dr. A. Brownlie Smith in the Chair.

A paper on "Ceruminoma" was given by Dr. B. Lennox and Dr. J. M. Johnstone. This was followed by a paper on "Physics and Hearing" by Dr. Lenihan.

Cases were shown as follows:

DRS. J. M. JOHNSTONE, BERNARD LENNOX AND A. J. WATSON

1. *Five Cases of Hidradenoma of the External Auditory Meatus: the so-called "Ceruminoma".* Five cases of the so-called ceruminoma were seen at the Western Infirmary, Glasgow, in an eight-year period. Clinically all began as firm masses obstructing the meatus. Three cases have had recurrences after excision, and one at least will almost certainly end fatally. Histologically, the tumours show great variety in structure, but correspond exactly with the varieties of sweat gland tumours (hidradenomata) seen elsewhere on the skin. As the so-called ceruminous glands, which do not secrete wax, are merely

https://doi.org/10.1017/S0022215100052464 Published online by Cambridge University Press

apocrine sweat glands differing little if at all from those seen elsewhere, e.g., in the axilla, this is not surprising. The importance of early and thorough excision in these cases was emphasized. (Published in full in *J. Path. Bact.*, **73**, 421, 1957.)

DR. R. J. WATSON

2. *Aural Cholesteatosis.* A woman, aged 29, had discharge from the right ear for 24 years. Attic granulations were present. The left drumhead was intact, scarred, retracted, and with impaired mobility. On X-ray examination, both mastoids showed evidence of cholesteatosis. A modified radical mastoidectomy was performed on the right ear, there being a sinus in the cortex with cholesteatosis presenting. The incus and head of malleus were absent. A modified Kettel's flap was stitched to the temporalis.

Dr. Simson Hall remarked with regard to the left ear, that in a patient on whom he was performing an intra-tympanic operation for adhesions, he discovered white, scaly material coming down from the attic and antrum. Before he had finished, an extensive modified radical operation had been performed.

DR. F. T. LAND

3. *Otosclerosis. Stapes Mobilization.* Mrs. A., aged 28, was operated on by Dr. Samuel Rosen in *January, 1956.* Her hearing was much improved, although lately there had been some deterioration.

4. *Tullio Phenomenon.* A man, aged 60, complains of pulsating tinnitus and giddiness of two months' duration. Tinnitus occurs only when lying on his left side. He feels giddy on exposure to noise of high pitch, not necessarily loud, e.g. light hammering on metal, brake squeal, etc. Drumheads appear normal. Audiogram shows no deafness. There is no loss of corneal sensitivity.

Dr. Land considered this a unique case. Previously recorded cases of mild Tullio reflex were always associated with gross hearing loss. There might be a psychogenic explanation, but this man, when being tested with the audiometer, not only fell over to the other side like Tullio's pigeons, but became pale, sweated, and was in great distress. Nystagmus was not noted.

Dr. Simson Hall mentioned a man who, following fenestration, became violently giddy when working inside a boiler.

Dr. Mitchell thought there was a psychogenic factor, the first attack in this case coming on when he was in a bus which made an emergency stop with loudly squealing brakes. Subsequent attacks always made him think of this episode.

Dr. Land recalled that in Tullio's original experiments an opening was made in the lateral canal. Professor Huizinga was able to produce the same effect when the cochlea had been ablated, thus showing that in animals the reflex was entirely in the balance part, as the auditory mechanism had been excluded.

DR. F. T. LAND

6-8. *Keratosis Obturans and Bronchiectasis.* Three males, aged 14, 19, and 20, suffered from keratotic masses in the ears, and established bronchiectasis. One

https://doi.org/10.1017/S0022215100052464 Published online by Cambridge University Press

had undergone lobectomy. They draw attention to an association of which we have become increasingly aware. It has been noticed that wax can become suddenly more abundant during a head cold, and in children with early otitis media. Now there is this accumulation of wax and epithelial scales in the canals of patients with sinusitis and bronchiectasis.

Dr. Mitchell, *Dr. Seex* and *Dr. Gabriel* had all seen several cases of this association.

DR. E. A. M. CONNAL

9. *Squamous Carcinoma of Nasal Septum.* A male, aged 40, had a perforation of the nasal septum with a history of previous fracture of the nasal bones. A biopsy from the posterior edge of the septal ulcer was reported as an anaplastic carcinoma. W.R. repeatedly negative. Kahn doubtful. He was treated with deep X-ray therapy, receiving 4,000 r in four weeks. Although it is now over five years since the treatment, he has remained well. Apart from crusting in the nose, there is no evidence of recurrence and no enlargement of glands.

DR. J. P. FRASER

10. *Acute Frontal Sinusitis with Osteomyelitis.* A woman, aged 40, had a head cold, followed six days later by severe headache, and swelling over both frontal sinuses. X-rays showed an opaque right antrum, but no obvious infection of the frontal sinuses or frontal bone. She was put on Penicillin $\frac{1}{2}$ million units 6 hourly. Tenderness persisted, and fluctuation over the frontal region appeared. Both frontal sinuses were therefore exposed by turning down a frontal flap. Pus was found over the anterior aspect on the right sinus, and although there was no obvious fistula, a burr hole into the sinus produced copious pus. Part of the anterior wall was removed, the fronto-nasal duct enlarged, and a rubber tube inserted from sinus into nose. Pus was also found in the left sinus, which was similarly treated. The antra contained pus on lavage, but cleared up during convalescence. About five weeks later the nose was quite clean and the sinuses clear on X-ray. The pus obtained from the frontal sinuses at operation, and from the antra on lavage contained *Staph. pyogenes*, insensitive to penicillin.

Dr. Mitchell asked if Dr. Fraser considered using a forehead skin crease incision. He also suggested that the sinusitis was started by jumping into a pond with a rush of water into the nose and sinuses.

Mr. T. O. Howie remarked that the patient had been treated with penicillin, although the organism was insensitive to the drug, and he thought it most important to find early the sensitivity of the responsible organism. He had seen only seven cases of frontal osteomyelitis in the last twenty years, and thought that the condition was becoming rare.

Dr. Fulton Christie thought that in acute cases it was better to keep the mucosa of the duct intact and drain the sinus. Stenosis, such as so often follows the enlargement of the duct, is thus avoided.

https://doi.org/10.1017/S0022215100052464 Published online by Cambridge University Press

Dr. McInlay made a plea for the skin grafting of the fronto-nasal duct to maintain patency.

DR. R. J. WATSON

11. *Naso-pharyngeal Fibroma.* B.M., aged 11, had nasal obstruction for six months. No discharge, pain, or epistaxis. A soft tissue mass occupied both sides of the naso-pharynx, extending into the nose and bulging the left antral wall. The upper left 7th molar was lying horizontally, and causing an ulcer of the cheek. Repeated biopsies were required before the diagnosis of naso-pharyngeal fibroma was established, finally from tissue removed from the left antrum *viâ* a Caldwell Luc operation. One month later the tumour was removed under hypothermia with preliminary ligation of the left external carotid. Approach was by a lateral rhinotomy, splitting the upper lip, and turning back a broad cheek flap. The tumour was found to fill the antrum with considerable erosion of wall, and also to fill the whole naso-pharynx. It was removed in three pieces. The attachment was to the left lateral naso-pharyngeal wall. The cavity was touched with diathermy. Bleeding was not unduly troublesome.

In reply to a question by *Dr. Connal*, that radiotherapy after excision should be considered, *Dr. Watson* said that it had been considered but that he had decided to await events.

DR. F. T. LAND

12. *Carcinoma of Naso-pharynx.* J.P., aged 51, complained of deafness in the left ear and left nasal obstruction of one year's duration. An irregular, granular mass was seen in the left naso-pharynx. No enlarged glands. X-ray shows no changes in skull. Biopsy revealed an anaplastic, epidermoid carcinoma. In *April, 1953,* he had 220 Kv. X-ray therapy, 4,000 r. He remains well in 1956, with some crusting in the naso-pharynx.

Dr. Collins said that he had seen similar cases which recurred 7 or 8 years later. Five years is the survival rate, but one cannot talk about "curing".

Dr. Connal said that the patient would not have had even five years without treatment.

DR. E. A. M. CONNAL

13-15. *Squamous Carcinoma of Uvula and Soft Palate.* W.M., aged 75, was admitted in *July, 1955,* with a history of sore throat for several years, and pain on swallowing for about a month. There was no bleeding, no loss of weight, and no cough. Examination revealed superficial ulceration and papillomatous areas over the right side of the soft palate and uvula, spreading to the hard palate and down the fauces to the lateral border of the tongue.

14. *Reticulo-Sarcoma of Left Tonsil.* A.N., aged 42, attended in *January, 1956,* complaining of a severe sore throat for one month. He gave a past history of left quinsy. He was placed on the waiting list for tonsillectomy. Ten days later it was noted that the tonsillitis was not settling even after administration of penicillin. The left tonsil was finally removed and found to be the seat of a

https://doi.org/10.1017/S0022215100052464 Published online by Cambridge University Press

reticulo-sarcoma. X-ray therapy was commenced in *February, 1956*, and the patient now seems well, with no evidence of recurrence and no palpable glands.

15. *Miculicz Disease.* Mrs. A. E., aged 61, complained of two lumps in the neck, just below the jaw. Hard, and at first painless, they tended to fluctuate in size. Five weeks before admission, swellings appeared in both parotid regions. The tongue was dry and fissured. In *November, 1953*, deep X-ray therapy was commenced. She steadily improved, and in *January, 1956*, could be regarded as cured. No glands were palpable. and the mouth was moist. Photographs showing the condition were shown.

DR. F. T. LAND

16. *An Unusual Foreign Body.* M.M., aged 71, had dysphagia for three weeks. He had no knowledge of having swallowed any foreign body. A loop of wire, about 4 cms. in diameter, was seen in the post-cricoid region, and removed by œsophagoscopy.

DR. D. GLYN JONES

17. *Bilateral Abductor Palsy of Obscure Ætiology.* D.C., aged 71, had hoarseness for 18 months associated with dyspnœa. No dysphagia. No history of any neurological disorder. Examination showed a bilateral abductor palsy, for which no local cause could be found. W.R. was negative. X-rays showed a normal mediastinum, some bronchitis and emphysema. There had been no change in his condition during the past twelve months.

Dr. Brown Kelly said that he had published a case of a Service Padre who had a bilateral abductor palsy discovered in the course of a routine examination. No cause could be found, until one day the patient got into a hot bath and burnt his feet due to them being anæsthetic from syringomyelia. In the present case, there is an admission that his feet are numb and tingling. Might this not also be a case of syringomyelia?

Dr. Connal remarked on the ease with which the patient was able to breathe. He had previously had to do a tracheotomy on cases with larger glottic openings.

Dr. McNaughton asked whether a tracheotomy should not be done in view of his bronchitis.

Dr. Jones, in reply, said the case had been thoroughly investigated by physicians and no neurological disorder found. Two other similar cases he had seen required tracheotomy, but this one had had no distress.

DR. J. P. FRASER

18. *Pharyngeal Pouch.* The patient complained of discomfort in the throat and slight dysphagia. There was no regurgitation. Barium swallow showed a small diverticulum at the upper end. This was confirmed by œsophagoscopy. Repeated barium swallows showed pouch to be increasing in size, so it was removed in two stages. In the first stage the pouch was separated from the œsophagus and stitched to the sterno-hyoid muscle. One week later it was

https://doi.org/10.1017/S0022215100052464 Published online by Cambridge University Press

completely mobilized and removed. Recovery was uneventful except for a transient paralysis of the left cord.

Dr. Findlay Brown suggested putting an œsophagoscope into the pouch and diatherming down the septum. It does not cure the pouch, but relieves the dysphagia.

Dr. Bailie thought that the case in question was not suitable for diathermy as it was difficult to define the spur. As a wide exposure was required for mobilization, it was thought safer to perform the operation in two stages.

https://doi.org/10.1017/S0022215100052464 Published online by Cambridge University Press