SOCIETIES' PROCEEDINGS

THE NINETIETH MEETING OF THE SCOTTISH OTOLARYNGOLOGICAL SOCIETY TOOK PLACE IN THE ROYAL NORTHERN INFIRMARY, INVERNESS, ON SATURDAY, 5 JUNE 1965. THE PRESIDENT OF THE SOCIETY, DR. J. F. BIRRELL WAS IN THE CHAIR.

After the Business Meeting, Dr. R. B. Lumsden showed a film entitled "Ultrasonics in Surgery". This is a sound film in colour made in Padua, in 1962, and was shown by courtesy of Messrs. Fraser Chemicals Ltd. In answer to questions Dr. Lumsden stated that a transducer is now available commercially which produces ultra-sound at a frequency of three million; cooling is necessary during its application in the form of continuous irrigation of the middle ear with normal saline. Dr. Lumsden advocated general anaesthesia for the surgical approach including the thinning of the prominence of the lateral semicircular canal, a step which all authorities regard as essential.

The patient is then allowed to regain consciousness so that his co-operation is available during the actual destruction of the semicircular canal.

Then followed a paper presented by the President, Dr. J. F. Birrell, entitled "Palatal Insufficiency". The following is a summary:

Insufficient closure of the nasopharynx on phonation may result from excessive scarring following removal of tonsils and adenoids in children or from a naturally occurring shortness of the palate relative to the depth of the naso-pharynx. Study of this has tended to be neglected by E.N.T. surgeons, since Mr. Alan Gibb mentioned it in 1958. The occurrence of the short palate may be classified as follows:

(*a*) Cleft palate which has been repaired by plastic surgery.

(*b*) Normal palate with unduly deep nasopharynx and usually associated with a long maxilla shown in profile by increased distance between nose and ear; it causes little other than speech defect.

(*c*) Normal palate with very large adenoid mass producing nasal and aural symptoms as well as speech difficulties.

The following report concerns thirty children who have been seen at R.H.S.C. Edinburgh, where there is a well established Speech Clinic under Dr. T. T. S. Ingram. The ages averaged 4–5 years and boys out-numbered girls by 3 to 1.

Particular attention should be paid to any remark by the mother, however casual, about speech defect. Palatal insufficiencies cause nasal escape of air which may be heard on phonation, seen by condensation on a cold tongue depressor, or even felt. Defects of the palate or its mobility may be seen on direct inspection. A frequent association is a pair of grossly enlarged but submerged tonsils which lean towards each other at the upper poles—removal

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may improve mobility but also reveal insufficient length which can only be made to compensate by intensive speech therapy.

Lateral X-rays of the nasopharynx (palatograms) are of great value, and are taken at rest, and with the child phonating "N" and "E". Treatment is by speech therapy with also surgery where indicated. Operative removal of only the upper two-thirds to three-quarters of the adenoid, including the lateral extension, is strongly advocated, so as to leave intact the lower portion with which the palate makes contact, i.e. Passavant's ridge. This can only be achieved by careful selective use of the adenotome, not the St. Clair Thomson or Popper curette. The adenoid remains have not been found to regenerate in up to 15 months.

Surgery is followed by speech therapy and results assessed by Dr. Ingram and his speech therapists; tape recordings and palatograms are used. Great improvement is noted in almost every case and the child's speech becomes intelligible beyond the family circle. From the standpoint of aural and nasal symptoms the results are as good as after a complete adenoidectomy.

Another paper was presented by Dr. A. G. Maran on "Electro-nystagmography" of which the following is a summary:

The apparatus used in this investigation consists of a high-speed recorder linked to electrodes placed on either side of the patient's head. There is no mechanical restriction on eye movements. The skin is prepared with ether and the electrodes attached with selotape. The recorder is adjusted to represent 1° of angular movement of the eyes as 1 mm. on the paper. The patient must be relaxed and does not fixate with the eyes; cortical control of the eye movements is abolished by giving the patient mental arithmetic problems to solve.

The apparatus has been used to investigate positional nystagmus in six head positions. Position changing nystagmus associated with upper cervical radiculitis can be distinguished from true vestibular nystagmus of vertebro-basilar ischaemia. The method can also be used to differentiate between ocular and vestibular nystagmus. It is considered a more delicate test than the caloric test with its inherent inaccuracy of measuring an end point to the duration of response.

The paper was illustrated with slides and representative recordings.

Discussion then followed on the clinical cases, patients previously having been in attendance for examination by members of the Society.

Dr. H. M. Urquhart showed three cases, the first being a gentleman of 78 who had been under observation since 1956. At that time a fleshy polyp removed from the right nasal passage had proved histologically to be malignant melanoma. Radium treatment had been given at the Western Infirmary, Glasgow, and regular follow-up revealed nothing abnormal until 1963 when a firm mass was found beneath the right angle of the jaw. A biopsy of this mass again showed malignant melanoma and he was then admitted to the Royal Beatson Memorial Hospital, Glasgow. On admission here, a portion of tissue came loose from the nasal passage and was confirmed as being melanoma; the cervical swelling thereafter regressed without treatment. Diabetes was then diagnosed and got under control. Despite the clinical regression a biopsy was taken from the neck and in one area was found a fibrous nodule encapsulating a mass of dead cells the appearance of which was compatible with melanoma,

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which had become inactive. In *April 1964* when in Glasgow for review he was noted to have a pustular-looking lesion in the lateral wall of the right nostril and biopsy again showed melanoma—this lesion thereafter disappeared. At that stage Dr. Stewart Scott the radiotherapist again discussed the condition with Dr. Lennox, pathologist, and Dr. J. Fulton Christie of this Society, and the decision made to take no further action.

Mr. E. G. Collins recalled a similar case which he had encountered also in Inverness, 30 years previously. The primary lesion had been on the inferior turbinate and removal of the lateral nasal wall had kept the patient free of recurrence for 4½ years. Mr. Collins considered the present case quite remarkable and urged Dr. Urquhart to publish it. Dr. G. C. McKinlay quoted from the Glasgow records and reiterated that spontaneous regression had occurred on several occasions in the present case and that it was difficult to accept that radiotherapy had contributed anything to the present good result.

The next case was a lady of 67 who had complained of swelling of the left cheek for 5 years; X-rays suggested erosion of the lateral wall of the antrum; surgical exploration had confirmed this and also revealed the content of the antral cavity to be clear golden fluid. The histology of the antral wall was fibrous tissue with chronic inflammatory cells, haemorrhage and cholesterol deposition—the underlying bone showed no remarkable feature. Discussion on this case was contributed by Dr. A. Brownlie Smith, Dr. Birrell, Mr. R. Thomas and Dr. I. M. Farquharson and various were the diagnoses suggested—hydrops antri, cholesterol granuloma, dental cyst; all agreed that the correct treatment was surgical drainage.

Dr. Urquhart's next case was a little boy of 3 years, with multiple congenital abnormalities (microtia heart disease, and bilateral ocular palsy) considered to be due to Thalidomide. Both ears had been explored surgically by Dr. Birrell in Edinburgh in late 1964 and the occluded external auditory meatuses opened up. Plastic inserts had been required since *January 1965* to maintain patency of the canals. The main problem here is his failure to acquire speech and this may probably be due to mental retardation rather than deafness. In the course of discussion Dr. Birrell explained to Dr. Lumsden the reason for operating on both ears, i.e. the left one had been infected at the time of intended surgery and the right one was dealt with; however, by the time of removal of dressings from the right one the left was found to be free of infection and Dr. Birrell went ahead with it too, because of the saving of time for the parents who live at a great distance from Edinburgh. Dr. Urquhart again expressed concern about the speech problem and Dr. Birrell suggested sending the child back to Edinburgh for speech therapy.

Dr. A. M. Grier's three cases then came up for discussion the first two being adults who had acquired sudden severe deafness in both ears. The first was a man of 30 years who was a known congenital syphilitic. He gave a history of recurrent episodes of bilateral deafness which had lasted a week or so in the past. In *December 1964* he was found to have bilateral perceptive loss more marked on the right. A hearing aid was fitted on the left side and after full blood and C.S.F. tests had been done by the venereologist he was dismissed; 5 days later another episode of deafness occurred—now being almost totally deaf (Audiogram shown). No help resulted from an intensive course of penicillin, stellate

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ganglion block and vasodilators. The second was a lady of 45 years who in *December 1964* presented with a history of bilateral severe pain in both ears 6 months previously. The pain had lasted 6 days and during that time she had taken a total of 150 tablets of Aspirin. Two days later she had developed a blood-stained discharge from the right ear; this was followed by sudden deafness with tinnitus and vertigo, the latter lasting only a few days. Examination showed a dry central perforation of the right drumhead with scarring of the left ear. Tests of hearing showed total bilateral loss and no vestibular responses on either side. Tests for psychogenic deafness were also negative, blood W.R. was negative and C.F. titre for mumps, measles, Herpes simplex, and influenzae A. and B. gave negative results.

In the course of discussion, Dr. A. K. Bain recalled a similar case of a young lady, a teacher of music, who came with a history of deafness, tinnitus, vertigo —the latter two symptoms cleared up leaving bilateral total deafness with bilateral loss of caloric responses. He had presumed the cause to be a virus infection.

Dr. Grier's third case—serous otitis media with a blue drumhead in a girl of 13 years was discussed along with another case of serous otitis media in a boy of 15½ who attended as an extra case. Doctors Smith, Birrell, Urquhart, Grier, Mr. Thomas and Mr. Collins took part in quite a vigorous discussion which revealed general dissatisfaction with the results and treatment of serous otitis media. All were agreed that the fluid whether it be serous or gluey must be removed repeatedly, whether by myringotomy, tympanotomy, insertion of plastic stopples or cortical mastoidectomy.

Another case shown by Dr. Grier was of unilateral serous otitis media in a man of 48 secondary to a carcinoma of the nasopharynx.

The final case, an extra one shown by Dr. Urquhart, was a "ticking lady" of 27 years who had been making a noise like the ticking of a clock for 9 months. Dr. E. A. M. Connal stated the source of the noise was a clonus of the palate muscles and that he had encountered a case of disseminated sclerosis which had presented in this way. Dr. Maran considered the present case to be hyperthyroid and also she had a habit tic; he suggested investigation of the thyroid function.

As there was no further discussion the President then closed the meeting.

ROYAL SOCIETY OF MEDICINE—SECTION OF LARYNGOLOGY

4 February 1966

Discussion on Mr. Wark's Paper

MR. F. C. W. CAPPS (London) said that he was quite sure that if Mr. Wark was still practising in the British Isles he would find that the incidence of Atrophic Rhinitis is also very low here. In the 1920's it was still quite well-known in Out-patient Departments and he thought that the improvement in this situation was generally due to the greater care, through school clinics etc., of children with muco-purulent rhinitis who undoubtedly in neglected cases got permanent damage to the nasal linings. Another condition now rarely seen was the chlorotic anaemia of young women which may have been a factor.

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With regard to multiple papillomatosis of the larynx in children, which also is a disappearing disease, it was significant that in a world-wide survey of this condition for the International Congress in Washington in 1957 the only two places where there was any great incidence were India and Finland and in the latter the numbers were also falling. As far as Europe was concerned, Finland was the last corner after the war to obtain and use the antibiotics. It is possible therefore that the very frequent use of these in modern times to prevent infection in the exanthemata in children may also inhibit this condition which seems quite likely to be of virus origin.

Discussion on Mr. McNeill's Paper

MR. J. W. DIXON (Cardross) said that the incidence of sinusitis appeared to vary with the locality, and perhaps climatic factors were important.

He and his colleagues at the Royal Infirmary, Glasgow, seldom saw chronic sinusitis and only very infrequently had to operate for this condition. The common nasal cases there have blocked noses and excess postnasal mucoid discharge due to a hypertrophic rhinitis. These cases often had X-ray evidence of mucosal thickening in the sinuses, but seldom any purulent infection of the nose or sinuses. In Mr. Dixon's opinion, the Caldwell Luc operation did not help this sort of case.

DR. H. D. BROWN KELLY (Glasgow) said that it was doubtful that a graft would remain viable in an antrum which had been diseased for many years as opposed to a short period. A recent article in the *Journal of Laryngology and Otology* had shown that in chronic sinusitis of long standing, not only was the mucosa diseased, but that there was an underlying chronic osteitis of the bony walls. Even running a burr over the bone would not eradicate this osteitis as it penetrated quite deeply. Could a graft be expected to live in a cavity lined by diseased bone?

MR. E. G. COLLINS (Aberdeen) said that Mr. McNeill had adopted a very sane attitude towards the necessity for any obliterative type of operation on the maxillary sinus. The occasions when it would be necessary would not be frequent, as the results from intranasal or radical antrostomy were fairly good.

Nevertheless, there were intractable cases of chronic maxillary sinusitis just as there were of chronic frontal sinusitis and if one was prepared to adopt an obliterative type of operation for the latter, there appeared to be no reason why this procedure should not be carried out in chronic maxillary sinusitis.

MR. S. R. MAWSON (Sidcup) said that discussion on any new operation must be set in relation to the known value of existing ones. In 1948 he had undertaken a review of all patients who had undergone the Intranasal Antrostomy operation or Caldwell Luc operation at St. Thomas's Hospital in the previous 10 years (Mawson, 1951). With the criterion of cure being clean, symptom-free noses three-quarters of the patients subjected to operation were cured in each group, slightly more (83 per cent.) in the Intranasal Antro-

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stomies. That this should be possible, even during the war years, seemed incontestable evidence of the value of these operations. He had personally examined every patient who was able to attend and was persuaded there was much ill-judged criticism of these operations.

REFERENCE

MAWSON, S. R. (1951) *St. Thomas's Reports* **7**, 72.

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