CLINICAL RECORDS

LIPOMA OF LARYNX.

By ALFRED WALFORD, Cambridge.

LIPOMATA of the larynx are of sufficient rarity to warrant recording, but this case is of additional interest for two reasons:—

(1) The very large size of the tumour. Weight $7\frac{1}{2}$ ounces.

(2) The long history combined with the fact that the patient had worn a metal tracheotomy tube for three years.

In 1917, a man aged 43 first noticed that his voice was becoming husky, and that he was snoring at night.

In 1924, as snoring and weakness of voice had increased, he consulted a doctor, who advised removal of the tonsils. This was done, but gave the patient no benefit. Nocturnal dyspnœa soon followed, and by 1927 dyspnœa had become very severe. A surgeon who was called in diagnosed malignant disease of the larynx, and advised a tracheotomy. This was done in May 1927, and during the next three months the patient had to be readmitted to hospital on three occasions, as the tracheotomy was not functioning properly. Rubber tubes were discarded, and a long metal tube inserted, which remained in position until March 1930.

In February 1930, the patient came to my out-patient department at Addenbrooke's Hospital, Cambridge, and on examination a soft swelling about the size of a large orange was felt on the right side of the neck in front of the sterno-mastoid at the level of the thyroid cartilage and hyoid bone. It moved with swallowing, and was thought to be possibly cystic. The larynx was displaced to the left, and the patient was wearing a metal tracheotomy tube which appeared to be the only air way he possessed. He was in excellent health, possessing general adipose tissues well above the normal.

As indirect laryngoscopy proved useless, a Jackson's laryngeal spatula was passed under general anæsthesia. It was then possible to see that the mucous membrane of the pharynx was invaginated from the right and completely excluded a view of the larynx, not even the epiglottis being visible. As no signs of ulceration or neoplasm were seen within the pharynx, the diagnosis was considered to be a cyst or lipoma.

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The Kahn reaction of the blood was negative. An external operation was advised, and after some persuasion accepted.

An incision was made along the anterior border of the sterno-mastoid muscle, and a large lipoma exposed. On attempting to shell this out, it was found to arise deeply internal to the great vessels in the region of the thyrohyoid space.

Suddenly the whole tumour delivered, and it was then seen to be dumb-bell shaped—the larger portion, which lay in the



Weight, 7½ ounces. *Length*, 4 inches. *Breadth* (widest part) 3½ inches.

neck, being separated from the smaller portion by a marked constriction caused by the upper border of the right ala of the thyroid cartilage below, and the lower border of the great cornu of the hyoid bone above.

The smaller portion of the tumour lay in a space on the inner aspect of the right ala of the thyroid cartilage, and had pressed the mucous membrane of the larynx and pharynx inwards, leaving a cavity large enough to hold a hen's egg between the mucous membrane of the larynx and the inner aspect of the right thyroid ala. The mucous membrane of the larynx was intact. The deep fascia was sutured together, a small drain being left in the wound for twenty-four hours.

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The patient made an uneventful recovery, and having assured ourselves that the air way per vias naturales was perfect, the tracheotomy tube was removed on the tenth day after the operation.

Breathing is now quite normal, and indirect laryngoscopy reveals a normal larynx.

The tracheotomy tube which he had worn for three years appears to have been less resistant than the trachea, for while the latter seemed unaffected, the tube in one place had been eroded right through.

TERATOID TUMOUR OF EXTERNAL AUDITORY MEATUS.

By JAMES ADAM, M.A., M.D., Glasgow, and MARY D. GILMOUR, M.A., Glasgow.

THE rarity of this sort of tumour is sufficiently shown by the fact that it is not mentioned in text-books on the ear. It has pathological implications, however, that render the case worthy of record.

Mrs H., aged 65, when first seen in 1928, had known of a growth in her right ear for at least eighteen years. There was no discharge, no pain. The growth filled the whole meatus, which it had enormously dilated. The patient was very deaf in each ear, the left tympanic membrane being retracted. She could hear shouting only. In the Weber test the fork was lateralised to the right ear. She came again in October 1929 complaining of pain in the right ear, discharge of pus and giddiness. She was taken into Stobhill Hospital and, after the usual incision in the post-auricular groove, the posterior meatal wall was split horizontally and the tumour delivered through this wound. The pedicle, which was attached behind the joint of the jaw, was easily severed with a gouge flush with the anterior wall of the meatus.

The post-aural wound healed by first intention, the others quickly epithelialised and the suppuration from the middle ear ceased. The tympanic cavity, however, was not really visible owing to the peculiar changes brought about by pressure of the tumour. The mastoid had lost half its antero-posterior width for the outer two-thirds of its depth but made up for this in the inner third by proliferating and mounding forward

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