SOCIETIES' PROCEEDINGS

THE SCOTTISH OTOLARYNGOLOGICAL SOCIETY

THE seventy-first meeting of the Society was held in the Victoria Infirmary, Glasgow, on Saturday, November 26th, 1955, with the President, Dr. J. Fulton Christie in the chair.

A discussion of the Sub-Committee's Report on the Training of Deaf Children (previously circularized) was followed by a discussion on the Training of Audiometricians.

DR. CONNAL said that he had trained a number of audiometricians in the past. He preferred not to train anyone for whom a job was not already fixed. Hitherto, applications have gone to the Board of Management, and no charge has been levied for trainees. The schedule of training issued by the Society of Audiometricians and Hearing Aid Technicians was adhered to, in order that the trainees were eligible to sit the examination. The length of training was considered by some members to be excessive, but he thought that the two years required might enable them in time to be recognized as medical auxiliaries. Lectures and training, as far as he was concerned, could easily be put into six months. At present, candidates had to travel to London to sit the examination. He felt that in Scotland we should hold our own examinations and have them recognized.

Cases were shown as follows:

MR. ALEX STRANG

2. *Hæmangioma of Right Middle Turbinate.* Male, aged 10 years, had bleeding from right nostril of one year's duration. Examination showed a hæmangiomatous swelling, the size of a cherry stone, below the right middle turbinate. Treatment consisted in X-ray therapy—300 r. The swelling is still present, although diminished in size.

3. *Syphilis of Nose.* A girl, aged 11 years, had obstruction and profuse purulent discharge from the nose of about eight months' duration. The nose was full of pus and crusts. After cleaning, a large perforation of the septum was seen, with granulations round the edges. The Wassermann reaction was triple plus. She has been put on anti-syphilitic treatment.

5. *Paresis of Left Masseter Muscle.* A schoolboy, aged 11, had been referred on account of frequent sore throats with the request to have tonsils and adenoids removed. When asked to open the mouth, the lower jaw was pushed well over to the left side. Electric reactions of left masseter muscle were normal. There was no sensory upset. The tonsils were very septic. Treatment consisted in electrical stimulation of nerve.

DR. FORBES WALKER thought that these cases of isolated paresis of muscles were worth watching. He had seen a number of cases of facial paralysis which

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were due to polio. A recurrent laryngeal palsy recently under his care also turned out to be due to polio.

DR. GIBB suggested that the case was not one of paralysis, but of spasm. On the affected side, spasm of the muscles would prevent the lifting of the articular surfaces of the joint.

MR. T. O. HOWIE

6. *Allergic Aural Polyposis.* Mrs. M. McA., aged 58 years, complained of intermittent discharge from both ears, and deafness of five years' duration. Examination showed pale, œdematous polyps in both ears. The polypi decreased in size with anti-allergic treatment (Lertigon), the left ear being now almost dry. The right ear is still active, and may require operation.

DR. GAVIN YOUNG suggested trying Hydrocortisone, as he had success with it in treating similar conditions affecting the skin of the meatus.

DR. VENTERS thought that the polypi should be removed physically to improve drainage.

DR. BROWNLIE SMITH recalled a patient with a large central tympanic perforation. The ear gave no trouble except when she ate tomatoes, when it discharged profusely.

7. *Dermoid Cyst in Middle-ear Cavity.* Mrs. S.F., aged 29 years, five months pregnant, had an attack of vertigo followed by deafness in the left ear. The right drumhead was normal. The left was translucent, and a small, sausage-shaped mass of reddish colour was seen in the lower part of the tympanic cavity. It was not adherent to the overlying membrane. Tuning fork tests showed a complete nerve deafness of the left ear, and the left labyrinth showed no response to caloric stimulation. A tentative diagnosis of glomus tumour was made. The lower half of the tympanic membrane was reflected and a biopsy taken. The histological report was "simple dermoid cyst". One month later, the ear was dry and the hearing good. A large perforation was present, and there has been a slight discharge on occasions. A left recurrent nerve palsy occurred six months after the biopsy, but this now seems to be clearing up.

DR. GIBB recalled a similar case which had presented originally with hoarseness due to a recurrent nerve palsy. Some weeks later a reddish fulness appeared in the ear on the same side as the palsy. Biopsy produced ordinary granulation tissue. X-rays showed abnormal mastoids, but no destruction of bone.

MR. GIBSON said that he was with Mr. Mitchell when he approached the middle ear through the mastoid. The postero-inferior half of the tympanic membrane was reflected forward and the tissue removed. The patient still has a recurrent palsy and changes in the petrous temporal. He thought that the vomiting and vertigo in Mr. Howie's case were due to the pregnancy.

DR. FULTON CHRISTIE thought that the associated nerve involvement was of central origin and due to a virus infection.

MR. HOWIE stated that dermoid cysts of the middle ear were very uncommon. It is odd that we do not see more cysts in the middle ear where so many clefts meet. One would expect malformations here. He agreed that she probably had a virus infection which would account for the separate palsies, as the middle-ear condition was local and non-irritating.

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8. *Non-chromaffin Paraganglioma (Glomus Tumour) of Middle Ear.* Mrs. M.A. aged 55 years. In 1937 was admitted to the Victoria Infirmary on account of polyp and fœtid discharge from right ear. *11.11.37* Radical mastoidectomy by Dr. Brand. Profuse bleeding. Facial palsy developed the same evening. Giddiness and nystagmus noted next day. One week later, meningitis developed, which cleared up with Prontosil and daily lumbar punctures. Biopsy at that time:— "highly cellular tumour composed of fibrous stroma cells of connective tissue type surrounding vessels? fibro-angiomatosis." *20.10.44* Polyp removed from radical cavity and reported as a hæmangio-endothelioma. Course of deep X-ray therapy given which shrivelled growth considerably, but it has never quite disappeared. It started to grow again in 1954 and occupied the whole mastoid cavity. Further X-ray therapy was given, which again reduced the tumour in size. Revision of the section by the pathologist led to the diagnosis of "Glomus Tumour or Non-chromaffin Paraganglioma."

MR. I. C. SIMPSON

9. *Non-chromaffin Paraganglioma (Glomus Tumour) of Middle Ear.* Mr. J.C., aged 43 years, had intermittent deafness, mainly left ear, for many years. A dark red, nodular discoloration was noted behind the left tympanic membrane, extending downwards from the attic region. Inflation failed to lift the drumhead off the growth. An endaural attico-antrotomy was done, and the mass removed from the attic, an extension downwards into the middle ear being hooked up. The incus was removed to improve access. Pathologist reported specimen as "glomus tumour". A full course of therapy was given. The ear is now dry, the tumour being still visible and little changed in appearance.

DR. MCKINLAY, in answer to a question by MR. MUNRO about metastases in these cases, said that there have been reports of "glomus" patients with a tumour in the neck, but not necessarily on the same side as the affected ear. This has been regarded as an independently arising tumour, rather than a secondary deposit.

MR. HOWIE thought his case was a very good test case. She had had the tumour for 18 years, it not having been completely removed. It has shown no sign of extension, even to her facial nerve.

MR. T. O. HOWIE

10. *Lymphoepithelioma of Nasopharynx.* Mrs. J.M., aged 61 years, complained of nasal obstruction and slight deafness. Glands excised from left side of neck at Ballochmyle Hospital, and reported as lymphadenoma. Nose appeared free anteriorly, but the nasopharyngoscope showed a mass in both ethmoidal regions. Nasopharynx full of growth. Biopsy showed lymphoepithelioma. One month after X-ray therapy, the mass had almost disappeared. Hearing is normal. No glands can be palpated in neck.

MR. H. D. BROWN KELLY

11. *Carcinoma of Nasopharynx following Rectal Carcinoma.* Mr. R.T., aged 56, underwent conservative excision of rectum and lower sigmoid on *26.2.53.* The growth was an active adenocarcinoma. On *20.7.54,* he reported with a gland in right side of neck and deafness of right ear. Although the presence of a

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nasopharyngeal growth was strongly suspected, none could be found on careful examination. Biopsy of neck glands showed carcinoma cells, less differentiated than those of the rectal growth. Treatment was by deep X-ray therapy and radium needles to the neck. On *25.10.55* a mass was seen in the right nasopharynx. Biopsy showed a squamous celled carcinoma of anaplastic type.

12. *Malignant Disease of Nasopharynx.* Mr. V.B., aged 26, attended Law Hospital in *November, 1948*, with a polyp in the left nostril and a mass of growth in the nasopharynx. The polyp was removed, and a biopsy taken from the nasopharynx. Both reported by the pathologist as carcinoma. Radiotherapy started in the Victoria Infirmary on *30.11.48*. Seen as out-patient on *22.2.49*. Breathing freely through the left nostril. There is a polypoid tumour attached to the posterior end of the left inferior turbinate. To-day, seven years after treatment, there has been no recurrence.

Mr. Gibson recalled seeing a patient with deafness due to Eustachian obstruction. The tube could not be inflated, and he was shown to students as a typical case of middle-ear catarrh. Some weeks later he developed a swelling over the sternomastoid, which turned out to be a squamous epithelioma. Careful examination of the nasopharynx showed no lesion. He had X-ray therapy, and is alive and well, but must have had a cancer in his Eustachian tube.

Mr. T. O. Howie

13. *Epidermoid Carcinoma of Left Maxillary Antrum.* Mrs. M.L., aged 59, suffered from nasal polypi for many years. In 1942 biopsy showed malignancy, and the left antrum was opened by diathermy and an extensive excision of its walls carried out. A dental prosthesis filled in the antro-buccal defect. She had a healthy operation cavity until 1948, when a small growth was noticed on the posterior part of the septum. This was removed with punch forceps and diathermy. Reported as "Infected squamous celled carcinoma". This area was cauterized again on two subsequent occasions. In 1949 a small polyp appeared close to the cribriform plate; it was removed and pronounced simple. Polyp re-appeared in 1955, but again found to be simple.

14. *Neuro-sarcoma of Orbit.* Mr. J.F., aged 56, had a swelling of the right frontal eminence since childhood. About six months ago, a swelling appeared in the inner and upper aspect of the right orbit, accompanied by double vision. Exploration of right orbit and frontal sinus. A cyst at the inner aspect of the orbit ruptured, the contents being mucoid and suggesting a mucocele. The frontal sinus floor and the roof of the ethmoid capsule were destroyed, the dura of the anterior fossa lying bare. Tissue removed from the ethmoids had a neoplastic appearance, and the pathologist's report was "neurogenic sarcoma". Patient has had a course of X-ray therapy and has returned to work.

15. *Probable Reticulo-sarcoma of Right Tonsil.* Wm. B. aged 14 years, was seen in *January, 1953*, with swelling in right side of neck for six weeks. No sore throats. The right tonsil showed a massive pale swelling firmly fixed in the tonsillar bed. Left tonsil appeared small and normal. A glandular mass in the right jugulo-digastric area was firmly fixed to the deeper tissues. The condition

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was considered to be a reticulosarcoma. In a child, there is a possibility of causing blood dissemination by doing a biopsy, and it was deemed advisable to use X-ray therapy as a diagnostic test. About three weeks, later, the gland mass was hardly palpable and the tonsil mass greatly reduced. The tonsils are now of equal size and there is no sign of recurrence.

DR. BIRRELL said that he had seen two children with swelling of one tonsil and glandular enlargement. Both had had antibiotic treatment. Differential blood count and E.S.R. made him suspicious of an infection, although clinically the condition looked like reticulo-sarcoma. He questioned the advisability of going ahead with radiotherapy in a child, unless the diagnosis was established.

DR. SIMSON HALL suggested doing a biopsy of the neck gland and leaving the primary growth alone.

DR. GAVIN YOUNG thought that one could justifiably call this case a reticulosarcoma without doing a biopsy.

MR. I. C. SIMPSON

16. *Reticulo-sarcoma of Both Tonsils.* Mrs. R. McK., aged 76, had pain and dysphagia of a month's duration. The left tonsil was grossly enlarged, the swelling extending into the soft palate. A large, firm gland was present in the left anterior triangle. Biopsy showed an undifferentiated reticulo-sarcoma of the left tonsil. Six months after X-ray therapy, both tonsils were small and the glands had regressed. One month later she attended with pain in the right side of the throat. A large sloughy ulcer was present on the right tonsil, and biopsy again showed reticulo-sarcoma. Further therapy was given. To-day, four years after onset of symptoms, the patient remains well, the tonsils being small and with no evidence of glandular enlargement.

MR. T. O. HOWIE

17. *Recurrent Pemphigus Ulceration of Pharynx and Hypopharynx. Treated by Cortisone.* Mr. T.K., aged 53 years had recurrent ulceration of the pharynx for about seven months. Both lateral areas of the hypopharynx showed indolent ulceration with no evidence of healing at the edges. The glottis showed heaped up nodular areas in the interarytenoid space. Scrapings from this area and from the ulcers showed non specific granulation tissue. Wassermann test negative. No pulmonary tuberculosis. In view of these findings and the relapsing type of ulcers, a diagnosis of pemphigus was made. The disease cleared up completely after a course of Cortisone, although since then there has been a slight relapse.

18. *Sodium Morrhuate Injections of Œsophageal Varices.* Mrs. S.D., aged 55 years, had repeated attacks of hæmatemesis. On œsophagoscopy, bleeding was noted from the left œsophageal wall, about 40 cms. from the upper teeth. Varicosities just above the cardia were injected with 1 c.c. of Sodium Morrhuate solution to each varix. There has been slight recurrence of bleeding, but the intervals have been much longer.

DR. MCKINLAY mentioned a similar case which he injected with Ethylene, using Dr. Ewart Martin's instruments. The result was good, with no recurrence after two years.

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MR. H. D. BROWN KELLY

19. *Fenestration Right Ear.* Mrs. A.C., aged 35, underwent fenestration of right ear in 1948. Healing of cavity was delayed by a mucor fungus infection, but eventually the ear dried up, with good hearing. To-day, audiograms show that the hearing in the fenestrated ear has deteriorated for the higher frequencies, although in the middle and lower registers it is better than it was three months after operation. A similar loss is seen in the unoperated ear.

DR. FORBES WALKER had watched Dr. Rosen perform stapes mobilization on a man aged 57, whose hearing was so bad that he would have been considered unsuitable for fenestration. The immediate post-operative result was very good, including return of hearing in the upper register.

DR. SIMSON HALL pointed out that otosclerotic ears tend to lose the high tones as they get older, and they are more vulnerable to noise than normal ears. This is borne out by the examination of patients for fenestration who have been using an aid in the better ear.

20. *Congenital Occlusion of Right Posterior Choana.* Miss L.C., aged 19, was first seen when 11 years old, complaining of right nasal obstruction. Pus was seen in the right nostril, there was a mass of adenoids present, and the right antrum was dull on X-ray. The antrum was washed out and the adenoids removed. It was only six months later that the true cause of her trouble was discovered—a bony occlusion of the right choana. This was operated upon in *April, 1948*, and again in *April, 1951*. The extreme thickness of the bone surrounding the thin centre of the occlusion presented difficulties. To-day, an opening is present, but narrow. Further operation based on the trans-palatal approach of C. P. Wilson is considered.

DR. SIMSON HALL warned that if the occlusion is not at the posterior end of the bony choana, the Wilson approach can be difficult unless the incision is made further forward than normal.

21. *Carcinoma of Larynx Associated with Tuberculosis.* Mr. J.C., aged 54, was seen in *November, 1954*, in the E.N.T. Hospital, Greenock, suffering from cough and hoarseness. Examination showed a laryngeal growth involving epiglottis and arytenoids. Biopsy proved it to be epidermoid carcinoma. He was transferred to the Royal Beatson Memorial Hospital for radiotherapy, and while there was found to be suffering from pulmonary tuberculosis. Admitted to Bridge of Weir Sanatorium in *January, 1955*, with bilateral, active pulmonary disease, cavities being present in both apices. The larynx showed ulceration and partial destruction of epiglottis, both false cords and arytenoids, with much œdema. Dysphagia was severe, each meal being preceded by an analgesic spray. The condition gradually improved, the œdema subsiding and the epiglottis stump healing. He has put on weight and feels well. The interesting question is how much of his laryngeal disease was tubercle, and how much carcinoma?

DR. SIMSON HALL thought that from examination appearances, most of the trouble had been caused by the tuberculosis and not by the cancer. He had seen several very similar cases.

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