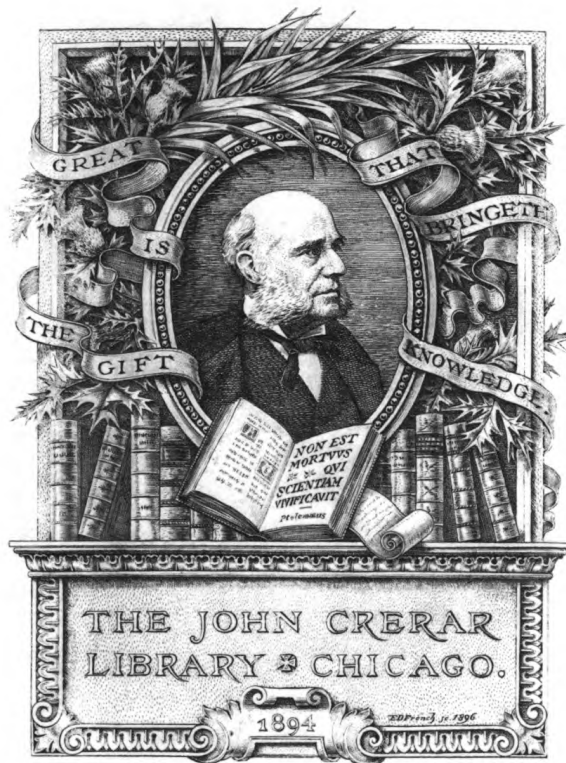


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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY

OF

LONDON.

VOL. XIV.

1906—1907.

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OF THE
Laryngological Society of London

ELECTED AT
THE ANNUAL GENERAL MEETING
JUNE 1st, 1906.

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The above form the Council.

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PROCEEDINGS OF THE LARYNGOLOGICAL
SOCIETY OF LONDON.

One Hundred-and-eighth Ordinary Meeting, November 2, 1906.

J. B. BALL, M.D., *President, in the Chair.*

HENRY J. DAVIS, M.B. } Hon. Secretaries.
W. JOBSON HORNE, M.D. }

Present—40 members and 5 visitors.

The minutes of the previous meeting were read and confirmed.

The following communications were made :

TUMOUR OF THE PHARYNX.

Shown by Dr. J. B. BALL. He said : The patient, a woman, aged fifty-three, first noticed a swelling in the left side of the throat, about five years ago. Previous to this she says that some gritty matter came from the left tonsil on several occasions. The swelling increased very slowly at first, but during the last twelve months it had increased more rapidly. On the left side of the throat is a tumour, about the size of a tangerine orange, pushing forwards the soft palate, which is tightly stretched over it. The tumour is of solid consistence, slightly elastic on pressure. On the external surface, just behind the ramus of the lower jaw, there is a distinct hard swelling, apparently continuous with the tumour inside. She has no pain, and only a little difficulty in swallowing food, and slight difficulty with her breathing occasionally at night.

Mr. BUTLIN said that he had only been able to make a short examination of the patient, but that he felt sure there was a tumour deep down behind the angle of the jaw. There could be little doubt that the tumour was continuous with the tumour of the palate, both on account of its hardness and its absolute immobility. He thought he had had a similar case about a year ago. A gentleman was sent to him by Professor von Bergmann with a hardness in the left side of the palate, which felt like a diffuse new growth. Mr. Butlin divided the palate in the middle line, made an incision into the tumour, let out a little fluid, and finding no tumour behind the palate, he closed the incision and hoped that was an end of the case. But within a few weeks the patient returned, complaining of discomfort in the mouth and deep down in the neck. As there was a swelling over the lower part of the parotid gland, which felt like a soft

lymphatic gland, an operation was performed from the outside. Even then the real disease was almost overlooked, for it was a hard tumour which lay right beneath the whole thickness of the parotid gland, well-defined, enclosed in a thin capsule and lying up against the base of the skull. It was quite white on section and cut like a very firm potato. It was completely enucleated, and proved to be a typical endothelioma. Mr. Butlin advised that a similar operation should be performed in the present case.

Dr. DUNDAS GRANT said he had had two cases which much resembled the present one, and in both he was able to shell out the tumour by an incision through the anterior half of the palate. In the first he thought he would have much difficulty, and went to it in the country with galvanocautery, snares, etc.; but after making an incision through the palate with scissors he was able to shell it out quite well. The second case was very similar. They seemed like the tumours described by Paget in his well-known paper.

Mr. E. W. ROUGHTON said he had seen a tumour in a similar position and it shelled out easily by an incision through the mucous membrane. He recommended that the case should be dealt with from inside rather than from outside the mouth.

Dr. FITZGERALD POWELL thought the tumour was attached to the angle of the jaw. On palpating the growth in that situation there appeared to be considerable tension, as if it was connected with the jaw. It looked rather like a fibro- or adeno-sarcoma. He thought the Society would be indebted to Dr. Ball if he would furnish a further account of the case if the tumour were removed.

Dr. BALL, in reply, thanked members for their opinions. He would report further if the patient agreed to operation.

SWELLING OF THE LEFT ARYEPIGLOTTIC FOLD.

Shown by Dr. J. B. BALL. He said: The patient, a man aged fifty-seven, complains of discomfort in the throat, and of feeling a lump, which he tries to dislodge by frequent swallowing. He has had these feelings for about three months. There is no actual pain, and the voice is not materially affected. He has had good health, except for an occasional attack of bronchitis in the winter. There are no physical signs in the chest and no albuminuria. On examination of the throat the lateral folds of the pharynx are seen to be thickened, and these thickened folds are continued down to the level of the larynx in the form of two symmetrical and very prominent swellings at each side of the posterior pharyngeal wall. There is a pale, œdematous, and somewhat pear-shaped swelling involving the aryepiglottic fold and arytenoid on the left side. The left vocal cord is largely concealed by the swelling, but is not fixed. He has been under observation for three weeks, during which time he has taken 10 grains of iodide of potassium three times a day. No change has been observed in the condition.

Dr. DUNDAS GRANT said he believed it to be chronic œdema, of which several cases had recently been shown before the Society. Their nature seemed to be very obscure. There was a suggestion that it might be lymphomatous.

Mr. H. BARWELL agreed that it was probably chronic hyperplasia. The lateral bands of the pharynx presented very much the same swollen aspect as did the arytenoid, and that would be strongly suggestive of this condition.

Dr. JOBSON HORNE considered that the swelling over the arytenoid was largely due to œdema. He once had the opportunity of observing both clinically and also *post mortem* a precisely similar case. At the autopsy the œdema was purely local, and beneath it, in the fold running down between the cartilages of Santorini and Wrisberg, there was a slight abrasion—in fact, a small ulcer. There was some slight necrosis of the underlying cartilage. There was no tubercle nor evidence of any other disease in the larynx. Death occurred, not from the laryngeal affection, but from chronic interstitial nephritis. The movement of the vocal cord in this case negatived any very deep seated disease of the arytenoid cartilage.

PAPILLOMATA IN THE NOSE.

Shown by Dr. BALL. He said: The patient is a woman aged fifty, who has complained for some months of obstruction in the left side of the nose. There has been no discharge from the nose, nor any bleeding. Several warty growths are seen implanted on the septum, floor, and inferior turbinal, in the anterior region of the left nasal fossa.

Mr. HERBERT TILLEY suggested the advisability of removing the anterior end of the turbinal and cutting sections of the growths. The one on the inferior turbinal he thought might be in the nature of granulations round an ulcer, possibly tubercular. The procedure he suggested would settle the diagnosis.

Dr. PEGLER asked whether the case had had any treatment, and if any of the growth had been removed, from which part, also had the specimen been preserved.

Dr. BALL, in reply, said he had had suspicions that there were some granulations. She came three months ago, and a couple of the warty growths were snared off. He thought Dr. Tilley's suggestion was possibly correct. There had been no treatment beyond removal. The specimen was not preserved, but to the naked eye it was a wart-like growth. In reply to Dr. Milligan, he would inquire about syphilis; he had not suspected it.

THIMBLES FOR MAKING ASEPTIC WOOL MOPS.

Mr. CRESSWELL BABER showed metal thimbles fitting on to the left forefinger and thumb, with which wool can be easily wound round a cotton carrier. They are grooved on the opposing surfaces and have small handles by which to hold them. They are sterilised by boiling.

The PRESIDENT said it was difficult to judge as to the usefulness of the thimbles until one had used them for a time, but if they could be easily manipulated they would be very helpful. It was often impossible to keep one's fingers absolutely clean, and he thought these thimbles might be useful, especially in ear work.

Dr. DUNDAS GRANT said the thimbles acted very well indeed.

BILATERAL TUBERCULOUS LARYNGITIS, COMPLETELY HEALED FOR THREE YEARS, WITHOUT LOCAL TREATMENT, IN A MAN AGED FIFTY-FIVE.

Shown by Dr. STCLAIR THOMSON. This patient consulted me first on August 10, 1899, when he weighed 10 st. 10 lb.; to-day he weighs 13 st. 2 lb. In 1899 there were symptoms at the right apex, and his sputum contained tubercle bacilli in considerable numbers. The left cord showed irregular granulations on its posterior third, a slight infiltration of the corresponding part of the right cord. In 1900 he had a long attack of pleurisy, and his chest and laryngeal symptoms became more marked. In 1901 there was infiltration of the interarytenoid region, injection and infiltration of the right cord with sub-cordal thickening, and the left vocal process was concealed with ulcerating infiltrations.

I did not see him again for nearly two years. On May 21, 1903, I found his larynx intact except for some slight interarytenoid thickening, and with white scars over and below both vocal processes. His larynx was seen by Sir Felix Semon and Dr. Watson Williams on November 7, 1903, both of whom agreed that there was nothing amiss with it. To the latter I am indebted for the sketch he then made showing the site of the scars. I have only to add that the patient's "cure" has been carried out in Plumstead, where he shares his bed with his wife, and until I converted him he had a dread of fresh air.

EXTENSIVE TUBERCULOUS LARYNGITIS, NO LOCAL TREATMENT, COMPLETE HEALING CAUSING STENOSIS OF THE GLOTTIS AND REQUIRING TRACHEOTOMY, HEALING MAINTAINED SINCE ONE YEAR, IN A WOMAN AGED FORTY.

Shown by Dr. STCLAIR THOMSON. The husband of this patient died in 1900 of phthisis. She first attended me on March 25, 1904, for hoarseness and marked dysphagia. There was œdema-like infiltration of both arytenoids, mamillary thickening of interarytenoid fold, and some sub-glottic infiltration on the left side. Fortunately, I can hand round the rough sketch which I made at

the time. The left upper lobe was dull and there were moist sounds. The sputum was scanty and no tubercle bacilli were ever found. She was put upon general and hygienic treatment. The condition had become more marked in July, and throughout 1904 there was increased œdema of arytenoids and ulceration of the interarytenoid region. In June, 1905, it was noticed that there was impaired abduction of the cords, but that they were clear, while the interaryténoid fold was less thickened and the posterior surfaces of the arytenoids were losing their œdema-like look. In November, 1905, there was no dysphagia. The voice was clear and fairly good. For two or three months the stridor at night was heard all over the house, and it was marked even when at rest. At this time it was noted that the appetite was poor, the temperature 98° F., and dulness and moist râles on the left upper lobe, with dulness and tubular breathing at the right apex. The vocal cords were then fixed, so that while they adducted easily the amount of abduction left only a small chink. A low tracheotomy under cocaine had, therefore, to be done on February 1, 1906. Since then the patient has gained in weight, and I have gradually, but with great difficulty, converted her to believe in fresh air, exercise, and rest, while diminishing her faith in over-clothing. She breathes freely, the voice is clear, there is no stridor. The larynx is completely cicatrised. Both vocal cords possess slight movement, but this is evidently limited in action by cicatricial tissue. The glottis is reduced to a slit. The arytenoids, and, in fact, the whole larynx, is otherwise quite normal.

The spontaneous healing of such a well-marked case of tuberculous laryngitis is extremely noteworthy, and that it should result in such glottic stenosis as to require tracheotomy is, I imagine, a most exceptional occurrence. The possibility of the infection being mixed with syphilis occurred to me, but neither the history nor the appearances at any time supported such a possibility.

The PRESIDENT said that in the case he examined the lesions had healed so completely that one would not have thought any tuberculous disease had ever been present. Both cases showed that tuberculous laryngitis would get well without any local treatment.

Mr. H. BARWELL said he saw only the second case, but the Society was much indebted to Dr. Thomson for insisting on the value of rest to the larynx in such cases. He did not know whether the voice was absolutely rested in those cases, but rest certainly was important. In the second case there still appeared to be a little infiltration at the back of the posterior wall of the larynx, though not inside the lumen. Such good results were, however, very uncommon.

Dr. FITZGERALD POWELL thought these cases very interesting and

strongly bore out the view he held that the improvement or cure of tuberculosis of the larynx depended in great measure on the state of the lungs, whether the disease was active or not in the lungs. He had had cases in which the disease was quiescent in the lungs and what appeared to be a complete cure took place in the larynx, but in a year or two afterwards the disease in the lungs became active again, when inspection of the larynx took place. These cases appeared to him to raise the question as to whether tubercular laryngitis should be treated in the London hospitals or sent to open-air sanatoria.

Dr. H. SMURTHWAITE said that within the last two months he had had patients with marked tuberculous disease of the larynx under sanatorium treatment. One man, who had put on two stones in weight, had a swelling of both arytenoid joints and ulceration of the right cord, and had practically lost his voice. After six weeks in a sanatorium the swelling of both joints had gone down remarkably, but there was still slight ulceration of the cord. A case sent for sanatorium treatment a fortnight ago had greatly improved in general condition; there had not been time to see whether the larynx would improve with the lungs. Such cases as shown by Dr. Thomson enabled a much better prognosis to be given to the patients and their friends. One was generally asked whether there was a complete cure for such cases, and while it could not be said that there was, it could be stated that there were cases which did get better.

Dr. DUNDAS GRANT asked whether the ulceration involved the framework and margins of the larynx—*i. e.* the edge of the epiglottis and posterior part of the ary-epiglottic folds, so as to produce odynphagia. That symptom seemed to justify some very active measures, to enable the patient to take food. Would Dr. Thomson consider it wise to supplement the open-air treatment by local treatment of the larynx?

Mr. BABER inquired whether antiseptic sprays, such as menthol, were employed in these cases. One often saw such cases run a very chronic course under this treatment.

Dr. WATSON WILLIAMS asked how long the cases had been under observation. He (Dr. Williams) made a sketch of the condition, but he did not remember how long ago. Still, he knew it was sufficiently long ago for any impending lesion to have declared itself long since. The cases showed the excellent results from open-air treatment, combined with complete rest of the larynx. In some cases so treated, however, a localised lesion remained, very chronic, and matters could be much expedited by local removal of that focus.

Dr. DE HAVILLAND HALL said that two years ago, in the spring, a gentleman, aged seventy-two years, consulted him on account of loss of voice, cough, and loss of flesh. Before examining his larynx he (Dr. Hall) thought he had malignant disease, it having lasted some weeks; but he found ulceration of both cords, and chest examination showed a suspicion of mischief at the right apex, slight impairment of resonance, and a little crackling on coughing. Tubercle bacilli were found in fair numbers in the sputum. He sent the patient to live in the open air at Bournemouth, and gave him an antiseptic spray, consisting of menthol, eucalyptol, and oil of cinnamon, to be used every four hours, and he was enjoined not to speak at all, but to write his requirements. In addition he had 5 grs. of carbonate of guaiacol three times a day. In three months the patient returned, having put on a stone and a half in weight, the ulceration was completely healed, and when nine months later he had to see the patient over another matter, the signs of lung disease had disappeared, and the larynx was

apparently quite well. It was unusual for a man of that age, previously well, to have tubercle and recover so well.

Dr. ATWOOD THORNE said that five years ago he saw a man with marked tubercular trouble in his larynx. He at once sent him to Ventnor. He had been a heavy drinker. After four months' stay he was quite well. There was no local treatment whatever.

Dr. STCLAIR THOMSON, in reply, said the woman who had tracheotomy done had much dysphagia at one time, and had the typical œdematous arytenoids. But there was never any ulceration on the pharyngeal surface; it was limited to the glottic region. Dr. Watson Williams made the drawing of the man three years ago. The cases under discussion had not had sanatorium treatment; they had not left their homes, one of which was at Plumstead and the other at West Ham. They were not good disciples at first; they were smothered with clothes, and had never slept with the windows open. He hoped on a future occasion to bring some private patients on whom he had carried out local treatment. In reply to Mr. Baker, he would say that while sprays were useful in keeping the larynx clean in hospital patients, they were not necessary in the open-air treatment, as the larynx then got clean of itself.

BILATERAL FRONTAL SINUS OPERATION (KILLIAN).

Shown by Dr. STCLAIR THOMSON. This patient, a man aged twenty-three, was operated on in June last. The frontal sinuses were very large. Although there is some depression over the left frontal sinus, it is seen that the æsthetic result is excellent. This result is due to the careful preservation of the Killian bridge and of the septum between the two sinuses, as well as to the carefully planned and adjusted incisions. The permanency of the opening into the left sphenoidal sinus is well seen. The patient still has some pus in the right nostril, doubtless from one of the ethmoidal cells.

Mr. STUART-LOW said he had examined the case and was pleased with the result. But there was a good deal of depression over the site of the bone removed on the left side, and he suggested that Dr. Thomson should do as Killian had done in such cases, inject paraffin to remove the deformity. Killian's usual incision was a little different from that done by Dr. Thomson, being carried almost straight down to the bony edge of the nostrils. Killian's incision enabled better access to be obtained to the ascending process of the maxilla, which, of course, had to be removed.

Dr. STCLAIR THOMSON, in reply, said he would put a little paraffin in if desired. He copied the incision which he carefully learned from Killian three or four years ago. Killian pointed out that in all operations on the face the incision should be a curved one, as that was less noticeable, following as it did the natural curves of the face, than a straight cut.

STENOSIS OF THE LARYNX.

Shown by Dr. H. J. DAVIS. A woman, aged forty-four, with dyspnoea and stridor, according to her statement of "twelve

months' " duration. The glottis was stenosed and ulcerated. She had had three miscarriages and pleurisy four times, and had physical signs of thickened pleura on left side. The throat was painless; no glands were present in the neck, and the patient was emaciating.

Dr. DAVIS said she had no physical signs of active disease, but she had signs of old pleurisy. She did not originally seek relief for herself, but when attending at the hospital in charge of a child her attention was called to her stridor; this was three months ago. The case was shown for diagnosis. She was now much worse, and he thought it was malignant disease, despite the fact that she had physical signs in the lungs. There was no sputum, but she was emaciating rapidly.

Dr. DUNDAS GRANT considered the evidence to be in favour of tuberculosis.

INOPERABLE CANCER OF FAUCES TREATED WITH A BACTERIAL VACCINE OF *Micrococcus neoformans*. (Shown on June 1, 1906.)

Shown by Dr. SCANES SPICER. The patient, a man aged seventy-five, was previously shown on June 1 with inoperable cancer of the fauces and the adjacent structures. The patient had undergone a further twenty weeks' treatment with a bacterial vaccine of *Micrococcus neoformans*. He had gained 2 lb. in weight. The malignant growth had receded in one part but was more prominent in another.

The PRESIDENT said he thought the case looked a little better now than on the last occasion he saw it.

Dr. B. H. SPILSBURY gave the following description of the microscopical appearances of the growth:

Histological examination of a piece of the growth, which was removed on April 6, 1906, showed a spheroidal-celled carcinoma. The masses of cancer-cells had very uniform appearances in every part of the sections; there were no degenerative changes in the cells, but very numerous mitotic figures were present indicating a rapid growth.

The stroma of the growth was small in amount and was closely packed with connective-tissue cells, the majority of which were mononuclear cells and corresponded in morphological characters with the plasma-cells of Unna; there were small numbers also of polymorphonuclear leucocytes and a few coarse eosinophilous cells.

A second piece of the growth was examined histologically six months later on October 10, 1906.

The masses of carcinoma cells showed no alteration in character

throughout the greater part of the mass, but in a few spaces the cells had shrunken in size, and their nuclei were smaller and more compact and showed fewer mitotic figures, suggesting some slowing in the rate of growth. There were no degenerative changes in the cells.

The chief changes were in the stroma, which in places was entirely free from infiltration with connective-tissue cells and in other places showed small collections of cells which were almost all of the type of polymorphonuclear leucocytes.

In short, there appeared to be some attempt at the production of an adult connective tissue, an attempt of which there was little or no evidence in the section examined six months previously.

Mr. STUART-LOW suggested that as practical surgeons they might make use of this treatment preparatory to operation to get rid of the suppurative and inflammatory conditions of the malignant tumours, these conditions being known to be very inimical to successful results.

Dr. SCANES SPICER, in reply, said the changes in size and the different parts of the growth varied very much. He feared that the growth was rather larger again since he saw the case a fortnight ago. Injections had been regularly kept up. There was sufficient proof of the influence of the injection in the fact that though it was eighteen months since the man came under observation he was still comparatively well, and had actually gained weight. He had had a second case, which was considerably improved in the matter of cleanliness and in the reduction of the swelling, as well as in the increased mobility of the tongue and jaw. He certainly thought the patient ought to be given a chance of the treatment if he had inoperable carcinoma of the pharyngo-oesophagus; he knew of nothing more promising.

FIXATION OF THE RIGHT VOCAL CORD WITH DYSPHAGIA FOR LIQUIDS.

Shown by Mr. STUART-LOW. The patient, a woman aged fifty-six, sought relief on October 20 last, on account of difficulty in swallowing liquids. She said that she had suffered from this for three months and that it was increasing. There was a history of recurrent attacks of rheumatism. One year ago she had an attack of influenza and since then she had been very liable to catch cold. There is nothing of the nature of specific disease in her past history. She is the mother of thirteen children, most of whom are living. There is no difficulty in passing the largest oesophageal bougie nor in swallowing solids. When an attempt to drink is made the fluid apparently passes through the fauces and into the upper part of the oesophagus, when coughing begins. It seems as if some of the fluid gains entrance to the

larynx and thus sets up reflex coughing. She expresses herself as certain that cold liquids pass with less coughing than warm. The right vocal cord is seen to be completely fixed in the cadaveric position. The arytenoid cartilage during voice-production moves a little forwards and inwards, but much less than normally. The tension of the fixed cord appears to be normal.

A small mass of rather firm, enlarged glands, somewhat painful on pressure, can be felt in the superior deep cervical group on the right side. The chest shows no evidence of disease and the nervous system seems normal, and a skiagram shows nothing unusual. She has lost weight to the extent of one stone in nine months, during the last month has felt very much less energetic than usual. The cause of the paralysis of the right vocal cord and of the peculiar symptom of coughing on trying to swallow liquids is difficult to explain; one explanation might be that there existed a malignant growth in the œsophagus implicating the right recurrent nerve, this nerve being situated more posteriorly than the left. This would not only account for the paralysis of the cord, but for the weakening of the sphincter muscle keeping guard over the entrance to the larynx. If some fluid entered the larynx on attempting to swallow liquids, the superior laryngeal being intact, coughing would ensue.

Dr. DE HAVILLAND HALL said that last year he had a lady, aged twenty-three, who complained of slight hoarseness and difficulty in swallowing liquids, though she could swallow solid food perfectly. He found paresis of the right vocal cord, and he heard that she had been exposed to cold. Probably she got a slight neuritis, and he put her upon iodide of potassium, and went in for electrical treatment. She was going out to India. She improved rapidly, and got quite well. He believed the difficulty in the present case arose from imperfect closure of the larynx. He could not say what was the cause of the fixation of the cord,

Dr. FITZGERALD POWELL said he understood there was a history of influenza in this case. The vocal cord was paralysed, but there was some movement in the arytenoid. Some time ago he had shown a similar case to the Society, and the general opinion of the members was that the paralysis of the cord was due to the toxin of influenza. The patient had had iodide of potassium and strychnine, but he got better suddenly and not apparently as the result of any treatment.

Mr. STUART-LOW, in reply, said his patient, like Dr. de Havilland Hall's, could swallow cold fluids better than warm, probably because of the stimulating effect on the sphincter of the larynx. He had not yet treated her, but proposed to try potassium iodide. The influenza occurred only three months ago, and this would be a very long time for the toxin to be still active, supposing influenza to be the original cause of the laryngeal paralysis.

A CASE OF EPITHELIOMA OF THE LARYNX.

Shown by Dr. WATSON WILLIAMS. The growth involved the epiglottis, the right aryepiglottic fold, and arytenoid region, extending to the right glosso-epiglottic fold and the contiguous portion of the lateral wall of the pharynx. There was an enlarged gland, corresponding to the tip of the great cornu of the hyoid bone on that side. The patient had complained of pain extending up to the right ear since June, and a month later hoarseness was noticed, and he had been losing flesh.

Microscopical evidence of a fragment left no doubt as to the histological character of the growth. He showed the case with a view to receiving suggestions as to the possibility of successful removal by operation.

MALIGNANT DISEASE OF THE RIGHT SIDE OF THE LARYNX IN A SYPHILITIC MAN AGED SIXTY.

Shown by Dr. STCLAIR THOMSON. This patient has been losing his voice for about a month. Lues was contracted twenty-five years ago. The right vocal cord is concealed by a diffuse ulcerating infiltration, which spreads all over the right ventricular band, the aryepiglottic fold, and upwards on the epiglottis. The sides of the ulcer are deeply cut. There is no fungation, sloughing, or odour; some dysphagia. The glands below the right jaw are enlarged but not fixed. The right vocal cord is concealed, so that we cannot tell if its action is impaired. He has taken 15 grs. of iodide with mercury for nearly three weeks, and for ten days he has had inunctions of mercury. At first the surface cleaned up in a remarkable way, but latterly there has been no progress. Opinion was invited as to whether the growth was undoubtedly malignant, whether anti-syphilitic treatment should be given a fresh trial, and whether the case was suitable for hemi-laryngectomy.

A CASE OF GLOSSO-EPIGLOTTIDEAN LYMPHO-SARCOMA.

Shown by Dr. DUNDAS GRANT. The patient was a man aged thirty-one, who complained of dryness and soreness of the throat of three months' duration, and of a swelling of which he had been conscious for one month. On depressing the tongue, an irregular, smooth-surfaced, fleshy growth came into view, and, by means of the laryngoscopic mirror, it was seen to involve the posterior part of the tongue so as to completely conceal the larynx. On raising

the posterior part of it a small portion of the right edge of the epiglottis was exposed; the voice was perfectly clear, and respiration so free that it was obvious that the deeper part of the larynx was not affected. There were no enlarged glands, and the microscopical examination of a small portion of the growth proved that it was a typical lympho-sarcoma. Opinions were invited as to the advisability and methods of removal, the exhibitor being inclined to think that trans-hyoid pharyngotomy would suffice.

[*Supplementary note.*—The operation, as described and recommended by Mr. Butlin, has since been carried out, and the patient is making satisfactory progress.]

Mr. BUTLIN thought that, for the purpose of discussion, it would be convenient to group together with Dr. Watson Williams' case those shown by Dr. StClair Thomson and Dr. Dundas Grant. The disease in all three cases was of the base of the tongue and upper part of the larynx. In two of them the glands were involved, but probably within the reach of an extensive operation. He was of opinion that an operation should be performed in all cases. It should comprise removal of the contents of the anterior triangle on the affected side, with ligature and removal of the external carotid artery and all its branches. It would be well at the same time to remove the external carotid artery and its branches on the other side of the neck. A few days later the removal of the primary disease could be performed with scarcely any hæmorrhage and as freely as might be desired by opening up the wound for the removal of the contents of the triangle. He had performed this operation on several occasions, and was quite satisfied that it afforded the best view of the affected parts and of the whole field of operation. Unless this were done, it was useless to attempt these operations.

A CASE OF ULCERATION (? MALIGNANT DISEASE) OF THE BASE OF THE TONGUE.

Shown by Dr. W. H. KELSON. The patient, a man aged forty-eight, first complained of swelling in his throat, and alteration in his voice in April; he was admitted into hospital August 25, when there was found to be a large, red, rounded swelling at the base of the tongue, which was bound down on the right side and could not be protruded; on the right side of the swelling was an ulcer. The administration of iodide of potassium gave no result, and a month after admission profuse hæmorrhage took place from the ulcer and the swelling subsided; the submaxillary lymphatic glands were enlarged on both sides. Since the hæmorrhage the patient has gained weight and improved in health. No tubercle bacilli or lung signs could be detected nor microscopical appearances of actinomycosis. Opinions were requested as to the nature of the case.

A CASE OF PAPILOMATA OF THE LARYNX.

Shown by Dr. H. J. DAVIS. A girl, aged eighteen, with papillomata in the larynx. Three years ago she had had the same trouble, and all the growths were removed with snare and forceps. "She kept well for three years" but now had recurrence. The growths were very easy to see, situated above and below cords, and he hoped that he could remove them again in the same way.

Dr. WATSON WILLIAMS showed a tongue clip, which he had devised and had found exceedingly useful in operations about the mouth. It was made by Messrs. Mayer and Meltzer.

Dr. WATSON WILLIAMS showed drawings illustrating the method which he had been in the habit of adopting in the operation for submucous excision of the septum, the essential point of which was a small preliminary incision made on the concave side, by means of which a narrow elevator could be inserted, so as to remove the muco-perichondrium from that portion of the quadrilateral cartilage which later corresponded to the incision through the cartilage, after the ordinary incision in the mucous membrane had been made and the muco-perichondrium lifted from the convex side, as was usual with the ordinary button-hole incision. The advantage, he pointed out, was that when the cartilage was incised there was no risk of the mucous membrane on the concave side being divided, because it had already been lifted. The method he adopted and advocated whenever suitable.

PROCEEDINGS OF THE LARYNGOLOGICAL
SOCIETY OF LONDON.

One Hundred-and-ninth Ordinary Meeting, December 7, 1906.

J. B. BALL, M.D., *President, in the Chair.*

HENRY J. DAVIS, M.B. }
W. JOBSON HORNE, M.D. } Hon. Secretaries.

Present—32 members and 2 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were elected as ordinary members :

GEORGE W. BADGEROW, M.B. Toronto.
CYRIL A. B. HORSFORD, F.R.C.S.

The following communications were made :

CYST IN THE FLOOR OF THE RIGHT NASAL PASSAGE.

Shown by the President, Dr. J. B. BALL. The patient is a woman aged fifty-two. There is a swelling in the anterior part of the floor of the right nasal passage, which is obviously a cyst. She thinks it has existed for about nine or ten years. Although it gives rise to slight deformity in the anterior naris, it causes no inconvenience, and she does not wish for any operative interference.

Dr. DAVIS said he remembered showing, five years ago, a woman who had a cyst on the same side. Each time it was punctured it refilled and expanded part of the inferior turbinate bone. The mucous glands had very long canals in those parts, and he thought it was a retention-cyst of one of those glands. He thought that it occurred, as a rule, in women.

Mr. H. B. ROBINSON said he could contradict the statement that the condition occurred only in women. He had removed one from the same position in a man.

Dr. HERBERT TILLEY confirmed Mr. Robinson's statement that cysts on the floor of the nose sometimes occurred in men. He had treated such in a man where one of the incisor teeth was at fault. When that tooth had been removed the cyst ceased to refill.

Dr. LAMBERT LACK suggested that all such cysts were dental in origin.

Dr. STCLAIR THOMSON said he had one peridental cyst which was

the right middle and posterior fossæ. Amongst them there is the triad of symptoms—paralysis of one and the same half of the tongue, palate, and larynx described many years ago by Hughlings Jackson and Morell Mackenzie, Bernhardt, Stephen Mackenzie, Barlow, and other authors. Cases of this description are sufficiently rare to be individually recorded.

The patient has not improved under mercurial treatment, electricity, and massage during his stay in the hospital. During the past fortnight his articulation has become rapidly worse.

CASE OF NÆVUS OF THE PHARYNX.

Shown by Dr. DUNDAS GRANT. The patient, a man aged twenty, was first seen by the exhibitor on November 9, 1906, complaining of pain and fulness in the left side of the throat. There is an extensive nævoid growth involving the left half of the palate, fauces, and lateral aspect of the pharynx. Externally, behind and below the angle of the jaw, there is a fulness giving the "wormy" sensation of a vascular swelling. The condition is reported to have been present since birth but to have been getting larger of late, and the question arises as to the possibility of its eradication by means of electrolysis, galvano-cautery, or free excision preceded by ligature of the branches of the external carotid artery, if the latter proceeding is not rendered impossible by the outward extension of the nævoid growth.

Dr. F. W. BENNETT said that as the condition was only found by accident, and as it gave rise to no symptoms, he would leave it alone.

The PRESIDENT agreed with Dr. Bennett, and counselled leaving it alone.

Dr. FITZGERALD POWELL said he had two similar cases, one of them a nævus of the tongue and palate, which he showed at the Society, and it was generally thought they should be left alone. They had remained in the same condition, and there seemed to be no ill effects. He saw another case in a French boy, for whom he recommended some treatment; but his friends took him away in a panic, and went to Paris, where his tongue was slit up, one flap being turned above and the other below, and the nævus dissected out. The boy nearly bled to death, but his nævus was now as large as ever. He thought these cases were better left alone unless bleeding occurred.

Dr. GRANT said, in reply, that the opinions expressed coincided very much with his own, but he felt it his duty to ascertain whether more heroic measures would be suggested. The patient had had no hæmorrhages, but if they were to set in, the complexion of the case might be altered. He thought the local application of the galvano-cautery would then be most likely to do good.

A CASE OF OZÆNA FOR DIAGNOSIS.

Shown by Dr. H. J. DAVIS. A lady, aged forty-three, had had ozæna for two months. There were present hypertrophic rhinitis and post-nasal discharge: transillumination gave a negative result.

The patient was the wife of a professional man, who had noticed the odour suddenly two months ago. She was now conscious of the odour herself, and said that a discharge trickled down the back of the throat. Pus was visible with a post-nasal mirror in the vault of the naso-pharynx, but the exhibitor was not sure that ulceration was not present: he would be glad of the opinion of members on the case as to diagnosis and advisability of operation.

Dr. HERBERT TILLEY said that in the post-nasal space there appeared to be the remains of an old adenoid, in the middle line, and on that mass were five or six small suppurating points, so that he took it to be a chronic abscess located in the post-nasal growth. The smell of the condition would be in keeping with that diagnosis. He had removed a suppurating adenoid from a patient aged thirty-five, and the wall of the abscess cavity was black. The patient had been seeking advice because of a very foul smell in the nose. This was always preceded by a headache, and the patient said that when something "burst in the middle of her head, and some stuff came away" the symptoms were relieved. When he broke into it on digital examination of the naso-pharynx the pus which escaped was of the foulest odour he had ever experienced. When he removed the adenoid he mopped out the post-nasal space with chloride of zinc, thirty grains to the ounce, but in spite of that and frequent douching she suffered from general septic intoxication, and came out in a rash resembling scarlet fever a few hours after the operation. Three days afterwards she had acute suppuration in the right antrum and exhibited a septic temperature, which lasted a week, and then the whole trouble passed off. He thought removal should be carried out in this case and the condition of the nasal passages investigated under an anæsthetic. Possibly at the same time the anterior end of the inferior turbinal on the right side could be removed, as it was very swollen. Information could be gleaned at the time of operation by looking at the deeper parts of the nose with a Killian's speculum. There might be a secretion of pus from the sphenoidal sinus, but from the patient's answers to questions he did not think this was the case; it was a question that could not be excluded without proper and detailed examination.

Dr. DAVIS, in reply, said he thought the patient had more discharge running down the back of the throat than she would have from mere suppuration of adenoids. He believed she had sphenoidal sinus trouble, but he agreed that she had a pad of adenoids. When he first saw her it looked like a case of Tornwaldt's disease; but that was very rare, and he had only seen it twice in his life, though but for the amount of discharge he would have regarded it as a case of that disease. The friends were anxious to know what was best to be done, and he did not want to suggest an operation which would not cure her. He thought it would be best to give an anæsthetic and remove the growth first. He gave her a spray of hydrogen peroxide to both nostrils, which effervesced freely and removed the odour. He was grateful for the advice which had been offered.

A CASE OF LARYNGEAL NEOPLASM FOR DIAGNOSIS.

Shown by Dr. H. J. DAVIS. The patient, a man aged forty-four, was taken suddenly ill six weeks previously with stridor, retraction of ribs, slight dysphagia. The aperture of the larynx was almost occluded by infiltrated arytenoids. There were no physical signs in the chest.

The exhibitor said he had never seen a similar case before and he thought that it might be anything—syphilis, tubercular or malignant disease. The severity of the symptoms was unusual; stridor was now less marked; the patient was under treatment with inhalations and a mixture of 15 gr. of iodide of potassium and 1 dr. of Easton's syrup three times a day. He would be glad of the opinion of the Society on the case.

Dr. GRANT thought the œdema in the arytenoids was secondary to some tertiary syphilitic condition in the posterior part of the larynx.

Dr. JOBSON HORNE said he was only able to make a hurried examination of the case, but it was one which required careful investigation. The first thing to exclude was malignant disease and then tubercle. The question arose whether the stridor and shortness of breath were entirely attributable to the laryngeal condition, or whether there was a mass of glands in the thorax, causing pressure and dyspnoea. An examination of the neck and thorax with the X rays, Dr. Horne thought, would be helpful in arriving at an exact diagnosis.

Mr. CHICHELE NOURSE said that besides the infiltration of the arytenoids, the ventricular bands were very much swollen. He agreed with the opinion expressed by Dr. Grant that it was probably a tertiary specific affection, and he thought there was some perichondritis.

Dr. STCLAIR THOMSON said that if tubercle had been excluded he agreed with Dr. Grant that it was most likely tertiary syphilitic. He had an exactly similar case in which the infiltration looked very œdematous. He pressed the man to enter the hospital and have tracheotomy done, but he refused. The stridor got worse, and one day he was brought into the hospital in a great hurry. The house-surgeon did tracheotomy, but the man was dead before it was completed. He (Dr. Thomson) had the specimen. There was a pedunculated thickening which, to the touch, was very solid and fibrous. But in the mirror it, like the present case, had looked semi-translucent.

Sir FELIX SEMON did not think anyone could say, from mere laryngoscopic examination, what the nature of the condition was. Certainly there was perichondritis, with œdematous infiltration of the mucous membrane, but whether it was tuberculous, malignant, or syphilitic was mere guesswork. Why should it be syphilitic? Was it a syphilitic ulcer? Or were there other syphilitic phenomena? And tuberculosis had not at all been "excluded." Again, the man was forty-four, therefore he might have malignant disease of the œsophageal aspect of the larynx, concealed at present by the œdema over it. He would give iodide, and at the same time examine the expectoration for tubercle.

Mr. E. B. WAGGETT thought that in all cases where there was doubt as

to the condition of the posterior aspect of the cricoid that part should be examined by inspection. It could be easily done by a method devised by Dr. von Eicken, and in vogue in Professor Killian's clinique, namely hooking forward the larynx with a very strong curved probe, the tip of which, covered with wool, was applied below the anterior commissure after a good cocainising of the part. In that way information could be gained in this case as to the suspected presence of malignant ulceration of the posterior aspect of the cricoid.

Dr. DAVIS, in reply, agreed with Sir Felix Semon. A remark was made about excluding tuberculosis, but how was that to be done? There was no sputum to be examined. One could only judge by the clinical results. The case was a very rapid one. The man was taken suddenly ill, and when seen in the out-patient department he was thought to be suffocating. He was given some Friar's balsam to inhale and an injection of morphia, under which he got better. He had been treated with iodide of potassium. He had never yet seen the ventricular bands, and if they were visible now the man was better. The only case at all resembling it which he had seen was where the swelling was translucent. That was secondary syphilis. In the present case the parts were very red, and he had never seen a man get bad so quickly or improve so rapidly. If it had been tuberculous he thought the man would have got worse under the iodide of potassium; that was his experience.

CASE OF MULTI-SINUSITIS.

Shown by Dr. STCLAIR THOMSON. Every cavity had been dealt with surgically except the right sphenoid. The opening into the left sphenoid was well seen, and also the complete clearance of the left fronto-ethmoidal cells. The Killian operation had been performed on each frontal sinus with removal of the entire roof of the orbit. In consequence of local foci of suppuration repeated operations on the fronto-ethmoidal cells were required, leaving scars on the forehead. Owing to local massage and the preservation of the Killian bridge hardly any disfigurement had resulted.

Dr. SCANES SPICER congratulated Dr. StClair Thomson on the excellent result of the left side. It was seldom one saw such a fine opening into the sphenoidal sinus and such complete quiescence after extensive interference. On the right side the tissues in connection with the adhesion looked to him congested, and he did not think the present satisfaction as to relief would be permanent, and that something more would have to be done for the patient before very long—*e. g.* division of the adhesion and submucous resection of septum. He did not think as things were there was sufficiently free drainage of the ethmoidal cavities, and he could distinctly see and feel small polypoid proliferations in the depths of the right nostril.

A LARYNGEAL CYST IN THE ARYTENO-EPIGLOTTIDEAN FOLD.

Shown by Dr. G. C. CATHCART. The tumour was about the size of a filbert nut, and extended from the left arytænoïd along the

ary-epiglottic fold, and projecting over the ventricular band on that side, it presented the appearances of a tense cyst. The case was exhibited to ascertain opinions as to treatment.

Sir FELIX SEMON said he had seen several cases of cyst of the larynx, and his universal experience had been that if they were simply tapped they filled again quickly. Even where a large piece had been removed from the cyst wall he knew of a case in which the cyst had refilled again and again. If it were to cause trouble in breathing, singing, or swallowing in the present case he recommended that it should be snared off *in toto*.

Dr. JOBSON HORNE said that a few years ago he showed a somewhat similar case, which he treated with a snare. He had treated similarly a case previous to that. He recommended the use of an electric snare. The snare should be applied cold, and when drawn home the current connected at the last moment. In that way a clean removal would be effected, and with a minimum destruction of the adjacent parts.

The PRESIDENT asked how the cyst was discovered, as the lady had no symptoms.

Dr. CATHCART replied that the cyst was discovered quite accidentally during the routine examination, the patient having come complaining that her nose was stuffed up owing to a cold. She wanted it washed out, as she was going to sing next day.

A CASE OF ULCERATION IN THE INTERARYTÆNOID SPACE.

Shown by Dr. CATHCART for diagnosis. The patient, a man aged fifty-two, had been unable to swallow solids for the previous six weeks.

Dr. DAVIS said he did not think the trouble in the larynx was sufficient to account for all the symptoms; he was of opinion that it proceeded from the œsophagus.

Mr. ROBINSON asked whether the patient's sputum had been tested for tubercle bacilli.

Dr. FURNISS POTTER asked whether Dr. Cathcart had passed an œsophageal bougie. He had carefully examined this case, but could see no ulceration. There was certainly no visible loss of tissue in the interarytænoid space.

Dr. CATHCART replied that the sputum had been examined for tubercle bacilli, but with a negative result.

A CASE OF COMPLETE ABDUCTOR PARALYSIS.

Shown by Dr. G. C. CATHCART. The patient, a woman aged thirty-six, had had tracheotomy performed. The left cord was now fixed in the cadaveric position; the right cord was slightly movable.

The PRESIDENT asked whether Dr. Cathcart had come to any conclusion as to the cause of the trouble and as to the nature of it.

Dr. GRANT asked whether the patient had been having specific treatment since the date two months ago which was mentioned.

Dr. CATHCART replied that the patient came in July with œdema of larynx, and was put upon antisyphilitic treatment. She remained on that for about a week, but did not return until two months ago. She was then so bad that intubation had to be done at once. Since he saw her a fortnight ago both cords were much more movable than the description mentioned. She had had no specific treatment since she left the hospital.

CASE OF PERSISTENT JACOBSON'S ORGAN.

Shown by Dr. LAMBERT LACK. The patient, a man aged about thirty, presents a small sinus on the left side of the septum near the floor of the nose about half an inch behind the vestibule. The opening of this sinus is about the size of a pin's head, and it admits a fine probe for three eighths of an inch. This sinus is obviously congenital and almost certainly represents the persistent remains of Jacobson's organ. Dr. Arthur Keith, who kindly saw the case with me, concurred in this opinion, and found a reference to a record of another similar case.¹

Dr. GRANT said that in a French paper on the subject a number of years ago it was pointed out that the cystic part landed considerably higher up on the septum of the nose and that the cartilage remained low down. One had to look considerably higher up for the duct and cyst.

A CASE OF EPITHELIOMA OF THE TONGUE AND LARYNX.

Shown by Mr. E. ROUGHTON.

Dr. SCANES SPICER said if surgical measures were adopted in this case he considered it was a case for complete laryngectomy and that some portion of the pharynx would also have to be removed, and in the light of Gluck's results he thought this was a favourable case if the trachea were completely divided and brought out into the neck and even to the skin, so as to shut off completely the lungs from the pharyngeal and buccal wound. He had had one such extensive case in conjunction with two of his general surgeon *confrères*, and had attempted to bring out the trachea, remove the diseased larynx, portions of pharynx, and œsophagus, and also the glands at the same operation, which lasted nearly four hours. The patient stood the operation, but succumbed from cardiac thrombosis twelve hours after. In discussing the case with Professor Glück afterwards, the latter advised in a similar case to remove the glands first, at an independent operation before the extirpation.

¹ Mangakis (Athens), "Ein Fall von Jacobson's-chen Organ beim Erwachsener," *Anat. Anzeiger*, 1902, Bd. xxii, S. 106.

A CASE OF ACHONDROPLASIA IN A CHILD AGED THREE YEARS.

Shown by Dr. SCANES SPICER to illustrate the congenital pug-nose, with all the axial and postural and many of the appendicular features of achondroplasia.

The case had been sent to him from the country on account of mouth-breathing and panting of an exaggerated type, with the tongue in a fixed extruded position on any exertion, extreme depression of root of nose, and alternating internal strabismus—all from birth. She could not talk, stand, or walk, though her mental state seemed not to differ much from the usual child of the same age. The parents had been told that the symptoms were due to adenoids and enlarged tonsils, and wanted to know if an operation would be remedial. On watching the child was seen occasionally when she pulled herself up to breathe perfectly through the nose for a short time, though she relapsed as a rule into mouth-breathing, which gave her a vacant imbecile look. On sitting her in a chair she assumed the position of kyphosis, and on placing her at a table she sprawled over it in a weary way, and rested in a position suggesting scoliosis. On trying to get her to stand she would often collapse on the buttocks and fall over so that the face touched the toes; or if she succeeded in standing her posture was that of lordosis, with protuberant abdomen, upper straight spine, head forwards, mouth open, tongue out, apparently short legs, and her profile and proportions identical with that of the recent photos of achondroplasia published in the *Transactions* of the Royal Medical and Chirurgical Society, vol. lxxxix, p. 409, 1905, and *Lancet*, June 9, 1906, p. 1598. The child was of an exceedingly restless and irritable temperament, and in order to secure skiagrams of the head and chest it was necessary to administer a general anæsthetic. Under anæsthesia it was found that all the deformity of the spine was postural and not organic, and that the height was 35 inches as against 28½ when measured standing against the door. Further, the nasal breathing became perfect, and was then associated with proper costal respiration. On recovering from the anæsthetic, the mouth opened and the breathing became exclusively abdominal again. It was therefore clear that the breathing obstruction was not in the main due to structural changes in the nasal passages or to adenoids; nor did the tonsils suffice to explain it, though they were considerably enlarged. I would provisionally tender the suggestion that the obstruction is due to an excessive flexure of the head on the cervical spine, so that

the body of the axis crowds into the stunted achondroplastic naso-pharynx.

On further examination of the case it was found to agree with previously published accounts of the disease in the following points: (1) congenital origin; (2) depression of the bridge of the nose at the root; (3) distinct shortening of the lower limbs with normal development of the trunk; (4) wheel-spoke appearance of hands (*main en trident*); (5) excess of adipose tissue in the folds of the skin; (6 and 7) protuberant abdomen and apparent lordosis when standing; (8) smooth, pliable skin with fine glossy hair; (9) palate of the high-vaulted character with irregular position and delayed eruption of the milk-teeth; (10) approximately normal mental condition.

It appears to differ from some previously recorded cases in: (1) size of the cranium not disproportionately enlarged, though dome is abnormally high; (2) no prognathus; (3) no beaded ribs or enlarged bone ends.

I must leave doubtful at present the position of centre of body, exact measurements and proportions, and results disclosed by skiagrams. The age and temperament of the child render it difficult to procure rapidly a complete examination and report, and a distant residence in the country makes it advisable that I should seize the opportunity of the child's being present in London on the day of the meeting of our Society to bring the case forward. The interesting problems arising around nasal obstruction in this case, that due to adenoids, extreme mouth-breathing, the typical achondroplastic features and associations here will at once occur to every member of the Society, and time will not permit me to discuss fully now even those which I have thought out.

Dr. SCANES SPICER said that two brothers and two sisters had shown similar symptoms in infancy but to a less degree. They had largely outgrown them. This rather pointed to the extreme nasal depression being due to an arrested or delayed growth of the bone centres of the sphenoid and occipital bones rather than a premature synostosis of the pre- or basi-sphenoid as was observed by Virchow in other cases of stunted nose. A specific history could be excluded with practical certainty. Many of the family had had post-nasal adenoid hyperplasia. The eldest sister has high vaulted palate, superior protrusion, and lost the upper front incisors at twenty-one. The elder brother (twenty) is now 6 ft. $2\frac{1}{2}$ in., hands and feet of acromegalic type, vaulted palate, superior protrusion, has lost upper front incisors. Second sister has had thyroid gland enlarged. Second brother had tonsils and adenoids removed for obstruction and mouth-breathing. Mother and maternal aunt have distinct acromegalic characters of nose, cheek-bones, lower jaw, and lower lip. In short, the morbid states of this family are chiefly those associated with pathological states of the bony cranial basis,

or the immediately overlying pituitary body, or the subjacent Luschka's tonsil. This can hardly fail to be highly suggestive to members of this Society, who in thinking out to the full the factors in any given case of nasal obstruction must often ponder over Luschka's tonsil, Rathke's pouch, achondroplastic sphenoid, persistent cranio-pharyngeal canal and morbid states of the pituitary gland, and wonder if their proximity anatomically lends itself to explain such associations as hinted at above.

CASE OF CHRONIC ŒDEMA OF THE LARYNX IN A FEMALE BOARD SCHOOL
TEACHER, AGED TWENTY-FOUR (FOR DIAGNOSIS).

Shown by Dr. SCANES SPICER. There is a high degree of firm, œdematous, pale swelling occupying the epiglottis and both ary-epiglottic folds. The appearances would be considered pathognomonic of tubercle if any confirmatory signs of tuberculosis could be found, but three examinations of the sputum for tubercle bacilli have been negative. Sir A. E. Wright reports the tuberculo-opsonic index on two occasions as .78 and 1.26, and that the oscillations are not sufficient to justify a diagnosis of tubercular infection. There is a slight difficulty in swallowing, and the voice is somewhat sharp and peculiar in timbre. There are no physical signs or symptoms of phthisis. On the other hand, the patient is a gasping mouth-breather, and has several foul carious teeth. Is septic infection from these the cause of the œdema? The practical question now was, whether this teacher were to be allowed to resume her duties or to be discharged?

Dr. JOBSON HORNE said he knew nothing about the history of the case or the condition of the lungs, but the condition of the larynx was suggestive of tuberculosis.

Dr. LACK said he had seen the case some months ago and had watched the œdema slowly increase. First of all there was symmetrical œdema of the arytænoids, the rest of the larynx being absolutely free. He at first thought it was tubercle, but the patient was in perfect health now and had put on weight, she had no signs of the disease in the chest and no bacilli in her sputum. He thought tubercle could be absolutely excluded. He did not see anything to warrant the view that it was syphilis, and he did not know what it could be.

The PRESIDENT said that, looking at it that day, one would at once have said, as Dr. Horne had, that it was tubercle, but after the history which had been given, it probably was not so.

Dr. JOBSON HORNE, in further remarks, said an X-ray examination of the thorax would be of great help because he understood that the results of an examination with the stethoscope and the staining reagents had been negative.

Mr. C. A. PARKER said he had seen the case when it was at the Throat Hospital, and that some months ago he had asked Dr. Ironside Bruce to kindly X-ray the patient, thinking that possibly there might be a foreign body lodged in the larynx, but nothing abnormal could be

seen. Dr. Ironside Bruce also took a radiograph of the apices of the lungs, but was of opinion that no trace of tubercle could be seen.

The PRESIDENT said he hoped the Society would be informed about the future of the case.

A CASE OF EPITHELIOMA OF THE LARYNX (SHOWN ON NOVEMBER 2ND, 1906).

Shown for Dr. WATSON WILLIAMS by Dr. SCANES SPICER. This case was admitted into St. Mary's Hospital in order that treatment by a bacterial vaccine of *Micrococcus neoformans* might be tried. This has been carried out by Sir A. E. Wright. In all five injections have been given, twenty-five millions at a week's interval four times and forty millions on the last occasion. The injections have not caused any marked negative phase at all, and the opsonic reaction keeps close to the normal line and rather above it. They cause the patient no malaise. He states he swallows well. Occasionally notices the same pain in the ear as before. He looks a better colour than when shown a week ago. A piece removed for examination confirms diagnosis of epithelioma. I have examined his pharynx and larynx twice a week and do not think the mass is larger or has extended; it is certainly cleaner and paler—less congested. Of course the patient has had the advantage of rest and warmth and ordinary hospital diet and was ordered an alkaline spray, and but for this the only treatment has been bacterial vaccine.

Mr. ROBINSON thought the condition of the larynx was now much cleaner, but that there was more growth than before.

Dr. LACK thought the case would be better operated upon than left until it was too late.

In reply, Dr. SCANES SPICER said that at the last meeting Mr. Butlin had expressed the same opinion as Dr. Lack. The patient was given the option whether he would be operated on for excision of the growth or would make a trial of the bacterial vaccine method. He thought Dr. Watson Williams rather favoured the latter, and the patient agreed. He was quite open to fall in with the suggestion of attempting to extirpate it, if the patient and Dr. Watson Williams desired it and if his surgical colleagues supported that course.

CASE OF SOLID OEDEMA ON THE LOWER PART OF THE FOREHEAD,
SIDES OF THE NOSE, AND THE LOWER EYELIDS.

Shown by Dr. HERBERT TILLEY. The patient, a man aged forty-three, had suffered from this condition since he served in the South African War. He thinks the condition started in the skin

near the left tear-sac and originated from a small scratch in that situation. The lower central part of the forehead, the sides of the nose, and the eyelids (more especially the lower) are red and swollen as though the patient had recently been stung in these regions. To the touch the parts are tense and resisting but not painful on pressure. He suffers from severe headache, especially when he stoops. The frontal sinuses had been opened at one hospital but were found to be healthy. Opinions as to diagnosis and treatment were asked for.

Mr. ROBINSON said he had seen three or four cases very similar to this rare condition. He had always called them chronic erysipelas or chronic lymphangitis. Those cases had complained about a sore or crack about the inner canthus, and they had attack after attack of acute redness and swelling until, after a time, they had chronic thickening about the eyes and cheeks. He did not know what treatment to suggest, but if he had a case now he thought he would try antistreptococcic serum.

Dr. GRANT said the man thought he had an undue tendency to bleed, so that it might be a case of defective clotting of the blood, such as was seen in people subject to chilblains and urticaria. The remedy now much recommended for those conditions—namely the salts of calcium—might be worth trying. Lactate of lime seemed to be the least nasty, and doses up to 10 or even 15 gr. three times a day might be given.

Mr. F. J. STEWARD supported the remarks of Mr. Robinson. He had had under his care for some time a somewhat similar case—a young woman whose trouble began with a definite severe attack of erysipelas. She had since had many attacks, each being slighter than the last. She now has solid œdema over the same area as the present case. He had not seen her recently, but was anxiously looking out for her, because he thought it possible that some benefit might be brought about by using a vaccine. His intention was to determine whether her opsonic index for streptococcus was particularly low, and if so, to try what a vaccine would do for her.

Mr. STUART-LOW said he had had a little boy in hospital who had a unilateral condition similar to the present case. He had purulent rhinitis on that side. That gradually diminished. It lasted six weeks. Frequently erysipelas of the face was traceable to sepsis of the nose, and it was possible that other cells in the nose might have a septic condition.

Dr. SCANES SPICER said the distribution on the face reminded him of cases of lupus erythematosus, but he hesitated to offer any suggestion that this case might be akin.

Dr. DAVIS did not regard the case as one of erysipelas at all. He had seen many such cases and they had repeated attacks. Some years ago he had shown a girl with the same trouble, where the antra had been drilled before on the supposition that the disease originated there, but it made no difference. He did not think there was such a disease as chronic erysipelas—one would not think of notifying each attack as erysipelas. Women were subject to this condition at their periods, and seemed none the worse in general health.

Dr. JOBSON HORNE agreed with Dr. Davis that it was not wise to put such cases down as chronic erysipelas. Some years ago he looked into those cases of chronic œdema, and found that very little had been written

on the subject. No attempt had been made to classify the cases, but from the fragmentary reports they all seemed to have one or two points in common. They were chronic, long-standing cases, very difficult to do anything for, and none of them had anything the matter with the interior of the nose, therefore they were distinct from the cases referred to by Mr. Stuart-Low. He believed they were brought about by a specific infection, and thought the site of it was intra-nasal.

Dr. DAVIS regarded it as angeio-neurotic oedema.

Dr. JOBSON HORNE considered it belonged to a group of cases distinct from angeio-neurotic oedema.

Mr. ROBINSON said in regard to lymphangitis he had now in the hospital a boy with some puffiness below his eyes. He also had chronic enlargement of the glands in the neck. He removed those freely, and for the next few days there was a marked increase of the swelling in that region. He considered there was some lymph-obstruction causing the thickening.

The PRESIDENT said he also had seen many cases of the kind, and had been in the habit of calling them lymphangitis, assuming in the majority of them some infection. They seemed very like the cases occurring about the alæ of the nose and upper lip, which were often associated with cracks in the skin just under the anterior nares, and these cases were cured by attention to the skin lesions. He had not been able to trace any similar cause for cases like that exhibited to-day, but had looked upon the condition as septic.

Dr. HERBERT TILLEY, in reply, said that, as far as he could see, there was no disease in the nose. The patient had been to many skin clinics in London, but the dermatologists seemed to have been unable to make a diagnosis, though they did not regard it as lymphangitis. He thought he would try the administration of lactate of lime, as suggested by Dr. Grant, on the principle of "any port in a storm." If that did not succeed he would see what antistreptococcic serum would do. Those who said the condition was chronic erysipelas had the satisfaction of knowing that it was the patient's own diagnosis.

A CASE OF CHRONIC FRONTAL SINUS SUPPURATION, RADICAL OPERATION, WITH IMMEDIATE CLOSURE OF WOUND.

Shown by Dr. HERBERT TILLEY. The patient, a male aged twenty-two, complained of a foul, purulent, nasal discharge "since he was a boy." On examination there was seen a purulent discharge from the right middle meatus and small polypi in the same situation. Pus was easily washed from the right frontal sinus, and also from the corresponding antrum.

The front wall of the sinus was removed and also the diseased mucous membrane. A large opening was made into the nose, and the external wound was sutured. There is now no deformity and no secretion of pus in the right nasal cavity. As there was little ethmoidal disease Killian's operation was not considered necessary in this case.

PROCEEDINGS OF THE LARYNGOLOGICAL SOCIETY OF LONDON.

One Hundred-and-tenth Ordinary Meeting, January 4, 1907.

J. B. BALL, M.D., *President, in the Chair.*

HENRY J. DAVIS, M.B., }
W. JOBSON HORNE, M.D., } Hon. Secretaries.

Present—25 members.

The minutes of the previous meeting were read and confirmed.

The following communications were made :

Dr. WATSON WILLIAMS showed stereoscopic skiagrams of the nasal accessory sinuses, from the lateral and transverse aspects, revealing the presence of pus in some of the cavities.

A CASE OF SUBMUCOUS RESECTION OF THE SEPTUM IN A MAN AGED THIRTY-SEVEN.

Shown by Dr. STCLAIR THOMSON. The operation was made from the free end of the quadrilateral cartilage. The specimen showed a large maxillary spine and a high deviation with a vertical ridge. The marked external disfigurement had been improved by the operation.

A CASE OF SUBMUCOUS RESECTION OF THE SEPTUM IN A BOY AGED FIFTEEN.

Shown by Dr. STCLAIR THOMSON. The specimen showed a large maxillary spine and a vertical bony spur removed from far back in the nose.

The PRESIDENT said the results appeared to be very satisfactory.
Dr. E. A. PETERS asked Dr. Thomson whether he intended to make
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a further resection of the nasal bones, so as to remedy the bony defect and give credit to the cartilaginous septum.

Dr. SCANES SPICER said in the cases shown the procedure had been carried out with great thoroughness. He thought Dr. Thomson and he had converted each other on the question of general *versus* local anæsthesia. At a meeting of the Royal Medical and Chirurgical Society in June he (Dr. Spicer) said he had never succeeded in *completing* a case to his satisfaction except under a general anæsthetic; but since July 1, 1906, he had done twenty-two cases with only local anæsthesia, which he found answered perfectly, and he understood that Dr. Thomson was reverting to general anæsthesia. The operation was necessarily a long one in most cases, but much time was saved by local anæsthesia as compared with general. He had never succeeded in getting away such a large piece of bone in one piece as Dr. Thomson had shown in one of these cases. He now provided himself with Wood's and Heath's septum forceps, chisels, and a Heath's big mallet, and felt that with these any bone could be effectually dealt with. He deprecated hurrying the operation so as to get it done in something like twenty minutes at the cost of thoroughness. Of course it was necessary to psychologise the patient to the extent of convincing him that he would not be caused pain, which was in truth the case. He now always rubbed in (as recommended by Otto Freer) solid cocaine powder at first, and frequently repeated it during the operation, asking the patient to warn him if he felt anything like a suspicion of approaching pain.

Dr. H. SMURTHWAITE said that eighteen months ago he read a paper on thirty-seven cases which he had done without once using general anæsthesia. He could bring up pieces of bone which he had removed as large as a florin. Naturally, neurotic patients were difficult. The object was to do one's best for the patient, therefore why should it matter whether the operation took twenty minutes or an hour? The improved instruments and technique would gradually lessen the time necessary. Novocain or eucaine could be injected under the perichondrium, and in the majority of cases the operation with adrenalin could be done bloodlessly. One heard of deaths under chloroform during operations on the nose and throat, and from that point of view also local anæsthesia was best. Women were not excepted; they sometimes stood it better than did men.

Dr. FITZGERALD POWELL thought Dr. Smurthwaite's experience hardly corresponded with the greater number of the members who had been in the habit of doing this operation. In his own case he found it much easier to do the operation under a local anæsthetic, when one had a good view of the field of operation and was not interfered with by the movements of the patient and the bleeding which was induced by the anæsthetic. Speaking generally, men bore the cocaine in local anæsthesia better than most women and boys, who were usually very nervous and liable to collapse from the effects of the cocaine, and when doing the operation in a sitting posture it was not uncommon to have the patient falling forward in a fainting condition. He thought a general anæsthetic better for most women and boys.

Dr. FURNISS POTTER said he had had some experience in performing these operations both under general and local anæsthesia, and gave his opinion unhesitatingly that where possible cocaine was much to be preferred to a general anæsthetic. The fact of the patient being under a general anæsthetic handicapped the operator considerably, owing to

mopping out of the throat and altering the position of the head. He had not found women or boys to be any exception if it were explained to them that they would not have to endure pain. He was in the habit of using a Thudicum's speculum with long but not fenestrated blades. He objected to the speculum referred to by Dr. Tilley because the fenestrations allowed the mucous membrane to bulge through and narrowed the field of view. The speculum he used was of a pattern suggested by Dr. StClair Thomson with two-inch blades—non-fenestrated.

Mr. HERBERT TILLEY thought there was an advantage in using fenestrated specula in a very narrow nose, because larger forceps could then be passed into the nasal cavities. He selected the form of anæsthetic according to the temperament of the patient. Though there might be no pain with local anæsthetics, some people were continually fidgeting, and no amount of persuasion seemed to diminish their alarm, and no anæsthetic had yet been invented which would allay this mental perturbation. In administering local anæsthetics he applied a 10 per cent. solution of cocaine in the form of a spray first of all, before puncturing the mucous membrane to inject eudrenine. After injecting the mixture of eucaine and adrenaline chloride (eudrenine) he waited ten minutes, and then was able to do the operation without being hampered by oozing of blood.

Dr. STCLAIR THOMSON, in reply, said he would like to improve the nasal bone of one of the patients, and perhaps some member would suggest how it should be done, whether from the outside by turning up a flap, or entirely from the inside. He had only had one or two such cases. In one he turned a flap up from the side of the nose and chiselled the bone away. The scar barely showed afterwards. He formerly operated on such cases under chloroform, because he thought people would not believe in the power of cocaine. Then he started with cocaine, and did thirty cases under it. The difficulty mentioned by Dr. Tilley in the case of nervous patients was a real one, and hampered the operator; they were particularly terrified at the sight of the chisel and mallet, despite the surgeon's assurances. One private patient still blamed him for having done the operation under a local anæsthetic. It was easier to do so. But with a really skilled anæsthetist the operation could be done as well and as bloodlessly under chloroform as under local anæsthesia. He advised operators not to use chloride of ethyl, or gas, or the least suspicion of ether. He operated with the end of the table well raised; it was quite easy to operate with the patient in a reclining posture. He had used the various instruments referred to, but where there was a big maxillary crest he had not been successful with anything but a Killian's chisel. With regard to time, one could get up to removal of cartilage in fifteen to twenty minutes. He had used Ballenger's knife ever since he saw it described. But he could not get a good pattern of it in England. Instead of being stirrup-shaped it should be V-shaped in the middle, so that it would cut out more bone than his did. Perforations afterwards were practically unknown. One of the patients shown was under cocaine forty-five minutes; the other was under a general anæsthetic two hours, but the actual operation did not occupy more than fifty-five minutes, as the patient took the anæsthetic very badly and the administrator was not particularly skilful in this sort of work. The really difficult part of the operation was the removal of the maxillary crest and of bony spurs situated far back. It was to illustrate the results in such cases that these two patients were shown.

A CASE OF CYST IN THE FLOOR OF THE NOSE.

Shown by Mr. C. A. B. HORSFORD. The patient, a woman aged forty-five, presented a cyst in the left floor of the nose, beneath and pushing up the left inferior turbinate body. She was unaware of its presence. There was a history of repeated "gumboils" over the left lateral incisor tooth up to five years ago, when a decayed tooth broke off; the stump was extracted six months ago. The right nasal cavity was atrophic.

Dr. SCANES SPICER said he had seen three cases apparently like the present one. The third one he incised three or four times from the nose, and it had filled up every time. Then he attacked it from under the lip, scraped the cyst out, and packed, and it got well at once. He thought it must have been dental in origin.

Mr. BETHAM ROBINSON suggested that the carious tooth should be extracted, and that boring should be done through the fang. With a little enlargement of the opening he thought it would drain and heal up all right.

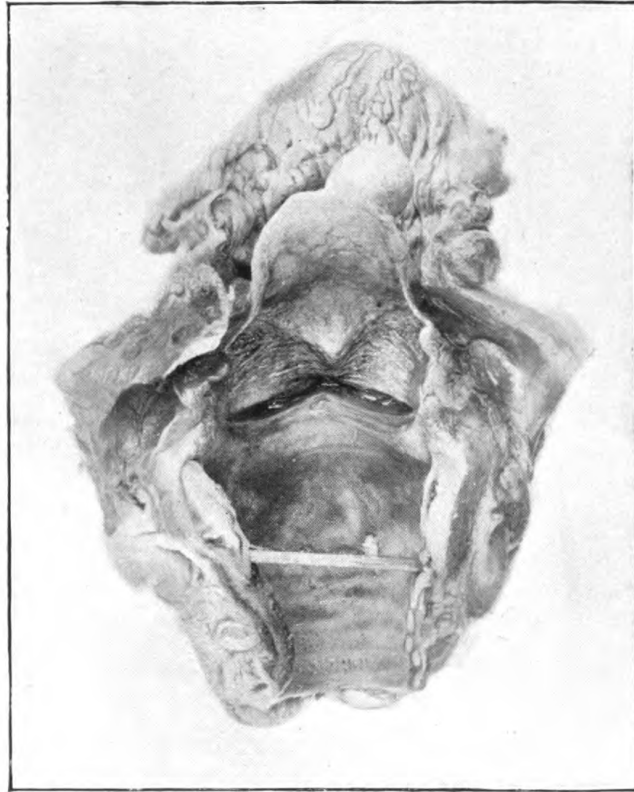
Dr. HORSFORD, in reply, said he had hoped to hear whether it was necessary to do anything for the condition; the patient had had no symptoms and no obstruction was caused. Some time ago he removed the stump from the lateral incisor.

CYSTOMA OF THE LARYNX.

Dr. JOBSON HORNE exhibited macroscopic preparations illustrating cystic disease of the larynx. One specimen presented a cyst in the usual situation, namely the lingual aspect of the epiglottis. The tumour, which was relatively of a large size, had occasioned no symptoms during life. The preparation had been made by the formalin method, and the clinical appearances of the cyst had been well preserved. Another specimen showed a condition over one arytenoid region which clinically simulated a cystoma, and from which it had to be differentiated, the condition being occasioned by œdema and not by the obstruction and subsequent distension of a gland-duct as in true cystoma. The specimens were of special interest in connection with the case shown by Dr. Cathcart at the previous meeting.

A CASE OF TUMOUR OF THE PALATE.

Shown by Dr. W. H. KELSON. The patient, a woman aged sixty-five, had noticed a tumour of the palate about six or eight weeks, but thought it had probably existed longer. Five or six



CYSTOMA OF THE EPIGLOTTIS.

To illustrate Dr. JOBSON HORNE's communication to the Laryngological Society
of London, January 4th, 1907. Vol. xiv, p. 32.

THE
JOHN G. ...
LETT...

years ago she had had stumps of teeth taken out near to the origin of the tumour.

On examination a button-shaped tumour about an inch in diameter was found at the junction of the hard and soft palates on the right side, extending inwards from the alveolar margin; it was firm in consistency and movable on the subjacent structure, and the mucous membrane, though tightly stretched, was movable over it. No enlarged glands were to be felt.

Mr. P. DE SANTI thought it was simply a fibro-adenoma, and that it would shell out easily.

Dr. H. SMURTHWAITE said he removed, a year ago, a similar tumour from a woman who had had it ten years. A circular incision was made, the finger placed under it, and it shelled out. A section was made, and it was found to be fibro-adenoma.

Mr. ROBINSON inclined to the view that it was an endothelioma.

The PRESIDENT said that in the case which he showed two meetings ago the tumour was larger and much more fixed. The woman refused to have any operation done.

Dr. JOBSON HORNE said that some years ago he had had a case which presented similar clinical appearances; the tumour came away quite easily. He was unable to say, without reference to notes, what its precise microscopic appearance was. He hoped Mr. Kelson would allow members to see a section of the tumour in his case after removal.

Mr. KELSON said, in reply, that though opinions as to the nature of the tumour varied, there seemed to be agreement as to the best treatment. He would bring forward the specimen. The patient said she had noticed it for quite six weeks.

A CASE OF ULCERATION OF THE EPIGLOTTIS AND OF THE BASE OF THE TONGUE.

Shown by Mr. W. H. KELSON. The patient, a man, aged sixty-nine, had suffered from difficulty in swallowing and loss of flesh of about nine months' duration.

On examination there was found to be a mass in the region of the base of the tongue, involving the epiglottis, in which situation ulceration had taken place. Neither cord moved well. There were a number of enlarged glands in the carotid and submaxillary regions.

Mr. ROBINSON said it was a case of malignant disease of the back of the tongue, creeping back to the epiglottis, with enlargement of glands. There was not any doubt as to its nature, and he did not advise operative procedure.

A CASE OF TERTIARY SYPHILITIC LARYNGITIS IN A MAN AGED TWENTY-NINE; QUESTION OF TREATMENT.

Shown by Mr. DE SANTI. The patient came to Mr. de Santi's

clinic some six months ago with a history of hoarseness, pain on swallowing, cough, and loss of flesh. On examination the epiglottis was seen to be red, infiltrated, enlarged, and bilobed in shape. A view of the larynx could not be obtained on account of the size and shape of the epiglottis. The appearances and history suggested tubercle, but the patient had a marked condition of advanced tertiary syphilitic glossitis. Examination of the chest and sputum on several occasions was always negative. The patient was put on iodide of potassium, which was gradually increased up to 30 gr. daily, but little improvement followed. He also had a course of iodide of mercury, and also of sarsaparilla, but really never at any time reacted to the drugs used. At one time Mr. de Santi thought there might be mixed infection of tubercle and syphilis, but, having watched the man for some months, was convinced the disease was entirely of specific origin.

He brought the case forward for views as to further treatment. These cases, if left alone, tended to end in contraction and stenosis of the larynx, a condition to be prevented by every means possible.

Dr. STCLAIR THOMSON said one could not get a good inspection of the inside of the larynx, but there was slight ulceration, and the man might have tubercle grafted on to his syphilis. Iodide and mercury had only been given him by the mouth, and no case of syphilitic disease of the larynx should be despaired of until mercury had been given by injection or by inunction. Many such cases resisted treatment by the mouth, and some even did not yield until tracheotomy had been done, thus affording rest to the part.

Dr. A. LIEVEN regarded the case as wholly syphilitic; ulceration must be expected in a case which had persisted so long. Iodide and mercury should not be used at the same time when calomel was injected, as the latter did not agree with the iodide; there was produced much local irritation, and sometimes swelling of the mucous membrane, which might be fatal in such a case as the present. He recommended tracheotomy, to keep the part at rest. In any case it might have to be done later, because of the narrowing of the part due to contraction. That occurred in a case in which the larynx yielded very well to treatment, but the air-passages became so narrow that tracheotomy had to be performed. He used a suspension of 1 part of calomel in 10 of vasenol, a new preparation of paraffin, which was the least irritating vehicle he knew. The dose was half a sixteen-minim syringeful, but a very small dose should be given at first, one third of a syringeful, as the idiosyncrasy of the patient might be intolerant of mercury, and when once it had been injected it could not be got out again.

Mr. DE SANTI, in reply, expressed his gratitude for the opinions expressed, and said he would advise the man to have tracheotomy done and have calomel injections. The patient was very anxious for relief.

A CASE OF LARYNGEAL DISEASE (? SYPHILITIC).

Shown by Dr. J. B. BALL. The patient is a married woman aged forty-seven. She has had ten children, of whom four were stillborn, and she has had one miscarriage, at four and a half months. She states that she has always had good health. She has had some hoarseness of voice for the last six months, and some increasing dyspnoea on exertion for about two months. There are two small scar-like depressions on the soft palate, but she has no recollection of ever having had a sore throat. In the larynx there is a pale glistening swelling situated over the left vocal cord. The appearance of this swelling is consistent with its forming part of a swollen œdematous cord, or with its being a swelling protruding from the ventricle and covering the cord. There is distinct subglottic swelling on this side of the larynx. The left vocal cord is fixed. The patient was seen for the first time a couple of days ago and has had no treatment.

Mr. HERBERT TILLEY thought the swelling was on the surface of the anterior half of the left vocal cord. Opposite that swelling one could see the right vocal cord, which also seemed slightly œdematous; it had not the clean-cut appearance of the normal vocal cord. Under both cords could be seen a swelling, which he thought was a subglottic hyperplasia. There was a strong history of syphilis, and he would treat the case from that point of view before actively interfering with the larynx. Indeed, he did not know what active interference could be carried out unless it were touching the swelling on the left vocal cord with the galvano-cautery. This would cause much irritation, and he did not think the result would be a beneficial one.

Dr. FITZGERALD POWELL said in their present knowledge of the history of the case, and the sputum as yet not having been examined, no one could give a very decided opinion as to its nature. There appeared to be a growth coming out of the ventricle and overlapping the cord. He thought the case was most probably syphilitic, but the possibility of tubercle should be considered and the sputum should be examined.

Dr. SCANES SPICER said his own view was that of Dr. Powell, relying on the general appearance of the mass and that the posterior wall was involved at the same time; but he did not feel confident about it.

Dr. STCLAIR THOMSON said there was much subglottic infiltration on both sides and marked subglottic stenosis. He thought the condition of the cords was due to their being pinched by the infiltration going on above and below. He thought it could scarcely be tubercle, because such an extensive deposit of that would have already broken down. The woman required tracheotomy and similar treatment to Mr. de Santi's case. Early tracheotomy tended largely to prevent the scarring and stenosis of which Dr. Lieven had spoken. He had done many cases in which tracheotomy and treatment with mercury, *viâ* the skin, had saved that stenosis which otherwise would have been likely.

The PRESIDENT, in reply, said he had felt doubtful about the nature

of the case, and even as to what the gelatinous swelling on the left side was. He concluded that it was more or less a part of the left vocal cord. He agreed that there was some subglottic infiltration on both sides. The history pointed to syphilis; she had had four stillborn children and some very early deaths among the children born alive. Also on the soft palate there appeared to be two depressed scars, though she said she had never had a bad throat all her life. He had only just seen the patient, and should have put her upon iodide of potassium at once but for the dyspnoea, which might have been increased by that drug. He did not propose to start with mercurial injections, but would take her into the hospital, and she would probably rapidly respond to syphilitic iodides if the case were syphilitic.

A CASE OF EPITHELIOMA OF LARYNX SHOWN ON NOVEMBER 2 AND
DECEMBER 7, AND TREATED BY A VACCINE OF MICROCOCCUS
NEOFORMANS SINCE THE FORMER DATE.

Dr. SCANES SPICER again brought this case for inspection by the members of the Society, that they might determine what, if any, progress had resulted in the local growth and general condition. The injections had been continued as before in the Inoculation Department under Sir A. B. Wright. Dr. Spicer's view was that the malignant mass was smaller, and was based on the fact that a much more complete view of the larynx was possible than on the previous occasions. The surface was cleaner, the patient swallowed better, and felt and looked well. In view of the opinion expressed by some members he had taken the opinion of his colleague, Mr. A. J. Pepper, as to the possibility of completely removing the diseased parts, and that surgeon had negatived that possibility with any reasonable probability of success, owing to the extension of the growth on to the pharynx and the glosso-epiglottic fold. That view was the result of experience gained together in several cases during the past eighteen years.

Dr. WATSON WILLIAMS (who had had to leave early) had asked Dr. S. Spicer to state that he considered that at all events the rate of growth over the two months had been very materially retarded, as compared with his previous observation of the case.

Mr. ROBINSON reminded members that when the case was last shown he said that although it was cleaner than before it had increased in size. But he did not think it had increased appreciably since then. If the patient consented to operation, what was to be done? He did not advocate operation. The growth was spreading out in the pyriform fossa and over to the other half of the larynx; moreover there were such marked hard glands that it was not a fit case for operation.

Mr. DE SANTI felt certain that nothing could be done from the point of view of operation. The main consideration in such cases was whether

the whole disease could be extirpated, and if this could not reasonably be done the patient should be left alone. In the particular case under consideration there was not the slightest hope of being able to remove the whole disease.

A CASE OF TONSILLAR DISEASE WITH CONSIDERABLE ENLARGEMENT OF THE CERVICAL GLANDS.

Shown by Dr. C. A. B. HORSFORD. The patient attended hospital on December 6, 1906, on account of soreness on the right side of the throat, of six weeks' duration. Two lumps had been noticed by the patient on the right side of the neck the day before admission; they were hard and painless. On December 11 the right tonsil was removed; severe hæmorrhage followed for a few hours afterwards and recurred five days later. The patient had an attack of shivers two days after the operation, and there had been continuous swelling of the neck since.

Mr. ROBINSON said the question was raised whether the tumour of the tonsil recently removed was syphilitic or not. He did not think there would be such a glandular swelling in the neck associated with chancre. Therefore it must now be considered as to whether there was some very slow phlegmonous condition or a malignant growth. His view was the latter, and that nothing could be done for it. It extended freely down to the side of the pharynx, filling the pyriform fossa on that side. It even spread over the back of the cricoid. It was also very hard, and if it were inflammatory there certainly should be signs of œdema over it.

Dr. LIEVEN thought it impossible to decide whether it was a primary chancre, because that condition tended to heal within two or three months, whether treated or not, and it did not leave a large scar. The sore which it made was not of the tissue it was in, but of its own tissue. But against syphilis was the fact that there were no secondary symptoms; and primary sores were very painful, whereas this man had not experienced much pain. Before operation he would try mercurial inunction for a few days. If no benefit resulted, he would make an incision in case there might be pus present; but the incision would not settle whether it was or was not chancre.

Mr. DE SANTI agreed with Mr. Robinson as to the nature of the glands. He did not think they could possibly be syphilitic; they were probably malignant. There was a large, hard, extensive mass of glands, with some tenderness in parts, whereas in the case of a chancre of the tonsil there was enlargement of the glands in the neck which, though very hard, were discrete, as a rule, and movable.

Mr. STUART LOW said he had carefully examined the case, and he watched a similar case two years ago, when it turned out to be a deep-seated phlegmon, with pus under the fascia. Dr. Grant operated upon this case. In another case a man came from a hospital, where removal of his tonsil had been carried out, perhaps too thoroughly, and probably the pharyngeal fascia had been wounded, as pus burrowed under the deep fascia. This being softer in the centre than in other parts, and the history being short, he advised incision.

Mr. ATWOOD THORNE considered that the case was probably malignant, but that it might possibly prove to be merely inflammatory, and that an exploratory incision should be made.

Dr. JOBSON HORNE said it was difficult to express an opinion upon what one had not seen—namely, the original condition of the tonsil. He had seen a precisely similar glandular condition secondary to primary chancre of the tonsil. He would try antisyphilitic remedies before operating.

Dr. FITZGERALD POWELL said it was not possible to say with certainty what the nature of the lesion in the tonsil was, which appeared to be responsible for the enlargement and hard, brawny condition of the glands; it must not be forgotten that in association with this there appeared to be a fairly general infection of the larynx. The arytenoid on the right side and the right cord appeared to have their movement impaired. He thought the condition was due to specific infection; the man was in a very weak condition, very pale and anæmic. He should be kept in bed, fed up, and put on anti-syphilitic treatment in combination with iron. If the case was malignant, it certainly, he thought, was inoperable.

Dr. SCANES SPICER said that, whatever else was done, the teeth should be seen to and the mouth made aseptic.

Dr. DAVIS thought it worth while to make an exploratory incision under an anæsthetic. There might be pus, as apparently there was œdema and deep fluctuation. If the glands were inflammatory, the trouble would be likely to extend into the larynx. He lately saw in hospital an urgent case of a man who had inhaled a husk while chaff-cutting. The foreign body had probably lodged in the pyriform fossa, but was invisible. There was great œdema under the chin and distortion of the larynx, but it was simply inflammatory œdema. He advised the application of three or four leeches to the part.

Mr. HERBERT TILLEY said he had heard there was an evening rise of temperature, suggesting that the swelling might be of an inflammatory nature. In view of the differences of opinion expressed, he thought it would be most instructive if the after-history of the case could be brought before a future meeting of the Society.

Dr. HORSFORD, in reply, said that a week ago the appearance suggested syphilis. He had seen a similar case in a girl who had a sloughy-looking unhealthy ulcer on the tonsil, with a large swelling of the glands, and she later developed secondary symptoms. It was not more than eight weeks since this man complained, so that there had scarcely been time to exclude the likelihood of secondaries appearing. He believed it was primary syphilis, the unhealthy tonsils accounting for the two attacks of hæmorrhage after the operation and the increased swelling of the neck—a septic complication—it had been too acute for a malignant condition.

THE SPECIMEN FROM A CASE OF FIBROMA OF THE LARYNX SHOWN AT
THE MEETING ON DECEMBER 7, 1906.

Shown on behalf of Dr. G. C. CATHCART by Dr. JOBSON HORNE.
In the absence of Dr. Cathcart, Dr. Horne said that subsequent to the last meeting he had been asked by Dr. Cathcart to see the

case with him with a view of deciding upon the course of treatment to be adopted. Upon a more thorough examination under cocaine it became apparent that they had to deal with a very tough and solid tumour attached by a very broad base to the summit and outer aspect of the ary-epiglottic fold, the cystic appearances subsiding under cocaine. It was decided not to attempt a removal by means of an endo-laryngeal operation. The tumour was successfully removed through an external incision, and was now exhibited to the Society.

The PRESIDENT reminded members that every one seemed to have seen the case last time, but nobody suggested it was not a cyst, yet it now was shown to be a solid tumour.

Dr. FITZGERALD POWELL asked whether the singing voice had suffered by the removal. He did not think it would.

Mr. ROBINSON asked whether members could be told what form of external operation was done.

Dr. ATWOOD THORNE asked if the patient and the specimen could be shown later.

Dr. JOBSON HORNE explained that Mr. Cathcart was away, and no doubt he would report more fully on his return.

SPECIMENS OF CARTILAGE AND BONE REMOVED BY SUBMUCOUS RESECTION OF THE SEPTUM.

Mr. HERBERT TILLEY showed a number of specimens which illustrated the ease with which the deviated cartilage could be removed with Ballenger's swivel knife. Luc's ethmoidal forceps with fenestrated blades were shown and recommended for the removal of the ethmoid and vomerine irregularities. A large self-retaining fenestrated nasal speculum after the Thudicum pattern was exhibited; it was very useful for keeping aside the flaps of mucous membrane while the bony portion of the deviation was being removed.

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PROCEEDINGS OF THE LARYNGOLOGICAL SOCIETY OF LONDON.

One Hundred and eleventh Ordinary Meeting, February 1, 1907.

J. B. BALL, M.D., *President, in the Chair.*

HENRY J. DAVIS, M.B. }
W. JOBSON HORNE, M.D. } Hon. Secretaries.

Present—26 members and 1 visitor.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were elected as ordinary members :

H. B. TAWSE, M.B.Aberd., F.R.C.S.
HENRY CURTIS, M.D.Lond., F.R.C.S.

The following communications were made :

A CASE OF FIXATION OF THE LEFT VOCAL CORD IN A WOMAN, AGED FORTY-FIVE.

Shown by Dr. FURNISS POTTER. The patient was a single woman and a teacher, who stated that fifteen years ago she had had a goitre removed at St. Thomas's Hospital, that she had known the "left side of her larynx had been paralysed" for at least the last four years, and that she had lost her voice a year ago, comparatively suddenly—*i. e.*, she felt it to be weak one day, and within a few hours lost the voice completely, being reduced to speaking in a whisper. This had continued up to the present, and was the only symptom complained of. She had, however, conceived the idea that she had a growth in her larynx, and it was for this that she sought advice.

Laryngoscopic examination showed that the left cord was fixed in, or near, the middle line. The right cord was freely movable, but repeated attempts to make the patient phonate failed to elicit any nearer approach to voice production than a grunt, or to bring the right cord into apposition with its fellow, although it came into close approximation. The region of the left arytaenoid was distinctly swollen as compared with the opposite side.

Examination of the chest revealed signs indicating old tuberculous trouble in the right upper lobe, but no evidence of present active mischief. It was stated by the patient's medical attendant that she had lost flesh during the last few months. Potassium iodide had been administered for a fortnight, but with no appreciable result.

Dr. Potter was inclined to the opinion that the aphonia was functional in character. He took this view because of the history, and because he did not consider that, from the appearances in the larynx, there was physical reason sufficient to account for such absolute loss of voice.

As regards the fixation, injury to the recurrent nerve on the occasion of the removal of the goitre was a possibility to be thought of, but he, personally, would suggest that the fixation was due to old tuberculous infiltration round the crico-arytænoid articulation, which had been arrested and replaced by fibroid material, with consequent locking of the joint.

Mr. BETHAM ROBINSON said he considered that the want of approximation and the air waste were due mechanically to the position of the cartilage of Wrisberg. When the cord tried to come over, it impinged on the cartilage of Wrisberg, which was in front of the one on the other side; and when the patient tried to phonate, the air waste was obvious.

Dr. F. W. BENNETT thought it was probably the result of an old paralysis of the cord, and the aphonia was due to the cords not coming into contact. Possibly the difficulty in approximating the cords was due to the debilitated condition of the patient. He suggested that perhaps the paralysis of the cord dated from the time of operation, but that until the more recent impairment of general health, the patient was able to bring the cords sufficiently into contact to produce clear vocal tone.

The PRESIDENT said he presumed that the term "fixation" was meant to include the result of paralysis. No doubt the left vocal cord was fixed by paralysis, but the question Dr. Potter raised was: why was her voice so much weaker than in most cases where one cord was paralysed? He believed Dr. Potter referred to an operation which had been performed.

Dr. POTTER, in reply to questions by the President, said he used fixation as a general term. The fixation he looked upon as the point of interest in the case, together with the aphonia. The patient had a goitre removed fifteen years ago, but had suffered from loss of voice during the last year only.

The PRESIDENT thought it most likely that Dr. Bennett's suggestion was correct. He believed the present weakness of the voice to be functional. There was not such good approximation of the cords as there should be. The cough was fairly loud, though gruff, and, during coughing, he thought it likely she brought the cords closer together than when asked to phonate.

Dr. H. SMURTHWAITE suggested that, following the operation for the removal of the goitre, adhesions had been left, and that the recurrent laryngeal nerve had become involved in them.

Dr. DUNDAS GRANT thought there must be something more than paralysis of the left vocal cord, because the rule was that, as time went on, the voice improved, through the compensatory action of the muscles on the other side bringing the healthy cord over the mid-line. He greatly favoured the idea that the vocal condition was now functional. Having been told that the vocal cord was paralysed, the patient might have an impression that the voice ought not to be operative.

Dr. POTTER, in reply said that he could hardly think that the prominence of the cartilage of Wrisberg would interfere to such an extent as to completely prevent phonation. Looking at the swollen condition of the arytænoid region, it was reasonable to suppose that this had been the seat of tuberculous infiltration, which, like the lung trouble, had been arrested in its progress, and that the crico-arytænoid articulation had been locked by fibroid material. He was much inclined to look upon the aphonia as functional. The patient stated that she had lost her voice comparatively suddenly. She had noticed it to be weak one afternoon, and within a few hours had completely lost it. He (the speaker) had seen the right cord come very nearly into apposition with its fellow, and did not think there was sufficient mechanical obstacle to prevent phonation. He had applied the Faradic current, but had failed to make the patient phonate. Notwithstanding this, he adhered to his opinion that the disability was functional, and that with perseverance the power to use the voice might be demonstrated.

A CASE OF TUMOUR OF THE NASAL SEPTUM.

Shown by Dr. FURNISS POTTER. The patient was a married woman, aged thirty-one, who had complained of increasing nasal obstruction on the right side for the last year, with occasional slight bleeding, chiefly on blowing the nose. On examination a red, vascular, sessile tumour was seen, about the size of a horse-bean, on the right side of the anterior part of the septum. It was soft, easily pierced by a probe, which produced some, but not profuse, bleeding. It was suggested that the growth belonged to the group described as "bleeding polypus of the septum."

Mr. C. A. PARKER thought that if cocaine were applied and a good view obtained, the inferior turbinal would be seen to be also involved. He regarded it as tuberculous infiltration of the nature of lupus.

The PRESIDENT thought the condition was extensive, and went a long way back. The septum was deflected to that side. If, as Mr. Parker thought, the lower turbinal was also involved, anything like scraping would be sure to cause adhesions. He suggested doing what he did in a case of lupus a few years ago. The septum was deflected and the passage was very narrow on the affected side, and both the lower turbinal and the septum were affected with lupus. He removed the diseased mucous membrane of the septum and the deflected cartilage, leaving the mucous membrane of the opposite side intact, thus correcting the septal deformity. He scraped the diseased lower turbinal. No adhesions resulted.

Dr. STCLAIR THOMSON thought there could scarcely be any doubt that it was lupus. He suggested the value of applying adrenalin. If that

were placed over a lupus surface like the present the tissue was rendered anæmic, except at the deposit, and then it stood out as a distinct apple-jelly mass. He came across that in a girl who had lupus of the inferior turbinal. She had a deviated septum, and in the out-patient room it was thought to have a normal appearance. Having, it was supposed, arrested the lupus of the inferior turbinal, she had adrenalin and cocaine applied before resection, and then the "apple-jelly" infiltration became so distinct that he did not operate, as lupus was one of the contra-indications to septum resection given by Killian. He had watched her since, and the condition had developed. He would like to hear whether there was any recurrence in the President's case. He suggested the application of the galvano-cautery as an alternative treatment, not applied over a large surface, but applied deeply at several points, so as to produce scar tissue.

The PRESIDENT, in reply to Dr. StClair Thomson, said that, so far as he knew, there had been no recurrence. He saw the patient a few months after the operation, but that was five or six years ago. He was not aware of there being any contra-indication. In the present case, whether one used the galvano-cautery or any such treatment, he thought there were sure to be adhesions, unless the deformity of the septum were corrected.

Dr. POTTER, in reply, said that his own opinion had been divided between tubercle and "bleeding polypus," but his inclination had been rather towards the latter. He intended to remove the growth, together with the cartilage underlying it, by a submucous resection, *i. e.* by dissecting off and preserving the mucous membrane of the opposite side of the septum—in fact, what was known as the Krieg Boenninghaus operation. He proposed to do this, in spite of Dr. StClair Thomson's caution as to possible recurrence. The affected part was clearly circumscribed, and could be completely removed. He, the speaker, had not observed anything abnormal in the inferior turbinal.

A CASE OF A LARGE TUMOUR IN THE SOFT PALATE AND THE LEFT WALL OF THE PHARYNX; OPERATION JANUARY 15; SPECIMEN; MICROSCOPIC SLIDE; PATHOLOGICAL REPORT.

Shown by Mr. STUART LOW. He said that this woman, aged sixty-five, came to the hospital complaining of some pain in the throat and difficulty of swallowing, which had increased very much during the last fortnight. She had been conscious of some obstruction existing in her throat for about eighteen months, but this had become much more marked since six weeks ago. There was no swelling nor glandular enlargement to be felt from the neck. The tumour was seen to occupy the whole of the left half of the soft palate and half of the right side, and was incorporated with the palate from the middle of the left half right over to the right side. It also occupied the left side of the pharynx between the palatal pillars. The swelling was very firm in consistency, and the soft palate was stretched over it.

At the operation for removal laryngotomy was first performed,

as the tumour seemed fleshy and vascular, and free hæmorrhage was anticipated; the pharynx was then firmly plugged with sponges. Having split the soft palate longitudinally the tumour was shelled out from the pharyngeal wall, but had to be dissected away from the structure of the palate, to which it was found to be firmly attached. There was considerable hæmorrhage. Three stitches were inserted into the soft palate, and the laryngotomy tube removed at once. She made an uninterrupted recovery.

REPORT BY DR. WYATT WINGRAVE.

“The growth is a typical endothelioma, consisting of a homogeneous stroma, enclosing groups of cells, which are arranged in cylinders (hollow and solid), becoming alveolated and fused. In some parts they have a laminated arrangement, and are calcified. There are no marked mitotic changes in the nuclei. In texture the growth was soft and friable, except in one part, which was firm and tough owing to excess of stroma. It is fairly vascular and encapsuled.”

Mr. ROBINSON thought there was no doubt that it was endothelioma. It showed definite cells round the vessels, and in places there was mucous softening, such as one found in similar tumours of the parotid.

A CASE OF LARYNGEAL TUBERCULOSIS.

Shown by Mr. BETHAM ROBINSON. The patient, a woman aged thirty-one, married ten years, had had frequent loss of voice in winter for ten to fifteen years. Now hoarseness for one year, with some dry cough, and only a little watery expectoration. She had got thinner lately, but otherwise felt and looked well.

The larynx showed a thickening posteriorly, with almost symmetrical warty granulations in the interarytænoid region. Some discoloration of both vocal cords, the right one being irregular. The epiglottis was normal. There were no physical signs in the chest. She has had six children, of which only two are alive, the rest dying shortly after birth. There had been one miscarriage. Before coming under Mr. Robinson's care she had been treated with potassium iodide, on the supposition the condition was syphilitic, but without any improvement. Her father had phthisis.

Mr. H. BARWELL thought the appearance was very suspicious of tuberculosis. There was a large, shiny, pale, œdematous-looking swelling of

the right cord, as well as the pale outgrowths in the interarytænoid space. It often happened in such cases that no physical signs could be detected for some time; and one could not diagnose the absence of tubercle in the chest without observing the temperature for some time, and watching the weight, as well as examining physically.

Dr. W. H. KELSON thought the possibility of it being papilloma should not be lost sight of, considering that no tubercle bacilli had yet been found, and that the lungs showed nothing. She seemed to have a very fair voice, and, for the quantity of the growth, if it were tubercle he did not think the voice would be so good, and he would have expected more infiltration.

Dr. ATWOOD THORNE thought it would be a mistake to rush to the conclusion that it was tubercle. The two little white, currant-like bodies in the interarytænoid space were the chief feature in the case; there was nothing suggestive on either cord.

The PRESIDENT said he thought there was some swelling of the right vocal cord.

Dr. STCLAIR THOMSON thought it would be a great misfortune if it were not concluded that the case was tubercular. That interarytænoid appearance in a woman who was not syphilitic, and not a drinker, was characteristic of tubercle. There was distinct infiltration of the vocal cord and loss of substance over the vocal process; she was losing weight, felt weak, and sweated a good deal. He thought the case should be at once treated on the assumption that she had tuberculosis.

Mr. ROBINSON, in reply, said his remark about tubercle bacilli was that the report had not yet been received, not that the bacilli could not be found. He had noticed the swelling of the right vocal cord, which increased the probability that it was tubercle.

NOTES ON THE PROGRESS OF A CASE OF ADENITIS SHOWN AT THE PREVIOUS MEETING, JANUARY 4, 1907.

Report by Dr. P. H. ABERCROMBIE. The case proved to be one of deep-seated abscess. On January 12 the swelling in the neck was incised, and fully half an ounce of pus escaped, in which Dr. Wyatt Wingrave found the *Streptococcus pyogenes*. The following are the notes of the case: The patient, aged forty-nine, a tobacconist by trade, was seen at hospital on Thursday, December 6, 1906. He complained of "sore throat," confined to the right side and low down, and also of "pain on swallowing" of about six weeks' duration. He knew of no cause for his throat affection. In spite of treatment his throat did not improve, but rather tended to get worse, and when first seen the tonsils were enlarged, especially the right one, which latter presented the appearances of chronic lacunar disease. The uvula was very long, and the teeth were far from clean. At this time there was no lymphatic glandular enlargement. There was some degree of nasal obstruction present from septal deviation. The

removal of the tonsils and shortening of the uvula was advised, and five days later (December 11) this was carried out. On the morning of the operation day the patient drew attention to two hard, painless swellings, evidently glandular, near the angle of the jaw on the right side, and which he had first noticed only a day or two before. On his return home from hospital a few hours later he bled a good deal, and he again lost blood five days after this, when he had an attack of "shivers," followed by sweating. On December 22 (*i. e.* eleven days after the operation) he went out for the first time, and he returned to business on December 24. The throat, however, never got quite well and he came to hospital on January 3, when the glandular enlargement was very much greater, and the right tonsillar region was swollen, red, and unhealthy-looking. There was also considerable œdema affecting the right side of the larynx (epiglottis, aryepiglottic fold, arytaenoid, and ventricular band) and interfering with the action of the right vocal cord. The temperature was 99° F. Dr. Abercrombie considered the condition was a septic one, probably coccal, and that the dirty state of the teeth might explain the source of infection. A swabbing from the right tonsil region was examined by Dr. Wingrave, who reported: "Agar inoculation from fauces afforded pure growth of *Streptococcus pyogenes*." The patient entered the hospital as an in-patient on January 4, when his temperature was 97° F. The next day it reached 99·8° F., the following day 101·4° F., when he developed in his left great toe-joint what he called "gout," and what certainly answered to the usual description of such given in the books. In addition to this, however, he had pain in the right ankle, which he described as being different from "gouty pain." The day following this the temperature was 102° F., and for the next few days it kept between 100° F. and 101° F. On January 10, at 4 p.m. (four hours after the patient's dinner), Dr. Wingrave examined his blood and reported that "no bacteria were found; the blood count showed leucocytes at 4500 per cubic millimetre." This is noteworthy, considering the fact that pus must have been present in the neck at that date. Two days later (January 12) an incision was made into the swelling, and quite half an ounce of pus escaped. This was examined by Dr. Wingrave, and was found to contain the *Streptococcus pyogenes*. The day following he sweated profusely, but there was no rigor, nor did he have any shivering attack during his residence in hospital. On the 15th the temperature suddenly shot up to 104° F.; he again perspired very freely, and he complained of some difficulty and pain in swallowing, with

slight obstruction to breathing. The laryngeal œdema had increased considerably, so much so, indeed, that it was thought tracheotomy might be required. It was found to be necessary to make a counter-opening lower down in the neck to ensure better drainage. Next day he was much better and perspired freely. The dyspnœa had gone. He swallowed quite comfortably and his temperature had subsided. On the 20th (four days later) he was suddenly attacked with acute pain in the right wrist, which was regarded as evidence of septic arthritis. Anti-streptococcic serum was then used. He had four injections in all, two on January 21 and two on the 22nd, each injection consisting of 10 c.c., but the benefit from this was not very marked. He has progressed favourably, if slowly, since then, and he is now convalescent, and will soon be able to leave hospital. With regard to his past history, his only trouble appears to have been "gout," of which he says he has had about twenty attacks, the first one being in 1883, when the left great toe-joint was the one involved. Since then he has had an attack, always in the same joint, about once a year, and usually in the spring. In this connection it is interesting to note that he has always consumed a good deal of malt liquor, and has been in the habit of eating butcher's meat twice a day. He smokes at least 3 oz. of tobacco a week. He has never had any form of venereal disease, and apart from his "gout" he has always been a very healthy man. He admits having neglected his teeth, and their appearance certainly confirmed this statement. Dr. Wingrave again examined his blood on January 22—ten days after the opening of the abscess—and again failed to find any streptococci, but there was on this occasion a marked increase in the number of leucocytes—14,500 per c.m. (3 p.m.). In the deposit round the teeth were found *Spirochæte dentium*, streptothrix, diplococci, and yeasts in great abundance. While in the hospital the patient took quinine and iron. The teeth and gums were cleansed with a 1 per cent., warm solution of lysoform, and the tonsillar region was painted daily with menthol in almond oil (20 per cent.).

With regard to the suspicion of malignant disease, Dr. Abercrombie thought the short course of the affection, viz. about two and a half months, was against this view. As to syphilis, no secondary symptoms have appeared, and a course of mercury, prescribed by his medical attendant, produced no beneficial effect; indeed, during its administration the throat steadily got worse. When the patient was first seen his medical attendant thought it might be a case of herpes of the tonsil, as there were several spots

which looked like ruptured vesicles, and the swelling was slight but the pain great.

The PRESIDENT said a few of the members at the last meeting held that it was inflammatory, but the majority who spoke believed that there had been a primary sore on the tonsil, and that the adenitis resulted from this.

Mr. ROBINSON said he was pleased to hear what had been the result in the case. He had expressed the opinion that it was malignant, and he had learned something now that it had proved not to be.

Mr. HERBERT TILLEY asked whether there was an actual abscess, or simply points of suppuration in the glands.

Dr. ABERCROMBIE, in reply, said there was an actual abscess. No secondary syphilitic symptoms had appeared, and, during a course of mercury, prescribed by the patient's medical attendant, the throat condition steadily got worse.

A CASE OF ABNORMALITY OF THE NECK.

Shown by Dr. KELSON. The patient, a man, aged twenty-one, complained of his neck growing to one side; he thought there had always been something wrong, but it had become more obvious lately. On examination there was found to be a very marked subcutaneous band passing up from the sternal origin of the right sterno-mastoid; at about the level of the cricoid cartilage it appeared to bifurcate, the inner band being lost in a small, doughy swelling in the region of the hyoid bone, whilst the outer division passed backwards, and was lost under the sterno-mastoid; the position of the head was normal, and no abnormality could be detected by internal examination.

Mr. ROBINSON thought it was a thickening in the fascia coming down from the anterior border of the digastric, and fusing with the cervical fascia over the sterno-mastoid. Why it should be thickened he did not know. He knew of no abnormal muscle which occupied that position.

Mr. STUART-LOW thought it was the omo-hyoid muscle. The late Professor Hughes had been particular to point out the vagaries of the omo-hyoid, which had much fibrous tissue in it. Probably there was but little muscle in the present one.

Dr. KELSON, in reply, thought it must remain undiagnosed at present. He could not accept the view that it was sterno-thyroid or sterno-hyoid, because he did not think they were found to arise from the anterior surface of the sterno-mastoid. And one could scarcely imagine any injury at birth damaging the sterno-thyroid and sterno-hyoid without also damaging the sterno-mastoid.

A CASE OF ULCERATION AND INFILTRATION MAINLY CONFINED TO THE RIGHT HALF OF THE LARYNX.

Shown by Dr. DUNDAS GRANT. The patient was a girl, aged twenty-one, who complained chiefly of hoarseness of seventeen

months' duration, which had been preceded by a sore throat for one month with pain in swallowing, this soreness continuing for two or three months longer. She first came under the exhibitor's notice about a month ago, when there was some delicate cicatrization of the left half of the fauces, producing partial adhesion to the posterior wall of the pharynx. There was some degree of tumefaction of the epiglottis, which was intensely red, and on the under surface could be seen an irregular row of very small, translucent granulations, which probably marked the upper limit of a concealed ulcer. The right aryepiglottic fold was infiltrated, its mucous membrane being very superficially ulcerated, this being continuous with a similar condition on the ventricular band. The vocal cord was irregular in outline, and superficially ulcerated at its posterior part. The probable diagnosis made in the first instance was one of syphilis, and iodide of potassium, in doses of 10 to 15 grains thrice daily, had been given for some time; the pharynx improved to some extent, but the ulceration in the larynx had persisted. There were no confirmatory evidences of a specific infection either acquired or inherited, the only thing suggestive of it being the occurrence of a severe sore throat, which lasted one month when she was twelve years of age. The appearances were compatible with those of lupus, but in view of the possibility of its being specific, and, therefore, amenable to treatment, the exhibitor proposed submitting her to a course of mercurial inunctions, and he was desirous of eliciting whether any of the members of the Society considered it contra-indicated.

Dr. SMURTHWAITE said it gave him the impression that it might be syphilitic, considering the posterior pillar of the fauces on the left side had become adherent to the pharynx, and the scarred condition of the latter; but, on the other hand, a lupus could have produced the same. The laryngeal appearance, with its mouse-eaten condition, favoured the view of tuberculosis. Especially was this the case on the right cord and arytaenoid joint, and on the glottic surface of the epiglottis.

Mr. BARWELL thought it tubercular rather than syphilitic, but rather of the nature of lupus, though one found it difficult sometimes to draw the line between the two. This case seemed to be a border-line one; the scarring on the pharynx could well be caused by lupus. The mouse-eaten appearance, mentioned by Dr. Smurthwaite, favoured the diagnosis of lupus. He would, however, try mercurial inunction. He asked that the subsequent progress might be reported.

Dr. GRANT, in reply, said he could not see any great objection to trying the effect of mercurial inunctions, watching her carefully during the treatment. If she were not given the chance that afforded, one might be making a mistake.

A CASE OF EXTREME WEAKNESS OF VOICE IN A MALE PATIENT,
AGED FORTY-ONE, OF FOURTEEN MONTHS' DURATION, APPARENTLY
AS THE RESULT OF A CHILL.

Shown by Dr. DUNDAS GRANT. The hoarseness first came on fourteen months ago, while the patient was acting in very wet weather, and, with very slight fluctuations, it has remained ever since. He was first seen by Dr. Dundas Grant, between three and four months ago; his voice was extremely gruff, and the swelling of the vocal cord was practically identical with what it is just now. There is a slight convexity towards the middle line, but then it was much more overhung by the right ventricular band, a portion of which was removed and found to consist of inflamed tissue. Appearances at first were suggestive of a tuberculous condition, but there is absolutely no physical sign of such disease in the chest, and the sputum has been several times examined, with negative result. Iodide of potassium was given in doses of ten and fifteen grains, three times a day, without any appreciable result, and no history of primary infection is obtainable. The patient went through great exertion, both as a soldier during the war and as a teacher of elocution, before the hoarseness commenced. At present the question is whether it is justifiable to remove a portion of the thickening of the vocal cord for microscopical examination, on the understanding that thyrotomy is to be sanctioned if the results of the examination render it advisable. Galvano-caustic puncture was made on the right cord without any effect, and a small nodule on the edge of the left one was also cauterised, but the voice became still weaker, as if the nodule which was destroyed had taken part in the production of sound.

Dr. JOBSON HORNE asked whether anything in the way of treatment had been done to the left half of the larynx.

Dr. GRANT replied that there was a little inflammatory projection on the surface of the left vocal cord, which he touched with the galvano-cautery. That shrivelled it up. That was ten days ago. The left cord was just as red then, so he thought it was not traumatic.

Dr. STCLAIR THOMSON said he was more impressed with the opposite side of the larynx, where there was an infiltration of the ventricular band; it was so thickened that it concealed the greater part of the vocal cord. Part of it might have been due to surgical treatment, but it had a rough edge, with small, white points. If it was formerly as red as Dr. Grant said, it was probably a very slow-moving tuberculosis. The right cord was succulent, but that might be due to the great amount of work it had had to do.

Dr. JOBSON HORNE thought it was premature to express an opinion

on that larynx at present. If Dr. Grant would show the case again at the next meeting, when the larynx had completely recovered from the local treatment, there would be a better opportunity of judging. He understood the patient was a professor of "voice-production."

Dr. GRANT, in reply, said he had never been able to dismiss from his mind the idea that it was tuberculous, and that was his opinion still. The patient was combatting tuberculosis most thoroughly, by eating largely and living in the open air, and was thus removing one of the diagnostic guides. He hoped members would keep the appearance in mind, and he would bring the patient again. He thought the idea of malignancy could be dismissed, and there was no occasion to remove a bit of the cord for examination.

A CASE OF LYMPHO-SARCOMA OF THE BASE OF THE TONGUE AND EPIGLOTTIS, PREVIOUSLY EXHIBITED; REMOVAL BY LATERAL PHARYNGOTOMY AFTER LIGATURE OF ARTERIES; RECURRENCE OF LEFT PORTION.

Shown by Dr. DUNDAS GRANT. The case was shown at the November meeting, on which occasion Mr. Butlin advised that an attempt should be made to remove the growth by a lateral pharyngotomy, the branches of the external carotid being ligatured a few days before. On November 9 the exhibitor ligated the external carotid on the left side, and the lingual and facial arteries on the right. The result, so far as hæmorrhage was concerned, quite confirmed what Mr. Butlin had said, and on the 12th the pharynx was opened on the right side, the hypoglossal nerve being retracted upwards and the disease removed, as was thought, completely, with hardly any hæmorrhage. Two secondary hæmorrhages occurred on the 17th and 19th, which caused some anxiety, but a rectal injection of gelatine was administered at the time of the second one, and no further hæmorrhage took place. On the left half of the site of the growth a recurrence has taken place. Arsenic has been given in increasing doses, and two interstitial injections have been made of 5 minims of a 1 in 15 emulsion of papayin. These injections have caused no reaction, but the result remains to be seen.

Dr. GRANT said that since the recurrence he had given two injections of papayin into the substance of the growth.

Mr. ROBINSON asked which vessels Dr. Grant had ligatured.

Dr. GRANT replied that he ligatured the external carotid on the left side and the lingual and facial on the right side. The patient was now taking arsenic.

CASE OF ULCERATION OF THE RIGHT TONSIL IN A MAN, AGED THIRTY-TWO.

Shown by Mr. CHARLES A. PARKER. The patient was first seen three weeks ago, when he complained of pain and discomfort of three weeks' standing. There was then an ulcer on the upper part of the right tonsil, rather larger than a sixpenny bit, and covered with a dirty grey slough. The whole tonsil was enlarged and somewhat hard. One or two slightly enlarged glands could be felt in the neck. Since then the ulcer had greatly increased in size, both superficially and deeply, and there had been great loss of tissue; moreover, the glands had become greatly enlarged, tender, or matted together. The question raised was that of the diagnosis; was it syphilitic? and, if so, was it a primary chancre or tertiary ulceration? Mr. Parker had at first thought it was a primary syphilitic lesion, and had put the patient on hydrarg. c. cret., but in spite of this the condition had become so much worse, and there was so much loss of tissue that he now doubted the diagnosis.

The PRESIDENT said he gathered that the patient had not had much treatment; he had had mercury for a fortnight. He thought it was probably tertiary ulceration of the tonsil, and one could not say it had resisted treatment unless iodide of potassium had been given. There was much adenitis, but the septic condition of the tonsil would explain this.

Mr. ROBINSON supported the President's suggestion as to treatment; he thought it was tertiary syphilis, *plus* sepsis.

Mr. PARKER, in reply, said he had not put the patient on iodides, because when he first saw him the evidence was in favour of a primary sore, and therefore mercury was prescribed. He would now give large doses of iodide of potassium, combined with mercurial inunctions.

A CASE OF EPITHELIOMA OF THE TONSIL.

Shown by Mr. HAROLD BARWELL. The patient was a man, aged fifty-nine, with a history of syphilis thirty years ago. He had noticed something in the throat for six months. There was no pain and no palpable enlargement of glands. The growth was hard and involved the left tonsil; it did not appear to go deeply, but had spread rather extensively on the surface on to the palate and anterior pillar. The opinions of members were requested as to the advisability of operation.

Mr. ROBINSON said it was, no doubt, epithelioma, and he advised Mr. Barwell to operate on it. The whole of it could now be got away; there were apparently no enlarged glands in the neck. Still, the neck should be opened, and any small glands taken away.



PROCEEDINGS OF THE LARYNGOLOGICAL
SOCIETY OF LONDON.

One Hundred and twelfth Ordinary Meeting, March 8, 1907.

J. B. BALL, M.D., *President, in the Chair.*

HENRY J. DAVIS, M.B., }
W. JOBSON HORNE, M.D., } Hon. Secretaries.

Present—45 members and 2 visitors.

The minutes of the previous meeting were read and confirmed.

The ballot was taken for

ALEXANDER R. TWEEDIE, F.R.C.S.,

who was elected an ordinary member of the Society.

The following communications were made :

MICROSCOPICAL SECTIONS OF NASAL POLYPI EXHIBITING PECULIAR
SPIRAL AND KNOTTED THREADS OF (?) MUCUS IN THE SUBSTANCE
OF THE GLANDULAR DILATATIONS.

Shown by Dr. HUGO LÖWY (Carlsbad) to illustrate a condition which, so far as he knew, had not been previously demonstrated. In the cysts and dilatations of the glandular structure scattered over the preparation were to be found, in the midst of the mucus and cells, threads of a peculiar twisted and knotted shape. These were partly spiral, and it had been ascertained that they consisted mostly of mucus, so as to be suggestive of the spirals in the bronchial mucus of asthma. Dr. Löwy stated that the sections had been fully described in his contribution to the *Schroetter-festschrift*,¹ and that he therefore need not take up time by entering into details. He showed the sections in order that the members might form their own opinions. Dr. Löwy stated that some years ago after making this pathological observation he entered upon

¹ *Zeitschrift für Klinische Medizin*, Bd. lxii.

a systematic research of nasal polypi which were found to contain cysts, and, after a long and laborious search, he was successful in finding an analogous condition in another case. An example from both cases was placed under the microscope. By the side of the specimens was placed a sketch of the part exhibiting the threads. Dr. Löwy regarded them as mucus worked up into thread-like structures by movement in the glandular tubes, brought about by variations of pressure on the polypi during respiration, similar to the formation of asthma spirals, but any other explanation might be offered without altering the value and the morphological interest of the observation.

Dr. H. PEGLER said the Society was much indebted to Dr. Löwy for bringing up these specimens. There were no sections of polypi in the Society's collection with which he could compare them, nor could he throw any light on the condition, but he agreed that these spirals were a peculiar form of coagulated mucus; and the surrounding conditions deserved investigation, particularly the dilated ducts that were so characteristic of these sections.

Dr. Löwy, in reply, said that he, like those to whom he had shown the specimen, was unable to offer any further explanation. It was difficult to say why only that part of the mucus which formed the threads had taken the hæmatoxylin stain; the threads were not distinctly separated from the surrounding mucus, but connected with it with irradiant lines of transition, and possibly might have acquired some chemical or physical property which enabled them to take the stain in the course of their formation. The mucus immediately surrounding the threads sometimes presented a more homogeneous appearance, like a mantle, different from the more distant mucus, containing more cells. The formation he had described and the analogy he had pointed out seemed not to be without interest in general medicine.

A CASE OF FISSURES ON THE TONGUE.

Shown by Dr. H. J. DAVIS. The patient, a man, aged twenty-two, presented oblique symmetrical fissures on the dorsum of the tongue. The possibility of the condition being due to lymphangioma or congenital causes was suggested.

The PRESIDENT said he rather doubted whether the condition was lymphangioma.

Dr. DE HAVILLAND HALL said he had seen similar fissures in the tongues of chronic dyspeptics, and had looked upon the condition as the outcome of the dyspepsia. He had had no idea that they might be regarded as congenital.

Dr. F. W. BENNETT said he had known cases with very marked fissures without any dyspepsia, and in one certainly the fissures had lasted all through life. He thought the present case was more likely to be congenital.

Dr. DAVIS, in reply, said the patient did not come to the hospital

complaining of his tongue, but because of trouble in his nose. Cases of dyspeptic tongue usually had some symptoms referable to the tongue; discomfort there at least was complained of. This patient said he had always had the fissures since he could remember. He (Dr. Davis) believed the lateral parts of the tongue were said to be developed from the muscle plates of the visceral arches. There was also a malformation in the patient's soft palate which supported the view that the case was congenital. One of his surgical colleagues regarded it as lymphangioma.

A CASE OF PAPILOMATA OF THE LARYNX (SHOWN NOVEMBER, 1906).

Shown by Dr. DAVIS. The patient was a girl, aged nineteen. When brought before the Society last November, the larynx was crowded with papillomata; these were removed by forceps and snare. The vocal cords were now red, and aphonia persisted. Suggestions as to further treatment to improve the voice were invited.

The PRESIDENT thought the voice was now very good and that the patient would not require treatment if the papillomata did not recur. She ought to be satisfied with the voice she now had.

Mr. F. J. STEWARD asked whether any special treatment had been used in the case with a view of preventing recurrence of the condition after removal.

Dr. DE HAVILLAND HALL was inclined to advise leaving the case alone now. She seemed satisfied with her voice, which appeared to be in a fairly healthy condition, and he would not irritate the cords by any local treatment.

Dr. DAVIS, in reply, said when first shown she had a mass of papillomata, which it was suggested should be removed by thyrotomy. However, he tried several times with forceps and the snare and got it all away. Some attached to the cords were removed with Dr. Dundas Grant's forceps. She was now able to breathe quite well, but her voice had not recovered, though it was very fair that day. The only local treatment he had applied was lactic acid (40 per cent.) by means of a miniature laryngeal spray used by the patient. She still had chronic laryngitis, which did not seem to have recovered as rapidly as it might.

A CASE OF TUBERCULOSIS OF THE LARYNX IN A WOMAN, AGED THIRTY-THREE.

Shown by Mr. CHARLES PARKER. This patient was first seen seven years ago with tuberculosis of the larynx and slight physical signs at the right apex, which were first noticed immediately after the birth of her fifth child. She was shown to the Society in February, 1905, as an example of a woman who had commenced pulmonary and laryngeal tuberculosis during pregnancy and had survived four subsequent pregnancies. Since 1905 she had had one further pregnancy, ending in a miscarriage. In all she had had ten con-

ceptions, including four miscarriages, and of the six children born alive three had died of tuberculous meningitis. This history suggested tuberculosis in the mother. Two years ago, when the case was shown, several members of the Society maintained that the appearance, at that date, suggested a chronic inflammatory thickening.

Mr. Parker had lost sight of the patient until last Christmas, when she was admitted into hospital with urgent dyspnoea. Then both the supra-glottic and subglottic regions were filled with what appeared to be chronic inflammatory overgrowth. With rest in bed and mercurial inunctions the swelling had so far subsided as to put the patient out of danger of suffocation, but there were still present large masses of this inflammatory overgrowth. Mr. Parker asked for an explanation of this transition from what was almost without doubt originally a tuberculous infiltration to the present condition of chronic hyperplasia. He would also like suggestions as to the treatment, though he felt inclined to leave the local condition alone.

ABSCESS OF THE RIGHT FRONTAL LOBE, SECONDARY TO CHRONIC BILATERAL FRONTAL AND ETHMOIDAL SINUS SUPPURATION.

Shown by Dr. W. MILLIGAN. The patient, a girl, aged twenty, was sent to me on account of persistent purulent discharge from both nasal passages and intermittent frontal headache of several years' duration. Examination showed that both frontal sinuses and both ethmoidal labyrinths were the site of suppurative disease. After a short preliminary antiseptic treatment both frontal sinuses were operated upon according to the Killian method, at the same time both ethmoidal labyrinths being opened up and drained. The operation took place upon October 11, 1906. The patient made excellent progress up to November 6, when she had a severe attack of septic tonsillitis which lasted for a few days. From November 13 to November 27 she appeared to be in good health, complaining only of a dull feeling in the head. She was able to assist in light ward work and appeared cheerful. The temperature was normal, the pulse regular, and there was no tendency to sickness or vertigo. There was still slight discharge from the right nasal passage of a distinctly foetid character. The left frontal sinus had entirely healed up and there was no discharge in the left nasal passage. Upon November 27 her temperature suddenly rose to 101·8° F., and she complained of intense head-

ache. Upon the morning of the 28th the temperature was 97·4° F. A careful examination was made under an anæsthetic, and search made for the source of pus from the right nasal passage, without, however, any definite result. By December 8 her temperature was again normal, and remained so until December 20. Upon the morning of December 20 she had a severe shiver, and her temperature rose to 101° F., while her pulse was 92. Her headache became very severe and distinct double optic neuritis was found. A lumbar puncture made the following day showed an opalescent cerebro-spinal fluid. For the next few days the temperature varied from 100° F. to 103° F., and the pulse from 80 to 108. The patient rapidly sank into a comatose condition and died upon the morning of December 26.

A *post-mortem* examination made twenty hours after death revealed diffuse suppurative pia-arachnitis over the base of the brain, especially over the under surface and lateral portions of the right frontal lobe. Upon the under surface of the right frontal lobe a small abscess cavity was found containing very foetid pus. This abscess cavity communicated with the general pia-arachnoid cavity and by a minute fistulous tract with the posterior ethmoidal cells. The discharge, which persisted in the right nasal passage after the first operation, was doubtless oozing gradually from the frontal lobe abscess.

Dr. STCLAIR THOMSON congratulated Dr. Milligan on giving the Society the lesson to be learned from the case. He had had a similar one, and as it had not been published he brought the brain to show. A transverse section across the frontal lobe showed the abscess in the centre of the frontal lobe, on the left side. There was no direct macroscopical connection with the frontal sinus; the pus had recently burst through the left side, and trickled down into the anterior fossa. But it was evidently a latent abscess in the frontal lobe. The patient was up and about seven days after he did a Killian operation on the left side. She was so relieved that she was most anxious to have the other side done. Her headache set in 16 to 18 days after the operation, and death occurred four weeks after operation. Dr. Milligan's case, like his own, showed the risks run by surgeons in serious operations on the sinuses, because, except that she fainted in the ward and was considered to have funny manners—being regarded as somewhat hysterical—there was no evidence that she had the abscess. The surgeon was apt to blame himself, and certainly the friends were apt to blame him, believing the fatal result to be due to the traumatism, whereas in Dr. Milligan's case the time which had elapsed—longer even than in his own—was sufficient to show that it was a latent abscess, although the traumatism might have precipitated the fatal termination.

Mr. HERBERT TILLEY said that one point which both the cases illustrated was that which had a bearing upon treatment in those cases. Affections of the meninges and frontal lobes did not occur as frequently

from the frontal sinus as from the ethmoidal cells. In the literature of the subject it would be found that in the vast majority of cases the fact seemed to be established. Therefore in the operation it was very important to thoroughly clear the ethmoid region. For thirteen years he had been looking for a case of abscess in the frontal lobe due to pure frontal sinus suppuration, but he did not think he had yet seen one. He thought he had experienced one a month ago when he saw a man in a very depressed condition, which was ascribed to his mother having died very suddenly a week before. Since that event he had not spoken to anyone. A small operation had been performed on his ethmoidal region a few weeks previously, and there were some indications that suppuration was still going on there. The case was difficult of diagnosis because it was impossible to separate the effect of the disease from his domestic trouble. Three days afterwards the man became comatose and died. *Post-mortem*.—A large abscess was found in the frontal lobe, but it was proved that it came from the ethmoidal region. If ethmoid suppuration was efficiently dealt with the frontal sinus disease would rarely cause fatal complications.

Dr. SCANES SPICER desired to repeat what he had often said before—how desirable it was in his opinion to thoroughly attack the middle turbinated and break down and drain the ethmoidal cells, especially the anterior group, before operating on the frontal sinus from the outside. He asked whether that was done in Dr. Milligan's and Dr. StClair Thomson's cases; did they resect the middle turbinated body and break down the anterior ethmoidal cells before tackling the frontal sinus from the outside? He must have had great good luck in his frontal sinus cases, as he had had no experience of any of the serious extensions referred to by other workers—at least, it was good luck unless, indeed, the avoidance of such extensions were the result of the antecedent ethmoidal drainage. If what he recommended were done, he believed, moreover, that Killian's, as well as other external, operations would be less needed.

Dr. PERMEWAN said he thought Dr. Scanes Spicer's luck consisted rather in not having found a latent frontal abscess, than in the method which he adopted. Dr. Spicer seemed to take the view that Dr. Milligan and Dr. StClair Thomson produced the abscess in their cases; whereas the notes made it clear that the abscess in each case was there before. All had probably seen cases of abscess thought to be due to frontal sinus cases which might perhaps be attributable to ethmoid cell-disease. Another lesson furnished by the cases seemed to be the need of trying to discover whether there was any intracranial suppuration before attempting operation on the frontal sinus. It was not easy to discover abscess in the frontal lobe, but it was well to bear it in mind.

Dr. WATSON WILLIAMS said he did not think many would be inclined to subscribe to the suggestion of Dr. Scanes Spicer that in such cases where it had been decided that an external operation on the frontal sinus was necessary the suppurating ethmoidal cell should be cleared away before doing the major operation on the frontal sinus. He thought one should avoid attempting to deal with suppurating ethmoidal cells, except the anterior and lower ones, until the frontal sinus was opened, when the cells could be attacked from the front, and when it was so much safer to be thorough in their removal. And, *à propos* of his own case that day, it could now be done with comparative safety.

Mr. WESTMACOTT agreed with Dr. Scanes Spicer that in the majority of cases one could deal with the ethmoidal labyrinth, especially the anterior division, from the interior of the nose. He had come across two

chronic cases only in which he had been obliged to do an external operation, and that experience was borne out by Hajek, of Vienna, who said that the external operation was required for only a very few cases. It was principally the anterior ethmoidal labyrinth which was affected with the frontal sinus, and that which mostly caused the intracranial abscess, subdural, or in brain matter, infection occurring either through a perforation of the posterior and upper wall of the frontal cavity or the cribriform plate of the ethmoid.

Mr. E. B. WAGGETT desired to speak in the same sense as Mr. Westmacott. Not only the anterior, but the posterior ethmoidal cells were easy to attack by the nasal route. Frontal sinus operations were very delightful to do, but a good many of the cases were not quite dry after the operation. He thought the cases attacked by the nasal route had, as a general rule, as good a result so far as clinical symptoms were concerned as those done by external operation.

Dr. FITZGERALD POWELL said that he understood that in Dr. Thomson's case the abscess occurred eighteen days after the operation, and in Dr. Milligan's case six weeks after. This rather gave one the idea that possibly the infection might have occurred at the time of operation. There was some doubt as to whether frontal sinus suppuration was responsible for the causation of latent frontal abscess, some holding that it was due to infection from the ethmoid suppuration. In some cases of frontal sinus suppuration which he had operated on there had been an opening leading from the frontal sinus to the meninges. No frontal infection had taken place. He would not like to say that the present frontal abscess was due to infection nor to the operation from the facts before them, but, of course, no blame attached to the operator.

Dr. STCLAIR THOMSON regarded Dr. Tilley's remarks as an expression of opinion, but he did not see how it was proved that the ethmoidal cells were the cause, and not the frontal sinus. He had made, from literature, a collection of thirty or forty cases of spontaneous abscess in the frontal lobe, where there was no traumatism, and where it was shown that the frontal sinus was the source of the latent abscess in the frontal lobe. Hajek had said that from the ethmoid one got meningitis; from the sphenoid, meningitis and thrombosis of the cavernous sinus; and from the frontal sinus, frontal lobe abscess. If Dr. Tilley was speaking of traumatic abscesses he agreed with him; but it was shown by the spontaneous cases that the frontal sinus was the chief cause of latent abscess in the frontal lobe. As to the frontal operations being necessary, he would be glad to send anyone six cases from his clinique in which he had cleared out the ethmoid—he always did as Dr. Scanes Spicer had suggested—under chloroform as thoroughly as possible; but it was impossible to clear out the fronto-ethmoidal cells from the nose, and that was why Killian introduced his operation. Those cases which he had done had been relieved of their obstruction and polypi, and there was very little left, except the fronto-ethmoidal cells, and those cases still had a discharge. He would be glad to hand them over to anybody. They were hospital cases, and were begging for relief.

Dr. MILLIGAN, in reply, said he thought there was no question that his case was a latent abscess. He did not take the credit of having produced it. As a fresh specimen it was quite obvious that it was a chronic abscess-cavity in the frontal lobe, and the history of the case lent support to that view. He admitted he did not diagnose the abscess, but if he had done so he did not know what operation would have been successful.

The importance of the ethmoidal cells as a causative factor in frontal lobe abscess was uncertain; only few recorded cases had been brought forward. He had seen one other case in which the cause of the abscess was the frontal sinus, because there was a direct communication between the abscess and the frontal lobe. With regard to clearing out the middle turbinate region first, sometimes he did that, but he had not done so in this case. He did not see any particular advantage in it when one had to do a fairly extensive operation afterwards. All could just as well be done at one sitting. With regard to Mr. Westmacott's remark about such operations being unnecessary, that gentleman's experience seemed to have been most fortunate. He had many times tried to deal with such cases through the nose, but had failed to cure them. He thought one could guarantee a cure with a properly-conducted Killian, but there seemed to be some diversity of opinion, as shown by practice, as to what a Killian was. There were many cases in which operation was urgently called for; they were almost entirely in hospital patients, who were unable to do their work, having severe frontal headache and an uncomfortable purulent discharge from the nose, which he regarded as legitimate indications for operation. It was rare to have a bad result.

A CASE OF EXOSTOSIS OF THE FRONTAL SINUS.

Shown by Dr. W. MILLIGAN. The patient, a male, aged sixty, consulted me in 1897, complaining of bilateral nasal obstruction, nasal discharge, and intermittent frontal headache. Examination showed the presence of nasal polypi. Under an anæsthetic a radical operation was performed, the growths being removed, and the middle turbinated body, together with the anterior group of ethmoidal cells, being scraped away with a Volkmann's spoon.

For seven years no inconvenience of any sort was complained of. In 1904, however, the patient had again slight nasal obstruction, and was treated by a medical friend, some small œdematous buds of granulation tissue being removed. A small exostosis was noticed at this time.

In December, 1906, he again came under my care, and was found to have a large, bony growth springing apparently from the left frontal sinus, and encroaching upon the left nasal passage and left orbital cavity. The left eye was displaced outwards and downwards, and the conjunctiva was injected. Vision was perfectly normal. The growth was very hard, and appeared to be firmly attached to its point of origin. An X-ray photograph was taken.

As the patient was aged—now seventy—and as there was no real discomfort complained of, the advice given was to wait for two months so as to watch the progress of events. At the beginning of February the patient again presented himself for examination. Pain was complained of at the back of the left eye, the conjunctiva

was deeply congested, and the eyeball was displaced still further downwards and outwards. Operation was now advised. The patient was accordingly put under an anæsthetic and a supra-orbital incision made, as if for opening the frontal sinus. The bony arch of the orbit was chipped away in the neighbourhood of the exostosis, and the frontal sinus opened. The growth was found to spring from the floor of the sinus, and to have a fairly broad attachment. Within the frontal sinus there was a considerable amount of muco-purulent secretion, and also an œdematous mucous polypus. By somewhat forcible traction and leverage the growth was removed. The sinus was now cleansed and packed, the incision being almost entirely sewn up with the exception of its extreme lower limit. Progress since the operation has been quite uneventful, and the eyeball now practically occupies its normal position.

A CASE OF VERY EXTENSIVE PAPILOMATA OF LARYNX (SPECIMEN EXHIBITED).

Shown by Mr. BETHAM ROBINSON. The specimen was obtained from a little girl, aged five, who was under treatment in St. Thomas's Hospital at different periods between March 12, 1904, and January 2, 1907, the date on which she died. On admission there was the usual history of difficult breathing and only a whispering voice. Examination was impossible without an anæsthetic, and on March 19, while this was being attempted, she suddenly stopped breathing, and tracheotomy had to be done. It could then be made out that there were very numerous papillomata all over the upper aperture of the larynx and also on the vocal cords. On March 23 many growths were removed intralaryngeally, and this was repeated on April 13. After this the tube was removed. The wound healed by the 21st, and she was sent out. She had to be re-admitted on May 14 for severe dyspnœa, and had to be intubated. Further growths were removed intralaryngeally, and this was repeated on July 9 and 23. On August 27, while away on my holiday, she had become so obstructed that the tracheotomy wound was re-opened and a tube inserted. On September 15 I did thyrotomy, removing all the evident growths with scissors and cauterising their bases. The tracheotomy tube was retained, but removed on the 20th, and the wound was healed by the 30th.

The breathing remained now free, and there was improvement

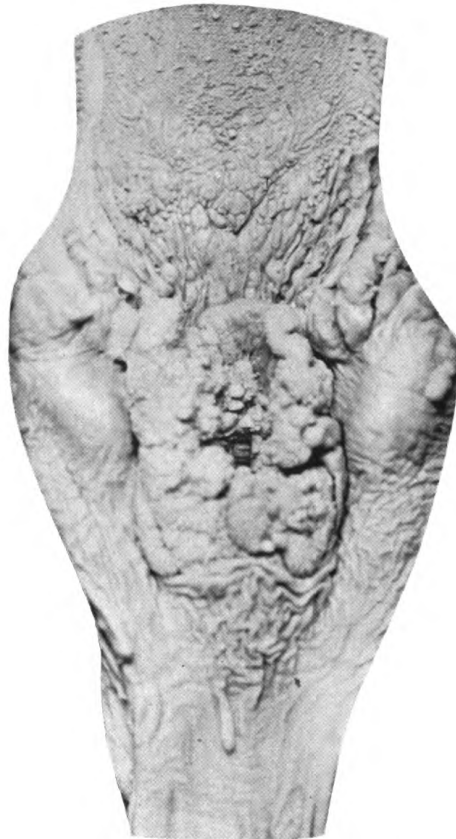
in the voice during the next three months. At the beginning of January there was more obstruction and fresh growths seen, so on the 6th they were again removed intra-laryngeally, which had to be repeated on February 11. In my absence on February 27 she suddenly became moribund, and laryngotomy was done. After this I again removed growths with the forceps, and was able to dispense with the tube. From then to the end of May she did well, and was out of hospital, but at the beginning of June she was admitted with broncho-pneumonia. Obstruction was so marked on the 16th that she was intubated, and the lungs having cleared more growths were removed with forceps on July 5. There was another period of respite till another sitting was necessary on October 31.

The rest of the history may be summed up by saying that there were varying periods of comfort followed by increasing difficulty of breathing, as a rule, demanding instant relief. For this an intubation tube was introduced, and I followed this by clearing the growths away as thoroughly as possible with forceps. During 1906 there were nine removals with forceps, the last one being on November 14. After this date she had seemed very much better, but at the end of the year the breathing was again becoming bad. She died quite suddenly on January 2 before any relief could be given.

All the endolaryngeal operations (nineteen in all) were done in the sitting position, under chloroform, with Mackenzie's forceps, both those cutting antero-posteriorly and laterally being used. Powdered alum and a weak formaline spray were used from time to time without apparently diminishing the growths.

The specimen shown is a very interesting one, demonstrating how wide-spread the growths are distributed, and how hopeless was the task of completely eradicating the disease. They are situated not only all round the upper orifice of the larynx, and in the larynx in profusion, but they spread downwards over the pharyngeal surface of the cricoid to the œsophagus; there are scattered patches also on the posterior part of the tongue and on the tonsils.

At the autopsy there was some collapse of lungs and some suspicious patches of caseating tubercle. The bronchial glands were definitely tuberculous, and at the roots of the lungs there were tuberculous nodules spreading inwards along the septa. There was also a doubtful tuberculous deposit in the spleen. It is an interesting speculation whether the papillomatous growths



Photograph of the specimen showing the base of the tongue and the upper orifice of the larynx displayed from behind by opening the pharynx and oesophagus. A piece of glass rod is passed into the orifice of the larynx. The papillomata are seen to be very freely distributed over the epiglottis, the ary-epiglottic folds, and the back of the larynx; they also pass outwards into the pyriform sinuses and downwards over the back of the cricoid into the oesophagus. There is to be seen a polypus in the oesophagus.

TO ILLUSTRATE MR. BETHAM ROBINSON'S CASE OF PAPILOMATA OF THE
LARYNX.

Communicated to the Laryngological Society of London March 8, 1907.

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themselves were of tubercular origin; those examined gave no evidence, however, of such being their nature.

The PRESIDENT said he thought the excellent photograph of the case which had been handed round might very well be reproduced in the *Transactions*.

RHINO-SCLEROMA OF THE NASO-PHARYNX IN A POLISH GIRL, AGED NINETEEN.

Shown by Dr. STCLAIR THOMSON. It is difficult to give a history of this case as the patient only speaks Polish, and communication has only been possible through one of her compatriots, who speaks very little German. It seems that for six or more years she has had increasing difficulty in nasal respiration. Some four years ago an operation was performed in Dr. Heryng's clinic in Warsaw, with some relief. But latterly the nasal obstruction has been increasing.

The patient complains of nasal obstruction and difficulty in clearing the nostrils of mucus. There is complete anosmia, but no interference with hearing.

The nasal chambers show a pale hypertrophy of the turbinals, with much stringy mucus on the floor; nothing abnormal is seen in the pharynx or larynx. With the post-nasal mirror a red, fleshy diaphragm is seen extending from the base of the soft palate upwards and backwards to the junction with the roof, and posterior wall of the cavum pharyngeum. There is an oval diaphragm in the centre of this fleshy membrane through which can be seen a small part of the posterior edge of the septum. This membrane bleeds when touched with a probe, and to the finger it is of cartilage-like hardness.

Although we have not yet obtained a portion of the growth for histological and bacteriological examination, this would appear to be a case of true rhinoscleroma. Apparently most cases have some manifestations in the nose, but the disease may begin primarily in the naso-pharynx. The first case published in this country was that of Payne and Semon in the "Transactions of the Pathological Society," vol. xxxvi, 1885. The only other case shown before our Society is that of Dr. Dundas Grant, published in the *Proceedings*, vol. vii, April 7, 1900.

I should be very pleased to have the opinion of members, especially in regard to treatment.

Mr. C. A. PARKER asked what Dr. Thomson founded his diagnosis

upon. He had only seen one case, and that was not in the post-nasal space. His idea was that rhinoscleroma was a red, smooth-surfaced infiltration, whereas in the present case the swelling looked rough and uneven, more like a growth filling up the naso-pharynx.

Dr. STCLAIR THOMSON, in reply, said it must be remembered that the case had been operated upon, and there was a distinct hole in the middle of it, through which one could see the posterior edge of the septum. He founded his diagnosis on the appearance of the diaphragm and the extreme cartilaginous feel of it. There was a history that it had recurred after operation when it was partly relieved. He overlooked the case the first time it came to his clinique, but the cartilaginous feel revealed the condition.

ENDO-LARYNGEAL GROWTH IN A MAN, AGED TWENTY-NINE.

Shown by Dr. STCLAIR THOMSON. This patient denies specific disease, and has never been ill before. He has been hoarse for ten months, with some occasional slight pain on the right side of his larynx, running up to the ear. He states he had not lost flesh, but has gained till lately. The patient was under the care of Mr. C. E. Bean, of Plymouth, who has watched the growth increasing, especially in its tendency to fungate, in spite of iodide of potassium up to 45 grs. a day and mercury. Chest examination is negative.

It will be seen that there is a fungating infiltration of all the right vocal cord, the anterior commissure, and part of the left vocal cord. The growth, in parts, has a necrotic, white look. There is a small gland to be felt on the right side of the larynx.

The points to be submitted are—(1) Is this a malignant growth in spite of the early age? (2) Should a part be removed for operation? and (3) Would thyrotomy afford any prospect of complete relief?

Recent loss of weight and strength, together with pallor of the mucous membranes, rather pointed to the diagnosis of tuberculosis.

Dr. PERMEWAN regarded the case as tubercular.

SO-CALLED PROLAPSE OF THE VENTRICLE OF MORGAGNI IN A WOMAN, AGED FIFTY.

Shown by Dr. STCLAIR THOMSON. The title of the case describes it.

INFILTRATION AND ULCERATION OF THE UVULA IN A MAN; TUBERCULAR.

Shown by Dr. STCLAIR THOMSON. Without the previous history of the case it would have been difficult to have diagnosed this con-

dition simply from appearance. The patient came to me some weeks ago complaining simply of sore throat. The uvula was then replaced by a large, irregular, firm, pale infiltration, with a sloughy ulcer running across the base of its attachment to the soft palate. There were no glands, no fever, and no general reaction. On the palatal side of the sloughy ulcer there was an irregular, half-inch margin of bright red hyperæmia. In the post-nasal space it was seen that the disease did not spread higher up than the uvula.

Although rapidly improving the condition well shows that one might have the suspicion that it was of specific origin. But the patient for over a year has been under treatment with a tuberculous ulcer on the left arm. The tubercular nature was proved by histological examination. This ulcer exposed the tendons, and was so deep and wide that no other remedy was suitable except tuberculin injections, which were given under the control of the opsonic index. It was some time after this ulcer had healed over that the pharyngeal condition developed. He has had no other treatment for the latter beyond peroxide gargle, and it is rapidly healing up under renewed tuberculin injections. The patient has no pulmonary or general symptoms.

I think his condition is distinctly tubercular, and although lupus is common enough in the pharynx it is rare to meet with what we clinically call tuberculosis of the pharynx except in the last stage of pulmonary phthisis. If we depended, however, on other than the simple appearance, I think it would be difficult to diagnose the present condition from that of a tertiary ulcerating infiltration.

Dr. WATSON WILLIAMS said he was struck with the remarkable resemblance between the case and one which was under his own care for some time, and which he demonstrated as a tuberculous lesion. She went to a sanatorium and was restored, but in spite of various curettements and other treatments the throat lesion did not clear up. She was a young woman above reproach, and unmarried. Yet when given iodide of potassium the whole thing cleared up. Unless Dr. StClair Thomson had given iodide of potassium he strongly suggested it, as it was not a typical tuberculous ulcer, and some features of it looked like those of syphilis.

Mr. CRESSWELL BABER thought the lesion was syphilitic, and recommended that iodide of potassium should be pushed. A supposed tubercular affection of the pharynx often turned out to be syphilitic.

Dr. STCLAIR THOMSON, in reply, said the man had had no treatment, but was getting well under tuberculin injection.

A CASE OF LUPUS OF PALATE AND LARYNX TREATED WITH TUBERCULIN R.; IMPROVEMENT.

Shown by Dr. E. A. PETERS. F. M——, admitted to hospital November 21, 1906, for lupus of larynx, pharynx, enlarged submaxillary glands, and tuberculide of the left leg; she had been previously treated elsewhere with arsenic for three months, and had not improved.

Dr. Rees injected .0002 T.R. in the positive phase at intervals of fourteen and six days. This treatment was followed by the administration of arsenic, but this was withdrawn when slight sickness and pyrexia appeared.

February 13, 1907.—There was inspiratory and expiratory stridor, due to large, flabby excrescences in the larynx. The glands were smaller and the chest sound. The upper edge of the palatal area was quieter, and the tuberculide on the leg had healed over in the centre and at one edge.

At present the stridor has disappeared and cicatrisation is very marked. The tuberculide has healed over, and the patient is receiving arsenic.

Dr. MILLIGAN suggested the advisability of tracheotomy, so as to ensure laryngeal rest.

Dr. STCLAIR THOMSON said he thought the result was very poor, and he said that with sympathy, because he put several very promising cases of lupus, limited entirely to the air-passages, under tuberculin treatment controlled by the opsonic index. Not one of them had been made better by the treatment, but one or two were distinctly worse. In one patient, each time she had an injection fresh nodules of disease appeared. The cases had, however, done well on galvano-cautery puncture.

Dr. PETERS expressed his thanks to Dr. Milligan and Dr. StClair Thomson for their remarks, and said he would bring the case forward again for observation.

FUNCTIONAL PARESIS OF THE PALATE.

Shown by Dr. E. A. PETERS. T. M——, aged twenty-four, five months ago was attacked with laryngitis, when she noticed her voice change. At times her voice is quite normal. She now suffers with a choking sensation in the throat. There is some vaso-motor rhinitis of the nose, and the palate is slightly full.

On attempting to phonate all the palate moves slightly, but the "pits" are only brought into evidence on stimulating the palate with a probe or requiring her to take a deep breath.

If the palate is stimulated while she phonates her voice loses the accent. There has been no evidence of diphtheritic trouble.

Dr. PEGLER regarded this as an interesting example of simulated or functional nasal obstruction, and questioned if the term functional paresis of the palate described the condition fully enough. In addition to a tardy contraction with dimpling, on stroking with a probe, there was sometimes spontaneous contraction of the velum, and then the "rhinolalia clausa" was well marked. In the functional paresis commonly seen with true nasal obstruction there was no such contraction, and the speech defect was of the opposite kind (*r. aperta*). He had recently been consulted by a lady in whom the prevailing pose of the soft palate was one of contraction, and the rhinolalia so marked that she was constantly credited with suffering from a bad cold in the head. The most rational way of regarding this condition appeared to be as one of mal-co-ordination of the palatal muscles, with consequent interference with their normal action during speech. It was analogous to the disordered co-ordination of the laryngeal muscles in functional aphonia, as evidenced by the fact that the two conditions, palatal and laryngeal, are sometimes associated.

Dr. PETERS, in reply, said he regarded it as functional paresis, very much on the same lines as functional aphonia. He believed there were all grades of the condition. He had several cases under his care. The present case had more cedema of the palate than usual.

TRACHEOTOMY FOR LARYNGEAL OBSTRUCTION, REMOVAL OF FIBROMA BY SPLITTING CRICOID; UNRELIEVED; LATER THYROTOMY AND REMOVAL OF ANOTHER FIBROMA.

Shown by Dr. E. A. PETERS. G. P—, aged six. Admitted to hospital June 6, 1906, for difficulty of breathing, which came on quite suddenly, after the voice had failed six weeks. Under an anæsthetic a white swelling appeared in the larynx, and tracheotomy was performed on June 13. On July 8, the cricoid was divided, and a smooth, white fibroma, the size of a hazel-nut, was removed from the anterior end of the right cord. During the manipulation something seemed to slip between the cords, but as the lower edge of the cords were seen to be free, the cricoid was stitched up. On October 11, as obstruction still persisted, thyrotomy was performed, and another fibroma, the size of a hazel-nut, adherent to the anterior end of the right cord was removed. The child has made a good recovery.

Dr. PETERS asked what the experience of members was in such cases. He learned that in children it was usual to split the cricoid, and remove the growths in that way, which was more desirable than doing thyrotomy. He did that in the present case, and it meant an additional operation, as he had to do thyrotomy eventually, and that was successful.

A CASE OF FRONTAL SINUS DISEASE, SHOWN ON JUNE 1, 1906;
KILLIAN'S OPERATION.

Shown by Dr. E. A. PETERS. A. W——, aged forty-six, last year presented an intractable sinus beneath right supra-orbital ridge. A probe failed to enter the right frontal sinus from the nose, but the left frontal sinus was patent and contained pus, which was also present in the right nostril. A radical cure for a suppurating left antrum had been previously carried out.

Dr. STCLAIR THOMSON suggested that a double Killian's operation should be performed, and the patient was now shown with an aluminium style *in situ* on the right side. There is no pus in the nose. There was no frontal sinus on the right side, but extensive fronto-ethmoidal and ethmoidal disease on both sides.

Mr. HERBERT TILLEY thought probably the sinus was possibly due to a septic ligature placed on one of the vessels while the operation was being performed. Dr. Law would remember a case in which they (the speaker and Dr. Law) had an absolutely identical condition. For many weeks a suppurating fistula baffled all attempts to close it, until a small stitch came away, and the wound healed in three days.

Dr. LOGAN TURNER agreed with Dr. Milligan that the term "Killian" was often used in a loose way. He would like to know if Dr. Peters had obtained proper access to the frontal process of the superior maxilla through an incision such as the patient showed, and whether he had really done a Killian, as the title of the operation suggested.

Dr. PETERS, in reply, said it practically was a Killian. He always opened the infundibulum and worked up from that. The incision was more extensive than it now appeared to have been. He got a very free opening there by retracting the parts. He left the bridge there, but the anterior and inferior walls of the frontal sinus were removed. The ethmoidal cells, which were full of pus, were scraped and nibbled away as far back as the sphenoidal sinus.

CASES OF CHRONIC FRONTAL SINUSITIS.

Shown by Mr. STUART LOW. He said that he had brought forward more cases as they showed a minimum of deformity and a maximum of good results which were not always obtainable in instance of old-standing frontal sinus disease, especially where marked polypoid changes of long duration existed. During the after treatment he objected to the usual method of fixing the dressing by means of bandaging the head, and said that he had found a protection shield, which he exhibited, very useful. It was used with the same object as the aural shield that he applied after mastoid operations. This protection shield prevented pressure on

the wounded and contused parts and encouraged drainage and healing by first intention, which were of the greatest value in diminishing scar and deformity. There was an additional advantage gained in the employment of this shield, because the elastic pressure assisted passive serous congestion, and in the manner of a Beir's band determined a large supply of blood serum to the part and so greatly aided primary union. This probably accounted for the average number of days that these patients were in hospital being only five. In all these cases the disease was of long standing, varying from three to twelve years, and seemed in three of them to originate in influenza.

The symptoms were periodically very greatly aggravated, and on such times the chronic supra-orbital pain became unbearable. One of the cases operated on a month ago afforded an example of an unusual procedure. Through a skin incision of not more than one inch and a quarter the frontal sinus cavity on the same side was cleared of mucous polypi. A partition between the two sinuses was then broken down, and the opposite frontal sinus was similarly cleared, being found packed with mucous polypi. Mr. Stuart-Low pointed out how the two sides had been radically cured. Drainage was accomplished from both sinuses down into the nose through one tube. This patient had been subject to epileptic fits, and had one while in hospital, but since the operation on the frontal sinus she had had no attack. Frontal sinus disease might be a causal factor in epilepsy. This had not been suspected hitherto, so far as he knew, and it would be interesting and instructive to look out for corroborative evidence.

Dr. DONELAN said an interesting point was the cessation of the epileptic attacks. He had a young lad who suffered from epileptic attacks two years ago. Polypi were removed from his middle meatus, and the attacks had not recurred since. He had looked up some of the literature, and the only reference he could find to epilepsy being due to anything of the kind was Féré's article in *Twentieth Century Practice* referring to a case of Lasalle's, in which "foreign bodies" in the frontal sinus had caused such seizures.

The PRESIDENT said he thought the cosmetic result in all the cases was very good.

Dr. PERMEWAN said that in one of the cases there was a good deal of pus inside the nose. The external results seemed perfect.

Mr. STUART-LOW, in reply, said the case in which Dr. Permewan said there was still a drop of pus was operated upon as long ago as August last. It was a very bad case and had been under treatment ten years. The pus now came from the posterior ethmoid cells, and, if this continued, a Killian's operation would become necessary. Her frontal sinus was found to be packed full of polypi, and it was impossible to cure such a case by attacking the ethmoid region alone; this would be futile. One

must operate on the frontal sinus. Killian's operation had not yet been done on any of the patients.

FOREIGN BODY REMOVED FROM THE LEFT BRONCHUS OF A MALE,
AGED NINETEEN.

Shown by Dr. D. R. PATERSON. This was a broken shell of a Spanish nut which a young sailor aspirated into his air-passages. There was a severe suffocative attack, which was relieved by the displacement of the foreign body downwards. When seen twelve hours later there was much wheezing but no physical signs to indicate its position. He was put under chloroform, which he took badly, there being much cough and cyanosis. Cocaine was applied to the air-passages and a Killian's tube of 9 mm. diameter introduced. The right bronchus was explored and found empty. In searching the left bronchus something was found blocking the entrance, but its relations were difficult to make out owing to insufficient illumination from a worn-out lamp. The examination was suspended, and on the following day, with a new lamp, patient was again put under chloroform, which this time he took quietly. The tube was at once passed down to the left bronchus, when it was seen that the nutshell lay inside the bronchus with a sharp, hook-like process over the bifurcation. With Killian's long forceps it was readily seized and drawn out. The nutshell was red in colour, which made it difficult to distinguish its relations clearly from the surrounding injected mucous membrane. A good light facilitated this and extraction was easy.

MAN, AGED SEVENTY-FIVE, SHOWN AT JUNE AND NOVEMBER MEETINGS,
1906, WITH INOPERABLE CANCER OF THE FAUCES, THE PHARYNX,
THE TONGUE, AND THE CERVICAL GLANDS, TREATED BY A
BACTERIAL VACCINE OF *M. neoformans*.

Dr. SCANES SPICER brought this case again for the inspection of the Society. The treatment had been continued as before. The faucial growth was smaller, and at some portions of margins looked like cicatrising. The cervical glands were very large, matted, and dense again. General condition as before. In the last report, vol. xiv, p. 9, reply: for "eighteen" months read "eight" months.

MAN, WITH CANCER OF LARYNX AND PHARYNX, PREVIOUSLY SHOWN
NOVEMBER AND DECEMBER MEETINGS, 1906, AND JANUARY,
1907, UNDER SAME TREATMENT.

Dr. SCANES SPICER again brought this case for inspection. It was the case originally brought before the Society by Dr. Watson on November 2, 1906, and which has since been under Dr. Scanes Spicer's observation in St. Mary's Hospital for treatment by a vaccine as above. The injections have been made as before in inoculation department under direction of Sir A. E. Wright and regulated by opsonic index to *M. neoformans*. The local appearances as to amount of swelling vary without recognisable cause. The superficial extension of the ulceration is trifling, if any; no part is now affected which was not described as affected in first report, so that it may fairly be said that the progress of growth, if not arrested, has been retarded to a degree which is unique in cancer of this region, as far as the speaker's observation has gone. The hoarseness and effort in speech varies, but the patient states he swallows well and has less pain, and less often. His weight two months ago was 8 st. 11½ lb. To-day it is 8 st. 11¾ lb. on same scales in St. Mary's Hospital. Patient states his weight on admission in November was 8 st. 11 lb.

Dr. WATSON WILLIAMS remarked, as Dr. Spicer had taken on the case from him, that, although he could not agree that the progress of the disease had been arrested, he thought its extension had been remarkably delayed. It was four months since he saw the case, and the disease was then rapidly progressing. It had certainly progressed since then, but more slowly than he would have anticipated.

MICROSCOPIC SPECIMEN OF A LIPOMA OF THE TRACHEA.

Shown by Dr. J. MIDDLEMASS HUNT. The patient, a man, aged sixty-eight, came under my care on November 22 of last year. He was suffering from severe dyspnoea, which had been gradually increasing for over two years. On laryngoscopic examination the larynx was found to be normal, but the lumen of the trachea appeared almost completely blocked by a smooth, rounded, pale-pink, solid-looking growth, which evidently sprang from the posterior wall of the trachea. The top of the growth was on a level with the lower border of the cricoid. I diagnosed the growth as a fibroma.

In view of its size, its firm consistence, and broad attachment,

as well as the urgency of the dyspnœa, I decided it would be best dealt with by an external operation. This was successfully carried out by Mr. Paul, one of my surgical colleagues. The growth, which was the size of a hazel-nut, was found to be attached by a broad base to the posterior wall of the trachea, opposite the first three rings. Microscopic examination showed it to be a pure lipoma.

So far as I can find, no case of lipoma of the trachea has ever been recorded. In fact, the only instance in which a pure lipoma has been met with below the larynx is one recorded by Rokitansky in 1851. In that case the growth, which was situated in the left bronchus, was discovered accidentally during a *post-mortem* examination.

MICROSCOPIC SECTION FROM A TUMOUR OF THE NASAL SEPTUM.

(The Case was exhibited at the February meeting.)

Shown by Dr. FURNISS POTTER. The report of the pathologist was to the effect that "the mucosal covering of the septal cartilage is replaced by vascular granulations containing foci of tubercle."

PROCEEDINGS OF THE LARYNGOLOGICAL SOCIETY OF LONDON.

One Hundred and thirteenth Ordinary Meeting, April 5, 1907.

J. B. BALL, M.D., *President, in the Chair.*

HENRY J. DAVIS, M.B., }
W. JOBSON HORNE, M.D., } Hon. Secretaries.

Present—26 members and 1 visitor.

The minutes of the previous meeting were read and confirmed.

The following communications were made :

A CASE OF MALIGNANT ENDO-LARYNGEAL GROWTH IN A MAN, AGED TWENTY-NINE, SHOWN AT THE LAST MEETING (*vide* "PROCEEDINGS," MARCH 8, 1907).

Shown by Dr. STCLAIR THOMSON. A portion of the growth was removed shortly after the Meeting, and found to be carcinoma. Although there was a small gland on one side of the larynx, it was thought that an attempt might be made to operate on this separately and clear away the endo-laryngeal growth by a laryngo-fissure. However, on starting the latter operation, the small gland lying on the crico-thyroid membrane was found to be infiltrated with hard growth, and as the disease had therefore spread through the larynx it was hopeless to think of eradicating it by thyrotomy. A tracheotomy tube was therefore left in, and the patient allowed to recover from the anæsthetic. When he was offered the alternative of excision of the larynx, he declined it.

The case was, of course, highly interesting from the early age of the patient. A microscopic section was exhibited.

Dr. JOBSON HORNE said he looked at the section, but was unfortunate in not being able to find that part of it which contained the carcinoma. He thought it would be well to refer the section to the Morbid Growths Committee for an opinion.

Mr. BETHAM ROBINSON seconded Dr. Horne's suggestion to refer the section to the Morbid Growths Committee. As some of the sections

were cut obliquely, and others did not clearly demonstrate the presence of carcinoma, that would be a wise course.

Dr. STCLAIR THOMSON, in reply, agreed to the suggestion. He had only received the section that afternoon. He had also the section of the gland which he removed from the front of the crico-thyroid membrane.

A CASE OF SO-CALLED PROLAPSE OF THE VENTRICLE OF MORGAGNI, IN A WOMAN, AGED FIFTY, SHOWN AT THE LAST MEETING (*vide* "PROCEEDINGS," MARCH 8, 1907).

Shown by Dr. STCLAIR THOMSON. The growth was removed in one piece, and under the microscope showed œdematous tissue with a very slight fibrous stroma.

The PRESIDENT thought it would be well to refer this case also to the Morbid Growths' Committee, as it was a very rare specimen.

Dr. HORNE, referring to Dr. StClair Thomson's remark that, so far as he could recollect, a similar specimen had not previously been shown to the Society, reminded members that some years ago he, Dr. Horne, showed before the Society a microscopic section cut vertically through the soft parts of one side of a larynx, showing the growth *in situ*, which, clinically, would have simulated prolapse, though under the microscope it was seen to be a genuine hyperplasia of normal structure. That section was illustrated in the "Proceedings," vol. v, 1898, p. 98.

A CASE OF APHEMIA.

Shown by Dr. H. J. DAVIS. This was the case of a boy, aged twelve, who, according to his mother's statement, "had never spoken, though he could hum airs in perfect tune."

The boy was unusually intelligent, could draw well (with his left hand), heard and understood everything perfectly, but he could not utter a word.

Though the frænum of the tongue was short, this was not sufficient to account for his inability to protrude the tongue when under examination. The larynx was normal and there were no post-nasal growth.

At the age of three and a half the mother noticed some weakness on the right side (infantile hemiplegia?) but this was indefinite, and the child had made no attempt to speak even before this.

If asked to draw a bird, or a wheelbarrow, or cart, he did so immediately, and when asked to write under the drawing what it represented he did so. When holding the pencil in his right hand he would stare vacantly at the paper, and he could do nothing, not even write his name; but if allowed to hold the pencil with both

hands he drew and made words correctly. The condition was not so much one of aphonia as of aphemia.

The movements of the palate were symmetrical but, the exhibitor thought, slightly impaired, and the tongue was not under complete control. He would be glad if members could offer opinions as to suitable treatment. The case, he thought, was a very unusual one.

The **PRESIDENT** remarked that he noticed the boy could not protrude his tongue.

Dr. J. DONELAN thought the case would benefit by education, as the intelligence was preserved in so marked a degree. The paresis of the speech organs apart from the larynx seemed chiefly from desuetude. Special attention should at first be given to the vowels. He had a very similar case six years ago—an Italian boy, who was sent to a deaf and dumb institution near Rome. He learned from a relative a few months ago that the boy had greatly improved and could speak very well. He was not deaf. In these growing patients, where the intelligence was so well preserved, in cases of right hemiplegia the third right frontal convolution could be trained to take on the functions of the left in a remarkable degree. He suggested that this boy should be sent to some similar institution. The case he referred to was under training for two or three years.

Dr. DUNDAS GRANT said there seemed to be considerable weakness in the muscles of articulation when used for other purposes. The boy could not whistle, nor blow out a light, nor puff out his cheeks, nor protrude his tongue, and, as he also had incomplete action of the palate, there might be some defect in the medulla. When asked to phonate the palate dropped, although it rose reflexly when the tongue was depressed. There was, therefore, much mechanical defect, apart from the cerebral. Education might eventually be successful, but it would be a very slow process. He suggested that the case should be brought before the Neurological Society.

Dr. WATSON WILLIAMS thought there must be a cortical lesion. The mischief was fairly extensive. Yet there was no obvious atrophy in the arm, nor in the tongue, and if it were medullary, with involvement of the nuclei supplying the muscles of those regions, *i. e.*, of the lower neurones, there would be atrophy of the involved muscles. He suggested that the lesion was in and around the neighbourhood of Broca's convolution: then the arm would be affected only on one side. He asked whether there was a clear history of an attack of hemiplegia coming on at the age of three. The mother seemed very indefinite about the onset, and he gathered from her that most of the defects observed dated from birth. The patient might have had a cortical injury at birth. He agreed with **Dr. Donelan's** suggestion to send the child to a deaf and dumb institute, for the case was analogous to many of the cases which were successfully treated by oral methods, and the fact that the boy heard better than some of those treated in that way was favourable to such a course. There was much difficulty in getting the constant and patient training required in any other way.

Dr. DE HAVILLAND HALL said the treatment of deaf and dumb cases was a very slow one, and required immense patience and perseverance on the part of both teacher and patient. He had been watching for nearly two years a patient who was being treated so, and who had previously

been quite neglected. He was under a German gentleman and could now make himself understood. In the case before them the boy heard well, and was intelligent, and it was a question of educating the muscles. Whether permanent damage had been done, or whether the right side could take over the functional activity, he did not know. It seemed, however, to be a case which should be trained, but the mother should be informed that the treatment was a matter of years.

Mr. C. A. PARKER said he had treated several boys and girls who had cleft-palate speech simply from lack of use of the palate—purely functional cases. When this present patient phonated he at once let all the air come through his nose, and his palate dropped on to the base of his tongue. All such cases which he had seen had been cured by teachers for the correction of stammering, and this patient should do well, unless the atrophy of his tongue had rendered articulation impossible.

Dr. DAVIS, in reply, said the point was this, if the boy could not speak because his tongue was paralysed, no amount of teaching would make the hypoglossal nerve take on its functions again. Though there was supposed to be a history of right hemiplegia, it was very indefinite, and if there had been hæmorrhage on the left side of the brain, the right side would have assumed the functions by now. If the boy took a pen in his left hand he was able to write, but if he held it in the other hand he could not think of, or write, the required word. It was not that the tongue was tied by the shortened frænum, but he had paresis of the anterior fibres of the genio-hyoglossus. But it could not be very extensive, because the tongue was fairly developed. The boy was unusually intelligent, and had the musical centres well developed—he could hum a hymn, or “God save the King,” perfectly,—and the musical centre was almost in contact with that for speech in Broca’s convolution. In reply to Sir Felix Semon, he thought that it was recognised that the musical centres had been located, and were situated behind the speech centre on the left side.

Dr. DUNDAS GRANT said there was a reference to such a centre having been proved by *post-mortem* examination, in a new book on the treatment of diseases of the voice, by Pertier, of Lyons. He did not know the details, but could supply the reference; or he would bring the subject forward for discussion. Dr. Grant considered the bilateral character of the defects difficult to reconcile with the purely cerebral origin suggested by Dr. Watson Williams.

Sir FELIX SEMON said he thought it was impossible, on the strength of a single case in which a certain faculty was absent, to localise the cerebral seat of the latter by one *post-mortem* examination. He would be interested in learning the reference which Dr. Grant had promised.

The PRESIDENT said he agreed with those who believed that the boy could not be trained on the lines of the deaf mute: there was something very special about this case, a difficulty in moving the tongue and lips. It was different from the case of the deaf mute, who did not learn to speak merely because he was deaf.

A CASE OF DESTRUCTION OF THE COLUMELLA AND PORTION OF THE NASAL SEPTUM.

Shown by Dr. DONEGAN. The patient was a man, aged thirty-

five. He had presented himself in the out-patient room of the Italian Hospital fifteen months ago. At that time his nose was enormously swollen, and had many of the characters of lupus. There was ethmoidal suppuration, especially in the right nostril. No history of syphilis could be obtained. Patient denied having had any other local sore, sore throat, or rashes. He attributed his disease to a bad smell from a drain-pipe he had been repairing.

A series of mercurial inunctions was immediately given, and this treatment, alternated with mixtures containing corrosive sublimate and potassium iodide, was kept up for six months; afterwards the treatment consisted of the mixtures only. The condition of the nose improved from the first, except the ethmoidal suppuration, which still continued. The lower portion of the cartilaginous septum was destroyed, except a narrow strip of its anterior margin, which was now the sole support of the tip of the nose. He had not seen the patient for over a month until the day previous, when he was arranging to show him here with a view to asking the opinion of members as to whether any plastic operation might be undertaken with advantage.

The PRESIDENT said the appearance of the nose was normal until it was turned up. It should not be very difficult to fashion something to take the place of the septum in front.

Dr. DONELAN wished to point out, before the discussion proceeded, that there was now a suspicious pimple on the tip of the nose, and he wished to hear whether there might not be lupus as well as syphilis in the case.

Dr. H. SMURTHWAITE said that, having no cognisance of the treatment, one would regard it as a case of lupus, especially as the cartilage had been affected and the process had stopped at the bone. The suspicious pimple also simulated lupus. He thought some mechanical treatment would be advisable. Surgery would result in contractions occurring subsequently, thus making the appearance worse. He suggested a flesh-coloured celluloid septum.

Mr. HERBERT TILLEY said he would not like to have to express an opinion as to whether the condition was lupus or tertiary syphilis. If it should prove difficult to get the wound to heal at the limit of the cartilage the trouble might be overcome by resecting the mucous membrane well on to the vomer, freshening the edges of the mucous membrane, and then letting them heal. These edges would thus be in the region of healthy mucous membrane. He did not agree with Dr. Smurthwaite with regard to mechanical appliances for correcting the deformity. Such might serve if the patient did not blow through the nose or otherwise move it, but in practice all mechanical contrivances were found to be irritating, and did not answer well. They were just as unsatisfactory as bougies for dilating mechanical obstructions; patients found them irritating after the novelty of wearing them had passed off. The speaker suggested it would be well to dissect up a strip of mucous membrane on the under surface of the upper lip and pass it through a hole cut between the upper

lip and the floor of the nose; the tip of this strip must then be secured to the freshened tip of nose. He referred members to the work of Roe, of Rochester, U.S.A. The particular method he had just mentioned was easy and the results excellent.

Mr. WHITEHEAD said he would have no doubt that the case was one of lupus, and he did not think it could be regarded as cured at present; there seemed to be still some active ulceration. To cure that, probably the best thing, as Mr. Tilley suggested, would be to bare and remove the edge of the cartilage. Any operative procedure until the cure had resulted would probably be disastrous. Dr. Roe's operation, as described by Mr. Tilley, sounded easy. He (Mr. Whitehead) had not tried it himself. There might be some difficulty about the hair, which might grow into the nose.

Mr. TILLEY, in reply to Mr. Whitehead, said Dr. Roe referred to that point in his description, stating that at first the hair grew, but in time the follicles degenerated, and long hair ceased to form. But even if the hair continued to grow long in its new situation the deformity would be much less than the man exhibited at present.

Dr. FITZGERALD POWELL said that in the present case it was not necessary to use the skin of the lip where hair grew; sufficient tissue for the purpose could be got from the floor of the nose.

Dr. DAVIS thought there was not much disfigurement in the case. The patient was a short man, and most people would not notice anything abnormal about him unless he raised his head.

Dr. STCLAIR THOMPSON said the case seemed to him to be one of lupus, and if any attempt at forming a natural columella were contemplated it should be remembered that the tissues there were of very low vitality and the attempt might fail; and if it succeeded, contraction might set in, and if the tip of the nose were drawn down, it would be uglier than at present.

The PRESIDENT said he would favour a mechanical contrivance for the case, in spite of Mr. Tilley's remarks, and he thought the reference to the intolerance of the nose for bougies did not apply. It was simply necessary in this case to supply an artificial columella, and this would be preferable to running the risk of a plastic operation which might not give a satisfactory result.

Mr. TILLEY, in further comments, suggested that the remarks of Mr. Whitehead did not apply to the case. He (Mr. Tilley) would turn up a piece of mucous membrane from the upper lip, and make a hole through the upper lip communicating with the floor of the nose, bring the flap of membrane up through the hole, and fix it to the tip of the nose. Then the epithelium became squamous and dry.

Dr. DONELAN, in reply, thanked the various speakers. It was with some hesitation he had at first ordered mercury and iodides in this case, as the appearances were very suggestive of lupus. The remarkable improvement in the first week warranted him in continuing the mixed treatment, and it had been taken with unvarying benefit for fifteen months. He had not seen the patient for a month, and it was only now he noticed the pimple to which he had referred. He thought it might be well to observe the case a little longer before deciding to do anything.

A CASE OF PHARYNGO-KERATOSIS STEADILY IMPROVING UNDER APPLICATIONS OF SALICYLIC ACID IN SULPHO-RICINATE OF SODA.

Shown by Dr. DUNDAS GRANT. The patient was first seen in March, 1906, when she complained of soreness of the throat of three months' duration. On inspection there was found well-marked pharyngo-keratosis. Various isolated applications were made; in the first instance a saturated solution of salicylic acid in alcohol to the spots on the right tonsil, the galvano-cautery to those on the left one, then pure formalin to the left one, and a 10 per cent. solution of sulpho-ricinate of soda to the right. In April she was given a 1 per cent. solution of formalin in glycerine and distilled water, which she applied daily for a month, at the end of which time comparatively no change had taken place. In April, 1906, she commenced the daily application of a 10 per cent. solution of salicylic acid in sulpho-ricinate of soda *to the right tonsil only*; a slow but steady diminution in the size and in the consistency of the spots was observed after a few weeks, and she was then instructed to make the application to both sides; very gradually but steadily this change has continued, until now there is scarcely a vestige of the disease remaining. The patient complained at times of the application producing a dry feeling in the throat at night, but she was very anxious to get rid of the spots, in spite of the fact that she was assured that their presence was not detrimental. The exhibitor would be glad if members of the Society would give the application a trial on any of their marked cases.

The PRESIDENT said he understood the case was shown to exemplify the efficacy of salicylic acid in the cure of the case. But it had been used for a year and the case was not quite well yet. A few years ago salicylic acid was put forward as an absolute cure for mycosis in a strength of 25 per cent. in spirit. There was, at that time, a nurse in the West London Hospital who had very marked mycosis, and he thought it would be a good opportunity to try the remedy. She had it applied, either by himself or by a resident, once every other day. She left at the end of three months, and the best he could say was that the condition was just a little better than before the treatment was commenced. Since then he had not had much faith in the treatment.

Dr. F. DE HAVILLAND HALL said pharyngo-keratosis was very much like warts elsewhere. Sometimes they would disappear in a marvellous way. Once he had a barrister with the condition, which annoyed him in his profession; it was at about the date when the salicylic treatment was first introduced. He applied it himself and instructed the patient how to do so. After three or four months the patient gave it up in despair and was lost sight of. But he heard since that it got well. In view of

the present case he would write and ask about the further progress of the case.

Sir FELIX SEMON asked why keratosis must be treated at all, seeing that it always got well of itself. There was no real remedy for the condition; constant applications rendered the patient needlessly nervous, and greater importance was attributed to the malady than it deserved. Moreover, the man who treated such a trifling condition for a long time exposed himself to recrimination. He wished the profession would recognise that keratosis occurred when the patient was run down, and that it would disappear under a change of air and tonic treatment. No local treatment was necessary.

Dr. FITZGERALD POWELL thought Sir Felix Semon's plan would have a serious mental effect on the patient, who thought he was suffering from a real disease, and if something were not done for him he would feel that he had not been justly dealt with. His cases had generally got well after the application of the cautery.

Mr. HERBERT TILLEY said that six months after a discussion on the subject before the Society he became a sufferer from pharyngo-keratosis. The general opinion then held was that if left alone the disease would do quite well, and consequently he did nothing for it. It lasted five months, and the symptoms which troubled him most was an irritating cough, which came on very suddenly. In a week the whole condition disappeared without any discernible reason, and during the whole period of its presence he was in good health. Had he applied any local applications he would probably have attributed the cure to their influence.

Sir FELIX SEMON, answering Dr. Tilley, said he would like to know how he proved a connection between the cough and the keratosis. Sir Felix did not believe keratosis would cause cough. No doubt the galvanocautery, as mentioned by Dr. FitzGerald Powell, would get rid of the exudation, as would any other mechanical appliance, but after curing the patient he would be found, possibly already a week later, to have keratotic spots as much as ever. That was what naturally made the patient nervous and anxious. He spoke from a large experience of such cases. The question was whether the medical man ought or ought not to do something if the patient wanted "something to be done." In such a case Sir Felix thought the practitioner served his own interest, the honour of his profession, and the interest of the patient best by not yielding to the patient's wish. Even if the patient, in consequence, went to someone who had not the same compunctions, the practitioner could at least "sleep well in his bed."

Dr. JOBSON HORNE said some years ago, after hearing a similar expression of opinion at a meeting of the Society, acted in accordance with it, declining in a case of keratosis of the fauces to do any local treatment. The patient's friends resented that, and he (Dr. Horne) was asked to do something more for the throat. He therefore applied a solution of formalin, and by the next visit the condition had cleared up, whether because of the formalin, or spontaneously, it was difficult to say.

Dr. DUNDAS GRANT, in reply, agreed with Sir Felix Semon, and said he had acted upon the principle which he had stated, regarding it as the correct one. He put before the patient, as was his custom, the fact that the appearance of the throat was of no significance, but the girl insisted upon trying something for it, and he therefore allowed her to use the remedy he had mentioned for herself. The discomfort she had gone through in using it, he thought, was out of proportion to the result. She used it for

one tonsil first, and the change in it was unmistakable. He thought it was his duty and privilege to bring the case before the Society as a properly conducted experiment, though he did not say he would recommend the treatment in every case of the kind.

Mr. TILLEY, in replying to Sir Felix Semon's question concerning the relation between the cough and the keratosis, said it was a cough of a kind which he had never before experienced; the disease produced a feeling as if a needle were scratching the mucous membrane. The cough was spasmodic and very violent, and he had never suffered from it before the keratosis appeared nor since its disappearance.

CASE OF IMMOBILITY OF THE LEFT VOCAL CORD.

Shown by Dr. DUNDAS GRANT. The patient, a woman, aged forty-one, complains of pain in the back of the neck and choking in front of the throat, which has lasted, on and off, for fourteen years. She has occasional attacks of hoarseness; the breathing is noisy during sleep. At the present time there is complete fixation of the left vocal cord in the cadaveric position, or probably somewhat internal to it. The tissues of the larynx behind and below the left cartilage of Santorini appear to be bulging slightly, and not very definitely, into the pharynx, making the hyoid fossa of the left side extend less far backwards than on the right. There are no physical signs, and no radiographic evidence of disease in the thorax. There is occasional difficulty in swallowing, which appears to be spasmodic; no œsophageal instrument has as yet been introduced. There are no enlarged glands, and no apparent involvement of any other cranial nerves. The exhibitor would be glad of opinions as to the diagnosis between paralysis and mechanical fixation, and, if the latter, the possible nature of the local disease.

Dr. WATSON WILLIAMS regarded the laryngeal appearances and the history as suggestive of syphilis, and in her larynx he found that some contraction and adhesions remained. The right vocal cord, as well as the left, he thought, was involved. She seemed to have cicatricial contraction of the left aryepiglottic fold. As regards her mother's family history one child was born dead, and he believed she had lost another. He could not see on her fauces any evidence of syphilis, but she suffered from intense bitemporal neuralgic headaches, and he would like to know if there was anything about her to support the suggestion of syphilis.

Sir FELIX SEMON regarded it as a case of mechanical fixation. There was considerable enlargement of the left arytenoid cartilage at its base, and it looked as if the left crico-arytenoid articulation were fixed. The right vocal cord was badly abducted, and she had not merely stridor in respiration, but some difficulty in swallowing, and that pointed to a considerable thickening of the cricoid plate. It might be syphilitic, and the abduction of the right vocal cord could be explained in that way. He advised energetic anti-syphilitic treatment.

Dr. GRANT, in reply, said there was a diffuseness of the swelling on the left side which biassed him in favour of the mechanical theory. He would certainly treat her with anti-syphilitic remedies.

A CASE OF THORACIC LYMPHO-SARCOMA, WITH CLINICAL AND PATHOLOGICAL OBSERVATIONS.

Shown by Dr. JOBSON HORNE.

Clinical history.—The patient, a man aged forty-nine, was quite well up to two months previous to his death, his weight being fifteen stone. He first noticed an increasing inability to eat meat, and within a month of the onset of this difficulty he was unable to take solid food, the attempt causing vomiting. He was able to take liquids by drinking fast, only about a teaspoonful returning from three quarters of a pint. Five weeks after the onset of the dysphagia—that is, three weeks previous to his death—there developed difficulty in breathing, which became worse, and was attended with “occasional spasm of the windpipe,” so that he had to sit up. Latterly the attacks became more frequent, recurring twice a day, and lasting half an hour; they were worse at night, so that he was afraid to lie in bed.

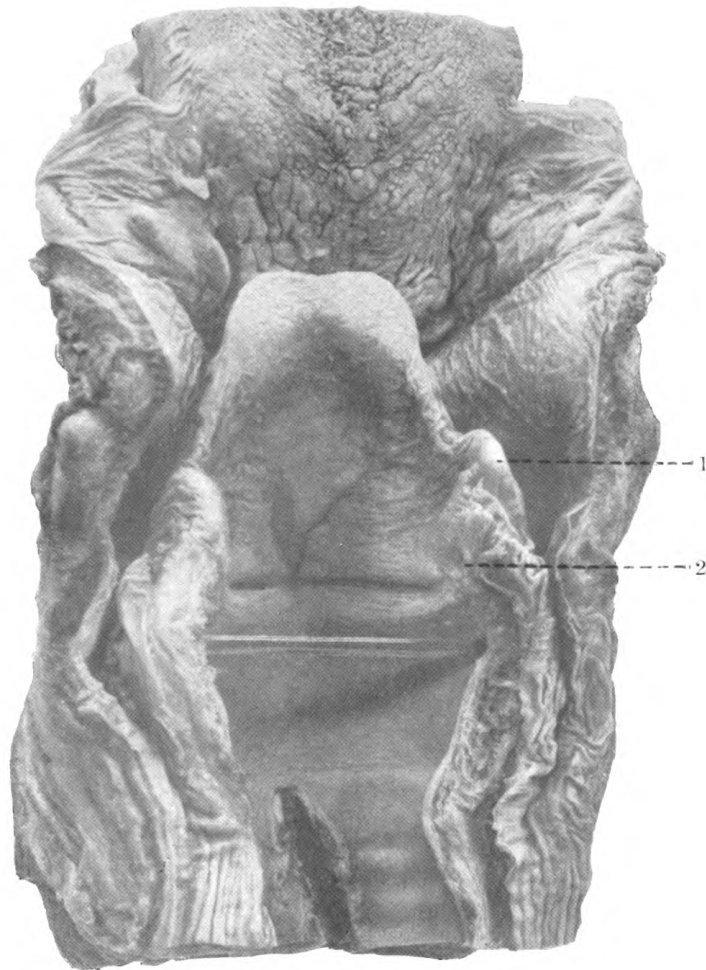
Condition on admission to hospital.—He had an anxious look. There had evidently been considerable wasting. The breathing was rapid, and associated with inspiratory and expiratory stridor, and much “wheezing,” as if bronchial. He experienced a feeling as though a weight were on the chest along the sternum.

The examination of the thorax revealed no physical signs of aneurysm. Both sides of the chest moved equally; there was no area of dulness. The area of cardiac dulness was diminished; the cardiac sounds were normal. The larynx was observed to be congested, but the vocal cords moved well, and there was no sign of obstruction. A radiograph of the chest was not obtainable.

The œsophagus permitted the passing of a bougie of the largest size.

The patient rapidly became much worse, very cyanosed, and distressed, and on the second day after admission death occurred from asphyxia.

The post-mortem examination revealed in the posterior mediastinum a lobulated mass of new growth, the size of a large pear, apparently springing from the bifurcation of the trachea, and extending forwards into the pericardium and downwards and

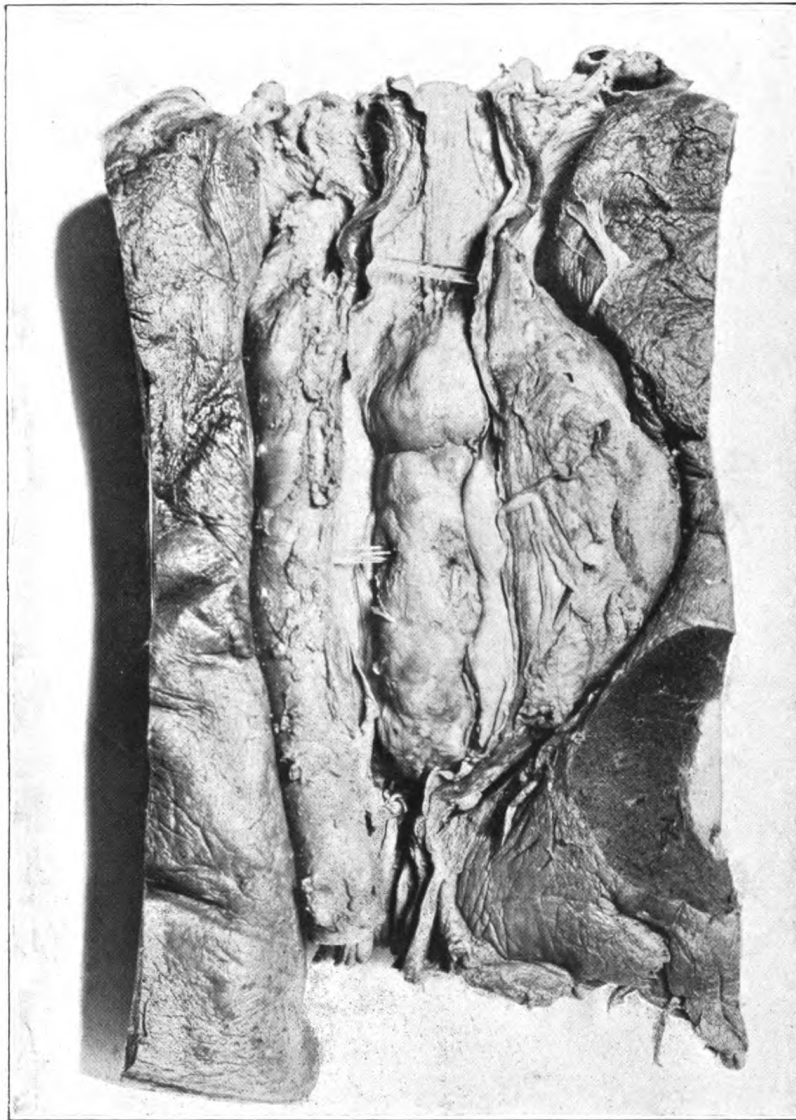


A photograph of the larynx opened from behind to show :
(1) The localised œdema over the right arytenoid. The œdema has somewhat subsided in the process of preserving the specimen.
(2) The puckered scar in the fold of mucous membrane passing down between the cartilages of Santorini and Wrisberg, and referred to by the author as the vulnerable spot of the larynx as a source of systemic infection.

TO ILLUSTRATE DR. JOBSON HORNE'S CASE OF LYMPHO-SARCOMA OF THE
MEDIASTINUM.

Communicated to the Laryngological Society of London April 5, 1907.

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A photograph taken from behind to show the invasion of the posterior mediastinum by the new growth. The structures entering into the photograph from left to right are :

- (1) The inner portion of the left lung.
- (2) The descending aorta.
- (3) The œsophagus laid open to display that portion of the growth which bulges into, and almost obliterates, the lumen to the extent of 115 mm. The walls of the œsophagus are separated by a glass rod inserted in the upper part at a level corresponding to that of the bifurcation of the trachea. The œsophagus above this level is dilated.
- (4) The main portion of the growth outside the œsophagus, and to the right of the middle line.
- (5) The inner portion of the right lung showing the direct extension of the growth into the lower lobe.

TO ILLUSTRATE DR. JOBSON HORNE'S CASE OF LYMPHO-SARCOMA OF THE
MEDIASTINUM.

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backwards for the most part to the right of the middle line. The growth had bulged into the lumen of the œsophagus so considerably that the mucous membrane covering it was extremely thinned and atrophied, the œsophagus itself being obstructed by the new growth to the extent of 115 mm. in the vertical direction, the growth within its walls measuring 40 mm. across, whilst the entire width of the growth in the posterior mediastinum was 70 mm. There was some dilatation of the œsophagus above at the level of the bifurcation of the trachea. Both pulmonary veins were surrounded by the growth, the right bronchus, although not invaded, was considerably narrowed. There was a direct extension of the growth into the lower lobe of the right lung. There was much surgical emphysema round the root of the right lung, and also between the chest and the pleura; the lungs were somewhat collapsed, but presented no further evidence of disease.

Microscopic examination of the growth showed it to be a rounded sarcoma.

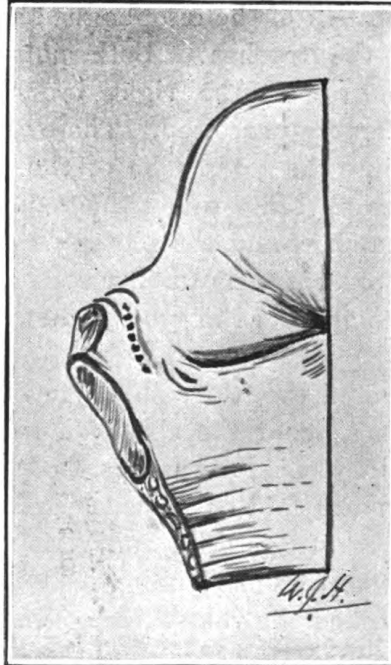
The larynx presented, over the right arytenoid region, a circumscribed area of œdema, about the size of a raisin. On the inner aspect of the right arytenoid there was the puckered scar of an abrasion, situated in the fold of mucous membrane passing down between the cartilages of Santorini and Wrisberg, a site which I have described elsewhere as one lending itself to systemic infection, and which I have termed the vulnerable spot in the larynx.¹ It is indicated in the accompanying diagram by a dotted line, and must be distinguished from the common site of a tuberculous ulcer, which is immediately behind and a little below the vocal process (the posterior sesamoid cartilage) of the vocal cord. There was no marked enlargement of the cervical lymphatic glands.

The case presents some unusual features of clinical and pathological importance:

- (1) The extent of the occlusion of the lumen of the œsophagus by an extrinsic new growth.
- (2) The possibility of passing a bougie of the largest size, in spite of such marked œsophageal obstruction, illustrates both a clinical fallacy, which may attend the use of soft rubber instruments, and also the value of œsophagoscopy in the diagnosis of such cases; it being improbable that a rigid tube would have passed the growth.

¹ Introductory paper to a discussion on "The Upper Respiratory Tract as a Source of Systemic Infection," British Medical Association Annual Meeting, Swansea, 1903.

(3) The localised œdema of the larynx might be accounted for by the conditions within the thorax. At the same time it is as well to consider the possibility of such œdema being occasioned by a local infection at the site indicated. The presence of the scar in the larynx raises the interesting question whether the thoracic growth were not the result of an infection, and whether lympho-



A diagram of the interior of the left half of a larynx to show the site referred to as the *vulnerable spot*, which is indicated by a dotted line.

sarcoma may not eventually have to be numbered, together with the lesions met with in Hodgkin's disease, amongst the infective granulomata. The question is not necessarily negatived by the absence of enlarged cervical glands, for I have shown experimentally that after an inoculation the proximal group of glands may not be permanently affected, whilst *post-mortem* a distal group may be found markedly enlarged.

PROCEEDINGS OF THE LARYNGOLOGICAL SOCIETY OF LONDON.

One Hundred and fourteenth Ordinary Meeting, May 3, 1907.

J. B. BALL, M.D., *President, in the Chair.*

HENRY J. DAVIS, M.B., }
W. JOBSON HORNE, M.D., } Hon. Secretaries.

Present—38 members and 4 visitors.

The minutes of the previous meeting were read and confirmed.

The following communications were made :

A POLYPOID GROWTH WITH DOUBLE PEDICLE REMOVED FROM THE TONSIL.

Shown by Dr. P. McBRIDE. The patient, when seen in May, 1905, had felt discomfort in swallowing for some time. A small white, lobulated tumour was seen attached to the right tonsil by a pedicle, which on examination was found to be double. It was removed with vulsellum and scissors. Afterwards it was seen that the points of attachment of the two pedicles were above and below a crypt.

TUMOURS OF THE VENTRICLE OF MORGAGNI.

Dr. JOBSON HORNE showed : (1) A macroscopic specimen demonstrating true prolapse of the mucous membrane lining the ventricle of Morgagni.

(2) A microscopic specimen cut vertically through the soft parts of one half of a larynx demonstrating a growth springing from the roof of the ventricle. Clinically it might have simulated a "prolapse" or might have been diagnosed as a fibroma of the ventricle ; it was really a hyperplasia consisting of structures similar to those of the ventricular band, so that it may be described as a supernumerary ventricular band.

(3) A macroscopic specimen of part of a tonsil showing an excrescence simulating a polypus. The excrescence was composed of tissue similar to the tonsil itself but presenting degenerative changes.

(4) A microscopic section of a "polypus" attached by a long pedicle to the base of the uvula. Under the microscope the structure was that of a true papilloma.

A CASE OF SUBACUTE LARYNGITIS WITH ULCERATION ; FOR DIAGNOSIS.

Shown by Dr. H. J. DAVIS. The patient, a man, aged twenty-nine, had been hoarse for three months; there was subacute laryngitis with a small ulcer on the right ventricular band. No history of syphilis, though the palate was perforated. There was some impairment at the right apex; the condition was painless.

Dr. DAVIS said he desired opinions as to whether the case was syphilis or tubercle, or a simple subacute laryngitis.

Mr. CRESSWELL BABER said he could not see any ulcer on the right ventricular band; probably it had disappeared under the influence of the iodide of potassium. There was a slight excavation on the right cord. He thought the case was probably syphilitic.

Mr. P. R. DE SANTI thought it was of specific origin, and he would favour hypodermic injections of calomel to try and reduce the condition. The state of the palate was very suggestive of specific trouble.

Dr. McBRIDE asked whether the sputum was examined; the case as it stood now must be either tubercle or syphilis in an early stage. The eaten-out appearance of the anterior part of the right cord looked more like tubercle than syphilis, although the perforation of the palate was rather difficult to account for on that hypothesis.

Dr. WM. HILL suggested inunctions of mercury over the larynx. He had occasionally seen iodide of potassium cause a good deal of trouble over the larynx, especially producing submucous swelling. The fact that the laryngitis disappeared under iodide did not exclude syphilis. But, in view of the perforation of the palate he would go on with the mercury.

Dr. STCLAIR THOMSON suggested that it was tubercle in a syphilitic subject. Dr. McBride had alluded to the waxy condition and the loss of substance of the right vocal cord, which could not be late tertiary, but it was like the nibbled condition seen in early tubercle. The patient said he had lost more than eight pounds in weight during the last five months, and his general health was poor. If he were treated too vigorously for his syphilis, it might bring out his tubercle, whereas if he were treated for his tubercle his syphilis would probably get well of itself. Open-air treatment was well known to improve syphilitics.

The PRESIDENT said it was a difficult case, but Dr. StClair Thomson's view seemed a very likely one. It would be interesting to have a later report of the case.

A CASE OF A GROWTH ON THE LEFT VOCAL CORD IN A WOMAN, AGED TWENTY-NINE; (?) MYXOMA.

Shown by Mr. DE SANTI. This patient complained of hoarseness of varying degree, and cough of three to four years' duration. On examination of the larynx a sessile growth was seen to occupy the anterior half of the left vocal cord. It appeared to grow from the edge of the cord and looked like a gelatinous nasal polypus. It was fairly firm to the probe. On the opposite cord was a small red eminence apparently produced by irritative attrition by the growth on the left cord. Mr. de Santi thought the condition probably myxomatous in nature, and proposed to remove the growth by endolaryngeal methods.

Dr. DUNDAS GRANT thought it was an œdematous fibroma, and that a very excellent result would follow its removal.

Dr. HILL asked Mr. de Santi to bring the specimen forward if it turned out to be myxoma, as that was one of the rarest tumours of the body.

Dr. McBRIDE said there seemed to be a small growth of similar kind on the opposite cord. Years ago he had a case of infiltrating myxoma, which was the pathologist's verdict. It seemed to have all the characteristics of a malignant tumour. The case was obviously rather urgent. He removed a piece for microscopical examination, and asked the pathologist to report quickly. The report was that it was epithelioma. Half the larynx was excised, then the pathologist reconsidered the matter, prepared the tissue carefully, and found he had cut the section diagonally, and so got the semblance of epithelioma. It turned out to be a true infiltrating myxoma—not merely œdematous connective tissue.

Dr. STCLAIR THOMSON said that years ago the Society had a discussion on myxoma of the vocal cord, and he, Dr. Bond, and another member showed what they considered to be myxoma. Yet Morell Mackenzie, in his book, said he had seen only one. The three specimens were submitted to the Morbid Growths Committee, on which Dr. Kanthack's help was available. It was decided that none of the three was true myxoma, but were œdematous fibromata. At the discussion it was concluded that there was no such thing as myxoma in the larynx, the idea being that what was called myxoma was always simply an œdematous condition of fibroma, or simply inflammatory tissue.

Dr. JOBSON HORNE said there seemed some confusion as to the precise terminology of the case. He thought many such cases were really instances of cystic disease of the vocal cord, the outcome of epithelial cells having undergone degenerative changes. He thought that the terms "œdematous fibroma" and "myxoma" were both unsuitable.

A MICROSCOPIC SECTION OF A LARYNX SHOWING A TONGUE OF THE MUCOUS MEMBRANE OF THE VENTRICLE.

Shown by Dr. WYATT WINGRAVE. Section of larynx (coronal) showing a peninsulated projection in the interior of the ventricle.

The "tongue" is attached to the outer wall and is apparently normal mucous membrane covered with columnar epithelium. It is one of four normal larynges cut for anatomical purposes, and is shown with the suggestion that it may help to throw some light upon the condition known as "eversion" or "prolapse of the ventricle."

A CURVED KNIFE FOR THE ENUCLEATION OF ENLARGED TONSILS.

Shown by Dr. A. BRONNER. The tonsil is pulled forward by vulsellum forceps, and then quickly cut off by the knife. The bent part is pressed well back between the pillars of the fauces, and thus practically the whole of the tonsil can be removed quite as completely as by enucleation by the finger, much more quickly and with much less hæmorrhage and danger to the patient. If not carefully done there is a possibility of wounding one or both of the pillars of the fauces, but with a little experience this can be avoided. If the pillars are attached to the tonsil they should be loosened before the tonsil is excised. This can easily be done with the end of the knife. It is double-edged, so that it can be used for either tonsil. Of course it is not suitable for every case. When the tonsil is soft or very flat so that it cannot be pulled forward, the punch forceps should be used, or the tonsil slit open with a sharp strabismus hook. The knife is made by Meyer and Meltzer, of Great Portland Street, W.

CASE OF LARYNGEAL SYPHILIS SHOWN ON JANUARY 4, 1907.

Shown by Dr. J. B. BALL. When this patient was shown at the January meeting there was some difference of opinion as to the nature of the case, although the history of several stillborn children pointed to the probability of syphilis. There was an œdematous swelling of the left vocal cord, and some subglottic swelling on both sides, but more especially on the left side. There was fairly marked laryngeal dyspnœa present. A few days subsequent to the meeting tracheotomy was performed, and she was put on potassium iodide in full doses. The next day a profuse, fœtid, purulent discharge came from the tracheotomy wound, and some days later a probe passed upwards towards the cricoid came on necrosed cartilage. Two pieces of necrosed cartilage were removed subsequently through the tracheotomy wound. At the end of the fourth week, as the laryngeal stenosis seemed to be sufficiently

relieved, and there was no more necrosed cartilage to be made out, the tracheotomy wound was allowed to close. At present the parts about the glottis are much altered in appearance. The voice is reduced to a gruff whisper, and there is a certain amount of dyspnoea on any exertion. Below the glottis, on the left side, a whitish projection is to be seen, which, it is thought, may be a fragment of necrosed cartilage.

The PRESIDENT said he showed the case in January also, and the point now was what the whitish prominent point below the left vocal cord was: was it a fragment of cartilage? Some pieces were removed through the tracheotomy wound, and when he allowed the wound to close he could not be certain that they had been entirely removed.

Dr. FITZGERALD POWELL said this was a most interesting case, and one would have to be well conversant with the history and former appearance of the condition to say what the nature of the case was; from its present appearance nothing definite could be said as to the diagnosis. With regard to the white patch seen below the cords, he thought it was a piece of necrosed cartilage. In a case of his of syphilitic stenosis of the larynx, in which a tracheotomy had been done, a small, white mass was observed below the cords, and above the tube it was difficult to say what it was, but on an operation being performed (removal of the right half of the larynx) to enable the patient to dispense with the tracheotomy tube, the mass was found to be a portion of necrosed cartilage.

A CASE OF ROUND-CELLED SARCOMA OF THE NASO-PHARYNX.

Shown by Dr. FITZGERALD POWELL. The patient, a man, aged thirty-eight, came under observation first in December, 1906, complaining of nasal obstruction and epistaxis; the obstruction was of six months' duration. He had been treated at Oxford in October, 1906, for nasal polypi.

On examination his general health was found to be good. There was an irregular, reddish mass extending from the right choana and basisphenoid, along the right side of the naso-pharynx to the level of the tonsil, filling up the right choana, and involving the right Eustachian cushion, deeply infiltrating the soft tissues of the naso-pharynx, causing the soft palate to bulge. The jaw was fixed. A considerable number of mucous polypi were found in the nose. A portion of the growth was removed, and the report of the pathologist was that it was a "round-celled sarcoma."

It was rather doubtful whether an operation could be done to entirely remove the disease, but the patient very urgently expressed the desire to have an operation. In consequence I thought it right to make an effort to relieve him. On January 12 he was placed under an anæsthetic. A temporary, loose ligature was

placed round the common carotid and a laryngotomy was performed, through which the anæsthesia was continued. His mouth was gagged wide open, and the pharynx plugged with sponges. The soft palate was split, and a portion of the hard palate removed with a chisel and mallet. A free incision was made as wide of the growth as possible, and it was dissected out, everything at all like growth being taken away, part of the septum, which was involved, being cut away.

The man made a good recovery. One or two curettings have been done since for the removal of suspicious-looking granulations.

Mr. DE SANTI said there was undoubtedly considerable recurrence in the case, and he did not think that at any time the whole of the disease had been taken away. There were portions of growth in the posterior part of the nose, which apparently had extended from the base of the skull, and it would now be better to leave the case alone. Operation undertaken in that locality for extensive sarcoma required more done than at first appeared. In such cases, not only had the palate to be chiselled away, but also part of the base of the skull; and in some cases it was necessary to turn both upper jaws forward, which was a formidable operation. He did not think the whole of the growth could now be got away. He did not know why Dr. Powell put a ligature round the common carotid; he would have thought it better to have ligatured the external carotid. He was perfectly sure of one thing—namely, that imperfect and frequent curettings did not prolong life; on the contrary, they sometimes hastened death.

Mr. HERBERT TILLEY differed from Mr. de Santi in no further operation being desirable in the case. Five years ago he, Mr. Tilley showed specimens from five operations on one patient, who had recurrences of a large fibro-sarcomatous growth in the naso-pharynx. The patient was now well, the growth having ceased to recur as the separate recurrences were removed. Since then he had seen two other cases. One had a sarcoma removed from the posterior outer wall of the left nasal fossa, and that had recurred three times. At the third recurrence, instead of approaching it from below through the palate, he made an incision as if for removal of the upper jaw, and removed the ascending process of the superior maxilla, at the same time making an opening into the antrum. By removing the whole ascending process he came on to the outer nasal wall, and removed the recurrent growth. That was fourteen months ago. He saw the patient three weeks ago, and there was no further recurrence. He did the same thing a fortnight ago in a case of epithelioma limited to the ethmoidal region, and it was surprising what excellent room and view it gave the operator, and the growth was rendered very accessible. It was an easier method than splitting the palate, and did not disturb one's knowledge of the topography of the parts. The hæmorrhage in such cases was very free (vascular fibromata, or fibro-sarcomata), and it was necessary to perform a preliminary laryngotomy, and to place a sponge above the larynx to avoid being inconvenienced by the anæsthetist, and to prevent blood getting into the larynx. He would not give up the case, but would attack the recurrences, as it was pointed out by Mr. Spencer a few years ago that those growths, though histologically malignant, were not

clinically so malignant as when they occurred in other parts of the body. He thought Dr. Powell might still prevent his case from going downhill.

Mr. STUART-LOW agreed that by the method advocated by Mr. Tilley the access obtained was most efficient. He had such a case, in which the patient did very well. Last week he assisted Dr. Grant in a very extensive operation, where there was epithelioma of the antrum extending far backwards and upwards. The upper jaw was removed, and the access thus obtained was exceedingly good.

Dr. H. J. DAVIS thought there was considerable disease in the nose itself, and it seemed to have spread to the anterior part of the nose.

Dr. PEGLER said he had had a similar case under observation in which the disease had spread into the nose, and in which, on two occasions, a serious operation had been undertaken and as much of the growth as possible removed. The patient turned up again at the hospital eighteen months ago with complete nasal obstruction. He failed to come again for operation, obviously because he had his living to earn, and he did not appear to be in bad general health. Dr. Pegler doubted whether further attempts at removal should be made in the present case. Such sections of this class of growth as he had been able to examine had not a definite sarcomatous structure. The section now under the microscope did not seem to represent the main mass of the growth very well; it was not sarcomatous.

Dr. JOBSON HOENE said it was necessary to make sure whether sarcoma was being dealt with or not. As Dr. Pegler had said, the section was not sarcoma, and if Dr. Powell agreed to refer the case to the Morbid Growths Committee he would perhaps supply another section. He believed that the case of five years ago, referred to by Mr. Tilley, proved to be other than sarcoma. Sarcoma of the naso-pharynx was not so frequent as the literature led one to believe.

Dr. FITZGERALD POWELL, in reply, said he was grateful for the interest his case had aroused in the Society. In reply to the remarks of Mr. de Santi he did not think Mr. de Santi was quite in a position to give very decided opinions on the case, as it would have been necessary for him to have seen the case before and at the time of operation to be at all able to judge of the procedure. The case was thought to be practically hopeless, but at the urgent desire of the patient he decided to operate. He selected the operation—a modification of Nelaton's—splitting the palate, and with the head hanging down over the end of the table on account of the tendency of the infiltrating growth to grow down towards the tonsil and palate, and not so much into the nose, the maxillary antrum also being quite free from growth, and he had found this method answer very well in the removal of large fibrous growths of the post-nasal space; besides, the face was not disfigured. He did not think there was much recurrence of the sarcoma in the nose—what was there appeared to be myxomatous. There was, he thought, some recurrence at the basi-sphenoid seen up behind the hard palate. He had removed all the growth he could possibly see or feel. It was very soft and infiltrating, and could not be got away as one complete tumour. With regard to the remarks regarding the section shown, several sections had been cut of the growth and also of the contents of the nose; he regretted he had unfortunately had the wrong section sent him, which was probably that of a polypus. He would obtain all the sections and submit them later.

DRAWING OF A TONSIL, SHOWING A BIFID GROWTH SPRINGING FROM
A LACUNA. UNDER THE MICROSCOPE FOUND TO BE COMPOSED OF
ORDINARY TONSILLAR TISSUE.

Dr. STCLAIR THOMSON brought forward this drawing and specimen, after seeing the cases of Dr McBride and Dr. Horne on the programme. The growth from the tonsil in his case had the clinical appearance of a polypus, and he had expected to find that it was a papilloma. As in the case of Dr. Horne the microscope showed it to consist of only tonsillar tissue.

CASE OF LUPUS OF THE LARYNX IN A BOY, AGED ABOUT TWELVE.

Shown by Dr. DUNDAS GRANT. Outgrowths above the vocal cords concealing them almost completely. Extreme weakness of voice. Question as to how far this is due to mechanical interference on the part of the outgrowth or how far to possible destruction of the hidden vocal cords. Is the present voice produced by the glottis or above it?

The appearance of the epiglottis is extremely characteristic, and there will probably be no difference of opinion as to the nature of the disease, more especially in view of the fact that there is, on the right forearm, the remains of a lupoid ulcer.

Mr. HERBERT TILLEY said he thought he could see the posterior ends of vocal cords.

Dr. GRANT said he would like opinions as to what the rest of the vocal cord was like, and why the patient had not a better voice. Ought he to remove the small lupoid outshoots above the vocal cords, and, if so, would he be taking away the tissues used vicariously by the boy for producing his voice?

Dr. DAVIS thought that, as it was unhealthy tissue, the sooner it was removed the better.

Dr. WATSON WILLIAMS said the condition on the right side of the nose was rather suggestive of lupus, and he suggested there should be active treatment in that region as well as in the larynx.

Dr. JOBSON HORNE considered that the growths should certainly be removed, which could be done by the endo-laryngeal method. His belief was that the tissue in question was not essential for the production of the boy's voice, in fact, his voice would be improved by its removal.

CASE OF ENDOTHELIOMATOUS INFILTRATION AND ULCERATION ON THE
POSTERIOR WALL OF THE LOWER PHARYNX IN AN ELDERLY MAN.

Shown by Dr. DUNDAS GRANT. Moderate interference with swallowing. Microscopical section shows typical endothelioma.

General condition good; no glandular enlargement. The approximation of the downward continuation of the posterior pillars of the fauces suggested a tertiary lesion, but the extreme induration (noted particularly by Mr. Stuart-Low), the negative effect of anti-syphilitic treatment and the microscopical report seem conclusive. Question as to feasibility of operation.

Dr. GRANT asked for opinion as to whether operation would be feasible; also whether the microscopical aspects showed it to be malignant in character or only semi-malignant. He would be glad to submit the specimen to the Morbid Growths Committee, but the question of operation could not long remain undecided.

Dr. PEGLER said he had no doubt about the malignancy of the specimen under the microscope, but he would require to examine it more carefully before pronouncing it to be an endothelioma. He supported the proposal to submit it to the Morbid Growths Committee.

MICROSCOPICAL SECTION OF A GROWTH REMOVED FROM THE LARYNX.

Shown by H. LAMBERT LACK. The patient, a clergyman, aged fifty-four, had been hoarse nine months. The growth involved the anterior half of the right cord and spread slightly across the anterior commissure on to the left. It was removed by thyrotomy. The sections show that the growth is a spindle-celled sarcoma. The growth had a warty appearance, was sessile and infiltrating. The right cord was immobile. It was considered to be an epithelioma.

SPECIMENS OF PAPILOMATA REMOVED FROM A LARYNX.

Shown by Mr. HERBERT TILLEY.

Dr. JOBSON HORNE spoke in favour of the direct method of removing laryngeal papillomata in children as advocated by Dr. Paterson. With the forceps devised by Dr. Paterson it was necessary to make a considerable allowance for the kick upon closing the instrument, and with it there was difficulty in clearing out the anterior commissure—the part which the operator particularly wished to reach. With a view of overcoming these difficulties, Dr. Horne had had an instrument made by Messrs. Mayer and Meltzer, and this he would be pleased to demonstrate at the next meeting.

Dr. STCLAIR THOMSON said that he also had invented an instrument, which he would bring. It left the eye open to see along the gunwale. For the last two years he had been removing such papillomata by the Killian method. But he did not find them soft to pull away, but remarkably tough, nor did he find it so easy to get "all away," as did Mr. Tilley. At the last meeting Mr. Robinson showed a specimen of papilloma of the larynx, all of which it would have been impossible to take away except by flaying the larynx, as the growths were spread over the ary-

epiglottic folds on both sides, the vocal cords, the ventricular side of the epiglottis, and below the cords. He had been disappointed to find that the growths recurred when removed by the Killian method, as by any other.

Dr. D. R. PATERSON said there were various sizes in which the forceps could be used. He had had one made in which the end was very narrow, and which could be got into any commissure. He agreed with Dr. Thomson's remarks as to the toughness of some of the growths, especially if they were sessile. Straight forceps would not grasp them, and he had found it necessary to use Löri's curette, which he had modified to use with a Killian tube. Various sizes were made, and they were especially useful in removing small pieces of growth from below the anterior commissure.

Mr. HERBERT TILLEY, in reply, said Dr. StClair Thomson must have misunderstood him, as he knew full well the difficulty of being sure that the whole of the growths had been removed. He meant to say that one was more certain of removing growths by the direct than by the indirect method. If the growths were fairly limited, probably all of them could be got away. He maintained that papillomata themselves were not so tough as Dr. Thomson and Dr. Paterson thought. When the forceps were fixed, and the growth would not come away, it was because they grasped not only the papilloma but also the tissue from which it was growing. The papilloma was a collection of "sprays" of epithelial cells supported on a fibro-vascular stem, and was quite soft. Last Wednesday he had a demonstration of that, because at the commencement of the operation he could see the growths and pick them off, but towards the end of the operation he had great difficulty in doing so when he endeavoured to get away the bases of the growths. He would be examining the larynx again next week, and would then apply a solution of salicylic acid in absolute alcohol to the growths.

Dr. WATSON WILLIAMS exhibited a Sphenoidal Sinus Syringe.

CORRIGENDUM.

On page 77, second line from top, for "aphonia" read "aphasia."

PROCEEDINGS OF THE LARYNGOLOGICAL SOCIETY OF LONDON.

One Hundred and fifteenth Ordinary Meeting, June 7, 1907.

J. B. BALL, M.D., *President, in the Chair.*

HENRY J. DAVIS, M.B., }
W. JOBSON HORNE, M.D., } Hon. Secretaries.

Present—47 members and 3 visitors.

The minutes of the previous meeting were read and confirmed.

Sir FELIX SEMON, K.C.V.O., M.D., was elected an honorary member of the Society.

The following gentlemen were elected ordinary members of the Society :

GEORGE K. GRIMMER, M.B., F.R.C.S.Edin.
WILLIAM GUTHRIE PORTER, M.B., F.R.C.S.Edin.
ALFRED JOHN MARTINEAU, F.R.C.S.Edin.

REPORTS OF THE MORBID GROWTHS COMMITTEE.

Dr. StClair Thomson's specimen from a case of malignant endo-laryngeal growth (vide *Proceedings*, April 5, 1907, vol. xiv, p. 75) was found to be spheroidal-celled carcinoma.

Dr. StClair Thomson's specimen from a case of prolapse of the ventricle of Morgagni (vide *Proceedings, ibid.*, p. 76) was a soft œdematous fibroma; it contained nothing but œdematous fibrous tissue covered by squamous epithelium. It contained no glands, nor anything suggesting that it originated from the ventricle.

Dr. FitzGerald Powell's specimen from a case of naso-pharyngeal growth (vide *Proceedings*, May 3, 1907, vol. xiv, p. 91) consists of a hyperplastic growth of lymphoid tissue, containing giant-cells, but not showing sufficiently clear evidence for a diagnosis of tuberculosis.

Dr. Dundas Grant's specimen from a case of malignant growth in the pharynx (vide *Proceedings*, May 3, 1907, vol. xiv, p. 94) is a squamous-cell carcinoma.

Dr. Lambert Lack's specimen from a case of laryngeal growth removed by thyrotomy (vide *Proceedings*, May 3, 1907, vol. xiv,

p. 95) is a squamous-cell carcinoma, the columns of which are thinned, broken up, and in places disintegrated by granulation tissue, unusual in amount.

The following communications were made :

A CASE OF SARCOMA OF THE TONSIL, TREATED WITH X RAYS.

Shown by Dr. STANLEY GREEN. The patient, a man, aged fifty-eight, first noticed a growth on his right tonsil in June, 1906, and was under his club doctor for six weeks, but the growth got larger ; he then went to the Lincoln County Hospital, and was an out-patient under Dr. Brook, and had large doses of iodide of potassium for two months. As the growth was increasing in size and he was losing weight he was advised to have an operation ; this he agreed to and the growth was enucleated. He says that the growth did not commence to grow again until January, 1907, but then the increase in size was very rapid. When I saw him on February 22 the growth was so large that the uvula was pushed over to the opposite side and he was able to swallow only liquid food and porridge, the mucous membrane covering the growth was bright red in colour, his breath was very offensive, and his weight was 7st. 6lbs. ; there was a mass of enlarged glands in his neck as large as an orange, and it was stony hard ; he had now been taking iodide of potassium for seven months. X-ray treatment was commenced the same day, and was given both externally as well as internally ; the dose was always as large as I thought the tissues would stand, and as the sittings were separated by an interval of six to seven days I never caused more than an erythema of the skin. On April 15 there was only a small nodule to be felt along the border of the sternomastoid, and I showed the patient to the members of the Lincoln Medical Society. The swelling between the pillars of the fauces was then about the size of a large walnut, and it continued to decrease in size until about a fortnight ago when he caught a bad cold, with the result that the growth has increased in size, but he can eat ordinary food, can do his work, and has already put on 8 lbs. in weight.

The case is not cured yet, but I thought it would be of more interest to the members of the Society in its present condition than it would be next session, when the growth will probably have disappeared altogether.

There were twenty sittings in all, seven external and thirteen internal, and the total time that he has been under the rays is six

hours forty-nine minutes. Microscopic examination revealed the nature of the growth to be sarcomatous.

The PRESIDENT said that apparently the point in the case was the improvement which had occurred, and on that members were not able to judge. Dr. Green said there had been a large mass in the neck, and that had now disappeared.

Mr. HERBERT TILLEY said that possibly the disappearance of some of the glandular involvement in malignant disease of the throat treated with X rays was due to the fact that the throat was made much cleaner by the treatment, and there was less septic absorption. He had in mind a case of his own, in which a large mass of malignant ulceration at the base of the tongue and the side of the pharynx was considered inoperable. There was also a large mass of glands in the neck. X rays were suggested, and they were administered with the same frequency as in Dr. Green's case. Three months afterwards practically all the glands had disappeared. It would be interesting to hear from Dr. Green whether the improvement was due to the parts becoming cleaner and there being less septic absorption, rather than that any metastasis had been caused to disappear. In answer to the President, Mr. Tilley said the growth which he had referred to became smaller and cleaner, but it was difficult to say what that was due to. He saw the patient ten months afterwards, and he seemed infinitely better. He did not know what had now become of him.

Dr. GREEN, in reply, said that what Mr. Tilley had suggested came into his mind, but there was not a foul condition present, and there was no ulceration. It was merely a large tumour, with inflamed mucous membrane, and he did not think there was enough in the throat to account for such a mass of glands in the neck unless they were malignant. The way in which the condition disappeared was very remarkable.

EPITHELIOMA OF THE LARYNX.

Shown by Dr. S. MORITZ. The patient, a man, aged fifty-three came under observation three months before his death. The tumour had already then attained almost the size seen in the photograph, the epiglottis being converted into a fungating mass and the interior of the larynx being invisible with the laryngoscope. The cervical glands were infiltrated, and the case was evidently too far advanced for operation. Speech was indistinct, but deglutition was only slightly impeded. Though the obstruction to the air-passages is apparently very great, the small amount of dyspnoea from which the patient suffered was remarkable; the air current evidently had to find its way through the upper part of the pharynx and from there through the partly destroyed posterior wall of the larynx. There was no sign of deglutition-pneumonia.

Sir FELIX SEMON said it was a very remarkable specimen. No doubt it was an absolutely fortuitous thing, but the formation of the new growth was such that it did not interfere very much with breathing, nor with

swallowing. There was a space on the left side where the air could be sucked in through a narrow chink which had been left open there. He could not remember having seen a case of malignant disease exactly like that.

A CASE SHOWING THE RESULT OF RADICAL OPERATION FOR DOUBLE-FRONTAL AND ANTRAL SINUS SUPPURATION.

Shown by Dr. WATSON WILLIAMS. The patient had undergone double radical, frontal sinus, and antral operations. On the left side the frontal sinus had been dealt with by the Killian method, and on the right by a modified Delsaux operation. The frontal sinuses were enormous, and the ethmoid cells had been very extensively diseased. The result had proved very satisfactory as regards cure of the condition, and the cosmetic results left very little to be desired, although, as was inevitable, there was some—though very slight—depression on the forehead, owing to the size and depth of the sinuses, which had to be obliterated. He had removed, a short time before presenting him to the Society, some remaining ethmoidal cells, and these, as he pointed out, had not healed, and yielded still some muco-purulent secretion. The patient had been a great sufferer for many years from asthma, which had almost incapacitated him from business. Since the operation last January he had been quite free from asthma, and there was every reason to hope that he might be reasonably regarded as a case of asthma cured by operation within the nose.

Dr. D. R. PATERSON thought the cosmetic result would have been better if Dr. Williams had left a larger ridge on the left side. It showed a ridge now, and there would have been no disadvantage in leaving a wider plate of bone there.

A CASE OF EXTENSIVE SUBMUCOUS RESECTION FOR SEPTAL DEFLECTION UNDER LOCAL ANÆSTHESIA.

Shown by Dr. H. SMURTHWAITE. He brought the case forward, not from any novelty in the operation, but merely to show how extensive an operation one could do under local anæsthesia. The operation had been done under preliminary cocaine swabbing, followed by injection of novocaine and epinephrin. The patient experienced no pain, and there was no bleeding. Most of the triangular cartilage had been removed, together with part of the perpendicular plate of the ethmoid and the maxillary crest. The specimen was shown.



MA OF 201

Photograph of
glands converted into a
to air passage.

For communication to
June 7, 1907, p. 4

100-1-1-1-1

...the patient was able to ...

By ...

The patient ...

...result would have been ...

...SARAT, DYNAMIC X ...

He brought the case forward, ...



EPITHELIOMA OF THE LARYNX.

Photograph of the posterior aspect of the larynx showing the epiglottis converted into an epitheliomatous tumour and the great obstruction to the air passage.

To illustrate a communication to the Laryngological Society of London, June 7, 1907, by Dr. S. MORITZ.

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Dr. J. DONELAN asked how long the operation took, and what Dr. Smurthwaite's experience had been in other cases with novocaine. He had tried novocaine frequently lately, and he could not say that it possessed any advantages over cocaine as an anæsthetic, though it may be less toxic. With regard to operating under a general anæsthetic, it was a great advantage to have the patient quite steady; the operator might be disturbed by the patient moving. He also asked what was the influence of the general anæsthetic on adrenalin. His experience had been that adrenalin did not act so well then, even if it were used a quarter of an hour before the operation. Under chloroform anæsthesia the hæmorrhage was apt to be less well controlled than when adrenalin was used for local purposes without a general anæsthetic.

Dr. STANLEY GREEN asked whether Dr. Smurthwaite had ever tried allypin in place of cocaine. The advantage afforded was that there were no toxic effects, and all met with patients who could not stand a large dose of cocaine. He also asked whether Dr. Smurthwaite usually put such cases first under chloride of calcium. His experience was that if the patient were given that drug for four or five days before the operation the hæmorrhage was almost insignificant. He considered the patient would want the anterior half of the inferior turbinate removed before he was clear on the right side.

Dr. FURNISS POTTER said that he had had some experience of novocaine in connection with submucous resections, and had been much struck by its non-toxic effect in a case which had exhibited marked intolerance of cocaine, so much so, that merely spraying the nose with a 4 per cent. solution produced symptoms. He used a mixture of equal parts of 10 per cent. solution of novocaine and adrenalin 1-1000 applied on cotton-wool and kept in position for half an hour previous to operating. The patient bore the operation—which lasted about an hour—without any complaint of pain, and showed no toxic symptoms. With regard to involuntary movements on the part of the patient, he had never had any trouble. In the cases in which he had operated under local anæsthesia, the patients had said they felt no pain except when the maxillary crest was being chiselled, or the bony septum bitten with forceps, and that then the pain was slight. He agreed with Dr. Smurthwaite that it was much more satisfactory to perform the submucous resection under local anæsthesia than to have recourse to a general anæsthetic. He had the patient lying down with the head and shoulders raised.

The PRESIDENT asked why local anæsthesia was preferable, from the operator's point of view. He had heard this stated. With regard to the question whether adrenalin acted when a general anæsthetic was employed, he was sure it acted if one took the trouble to use it properly, and to allow half an hour or so for it to act.

Dr. PATERSON said that perhaps as one who had undergone the operation under local anæsthesia he might be allowed to give his experience. It was absolutely painless, the only thing he felt being the pressure of the speculum on the nose. It lasted half an hour, and was a fairly extensive operation. He did many of his own cases under local anæsthesia. With anxious, apprehensive patients one was obliged to use a general anæsthetic. He always liked the patient in the sitting posture. If the patient felt frightened or faint, it was good to have him reclining on a couch with an adjustable back. From the patient's point of view local anæsthesia was a simple and easy matter. From the operator's point of view the position was the normal one for nose work, and one

could get a more satisfactory view of the floor of the nose, which was more difficult with the patient lying down. On the other hand, in a long sitting it was necessary to stop the operation where a general anæsthetic was used, in order to administer more chloroform, and also on the occurrence of sickness, which brought the risk of stomach contents getting into the nose.

Mr. F. H. WESTMACOTT said he had tried both forms of anæsthesia, and had found it quite easy to see the floor of the nose with general anæsthesia. He had the patient lying on the operating table, with the head well over the end, the head being held in the same position as in the operation for post-nasal growth. He had never yet taken an hour over the operation.

Dr. WILLIAM HILL thought there were at times disadvantages in doing the operation under a general anæsthetic, more especially in the matter of hæmorrhage. He preferred a general anæsthetic when the patient was a nervous lady, or a person who had not any great fortitude. He had had some people collapse in the chair who had had a local anæsthetic, and in one instance this was after novocaine.

Dr. SMURTHWAITE said he had never done the operation under chloroform, and he did not like to attempt it; he followed the line of least resistance. He saw the first operation done under local anæsthesia, and he copied his teacher, and had done it ever since. If he had not seen that done in Vienna he might have used a general anæsthetic until he had a mishap. It must be admitted that a general anæsthetic was a danger, but what danger had been traced to local anæsthesia? Moreover, one could guarantee that the patient would be about sooner. He did it with the patient sitting upright in a movable chair, and directly the patient felt faint down came the chair. There was more bleeding under chloroform with adrenalin than in the case of local anæsthesia; in fact, in the latter case there was often no bleeding until after the operation. There was no bleeding until the maxillary crest was chiselled away. It was only in the last two months that he had tried novocaine. He had also been trying epinephrin, which was cheaper than adrenalin, and it acted just as well.

A CLERGYMAN WITH EXTENSIVE TUBERCULOUS LARYNGITIS, WHICH HAD RESISTED TREATMENT BY SANATORIUM METHODS, SILENCE, LOCAL ANTISEPTICS, AND ESCHAROTICS. NOW COMPLETELY CICATRISED SINCE FIFTEEN MONTHS BY LOCAL TREATMENT WITH THE GALVANO-CAUTERY.

Shown by Dr. STCLAIR THOMSON. The patient entered a sanatorium in June, 1902, with tubercle bacilli in his sputum, and involvement of the right upper lobe. He was due to return home at Christmas, 1902, with the lung process quite arrested, when he suddenly developed laryngitis, which proved to be tubercular. He therefore remained on till Christmas, 1903—*i. e.* he gave sanatorium treatment and silence another year's trial.

He came under my treatment in March, 1904, with tubercular disease of the left vocal cord, the left ventricular band, the anterior

arytenoid region on both sides, and part of the right ventricular band. The left vocal cord was ulcerated in its whole extent.

The patient was kept upon sanatorium principles, and the larynx insufflated daily with iodoform for three months. Owing to the skill and kindness of Dr. Gambier this treatment was carried out at St. Leonards.

In June, 1904, a portion of the tissue was punched out, and the wound painted with Lake's strong mixture (carbolic acid 10 parts, lactic acid 50, formalin 10, water 30). The removed portion showed tubercle. Painting and insufflations were carried out until September, 1904, when the first application of the galvano-cautery was made. In February, 1905, after six applications and strict silence, decided improvement had taken place. The patient was allowed to speak in May—*i. e.* after seven months of silence—but ten more applications of the cautery were made, extending from February, 1905, to March, 1906. At this date his larynx was soundly healed. He had re-commenced some clerical duties in November, 1905, and in May, 1906, he resumed preaching and also smoking. Last summer he acted as a continental chaplain, and last winter he not only carried out the same duties single-handed, preaching two sermons every Sunday, but he also skated, tobogganed, and lugged.

He never "catches cold," or has laryngitis. When examined during respiration it will be seen that the anterior third of the left vocal cord is concealed beneath the scarred margin of the ventricular band, but on phonation a good new cord comes forward. Extensive cicatricial tissue is seen on nearly all the left ventricular band, the inter-arytenoid region, the posterior end of the right ventricular band, and the region in front of the right arytenoid, which Dr. Jobson Horne has frequently called attention to as being the vulnerable point. It will be seen that healing was established and voice use allowed after six monthly applications of the galvano-cautery, and that, in all, sixteen applications were made.

One rough sketch indicates the extent of the disease, and the other shows the sites of cauterisation, frequently eight points being made at one sitting.

Mr. BARWELL congratulated Dr. StClair Thomson on the result. Although he had not seen the case before operation, the cord was now healthy, and there seemed to be no active disease there, and there was only slight thickening of the band. It was his intention now to try the galvano-cautery in some of those cases. He thought it would act best in such a case as the present, where the infiltration was somewhat scattered and not massive. He was glad to see that Dr. Thomson employed active treatment in some cases of tuberculous laryngitis.

Sir FELIX SEMON said the galvano-cautery had recently been again warmly recommended by Grünwald in certain cases of laryngeal tuberculosis. He (Sir Felix) could not speak from personal experience in cases of tuberculosis, but he had cured a most extensive lupus of the larynx by means of the galvano-cautery. Had it not been for the perseverance of the patient, however, he would not have gone on with it. The cure, which was reported about sixteen years ago, had remained complete to the present day. He earnestly hoped the negative result of the silence treatment in this case would not deter members from trying the method, irksome as it was. He referred his hearers to a paper published that day in the *British Medical Journal*, by Drs. Bardswell and Adams, from King Edward's Sanatorium, setting forth a number of cases which had been cured, either by silence alone or by that method combined with local measures.

Dr. STCLAIR THOMSON, in reply, said he would be the last person to say anything against the silence treatment of tuberculosis of the larynx. He thought it had been a great advantage that his patient had been kept on the silence treatment during the first six months' treatment with the galvano-cautery, and this had helped to avoid a reaction. He was cured with fifteen applications of the galvano-cautery, and, if the number of sittings was small, it was compensated for by the number of punctures made at each sitting. He went deeply into the tissue until he struck healthy tissue. The tubercle had been completely arrested in the chest before the larynx was treated.

TWO DISSECTED SKULLS TO SHOW EXTENSIVE ETHMOIDAL-FRONTAL CELLS.

Shown by Dr. STCLAIR THOMSON. In both these skulls the frontal cell was small and easily reached. When viewed from above the presence of the large ethmoidal-orbital might readily be overlooked, but on viewing them from below the supra-orbital ridge it was seen that this cell ran a long way backwards and outwards in the orbital roof. The skulls were shown to demonstrate the fact that it was utterly impossible to reach such a large ethmoidal cell from the nose, and that the only way of reaching it from the outside would be by a complete Killian operation.

The PRESIDENT said if there had been any doubt in anybody's mind about the possibility of treating the anterior ethmoidal cells effectually through the nose these specimens must settle the question.

Mr. WESTMACOTT said he was still unconvinced that it was necessary to open up from the front in such cases. In both the skulls exhibited there was simply an aberration of the first basal plate of the ethmoid. In the one case the basal plate was incomplete; there was a fronto-ethmoidal cell, but somewhat external to the usual situation, and over the orbital cavity. In the half-skull there was not a failure of the basal plate, but rather a deviation. Instead of coming up in the transverse method, it was twisted, coming out antero-posteriorly, and shutting off a cell in the roof of the orbit, which might be termed the anterior ethmoidal cell, pure and simple. In both of them the dependent point was downwards and into the infundibulum, and if one removed the anterior end of the

middle turbinal and opened up the ethmoidal labyrinth with punch forceps from the interior of the nose there would be drainage into the nasal cavity; if there were granulations coming down from the frontal sinus and other cells in that region, and one wished to remove them by scraping or any other radical measure, it would, of course, be necessary to operate from the front. He maintained that those cells, by appropriate treatment, opening up from the interior of the nose, would drain into the nose, and one could wash out the cavities and use instillations in a manner which would prove satisfactory in most cases.

Dr. W. HILL asked why the current name "fronto-ethmoidal cell" should not be applied to what Dr. Thomson called "ethmoidal-orbital"? A fronto-ethmoidal cell did not normally communicate with the frontal sinus. He maintained that those indicated were the genuine fronto-ethmoidal cells which one opened every time one performed a radical operation for frontal sinusitis. Moreover, the cells could be seen opening at the typical place in the nose. The ethmoidal part of the cell was rather small, and the frontal part was very well developed in the specimens shown.

Dr. LAMBERT LACK said he thought the practical point had been rather overlooked. After the anterior ethmoidal cells had been opened up as freely as possible, if there was still pus coming down from the anterior ethmoidal region one would probably diagnose suppuration in the frontal sinus, proceed to do a radical frontal sinus operation, and then those cells would be opened. It did not matter whether it was an ethmoidal cell or the frontal sinus; if it was diseased, obviously an external and extensive operation would be necessary, as if it were a frontal sinus. The occasional presence of such a cell was no argument against attempting to operate on the ethmoidal cells from the nose.

Dr. HERBERT TILLEY agreed with Dr. Lack. Yesterday afternoon he had an illustration of his contention in a patient who had had four operations done on the frontal sinus, but there was still two suppurating fistulæ, which came out above and below Killian's bridge. Yesterday he opened up the sinus, and the whole trouble was discovered at the back of the sinus, where there was a small suppurating cell extending backwards nearly to the small wings of the sphenoid. It had infected the floor of the sinus, and it could not have been reached from the nose—it was too lateralised. He could only deal with it by taking away its lower wall, so as to expose the roof of the orbit, and let the orbital tissues rise into it. That was really the essence of Killian's operation. The fronto-ethmoidal cells, which spread outwards or backwards through the roof of the orbit, would infect the most complete operation one could do on the frontal sinus, and such cases could not be cured, and got dry unless those cells were obliterated.

Dr. PATERSON said the cells in question were part of the frontal sinus. It was the orbital recess which was often partially shut off by thin septa from the main part of the sinus, and in both those specimens the septa were rather imperfect. It was described in Killian's atlas as the orbital recess of the frontal sinus. He knew the recess from practical experience, because in very extensive operations which he had to do in connection with the sinus it was found very large, and it was necessary to strip off the periosteum from the plate of the orbit before getting to the bottom of it. He did not think it would be necessary to excise the eyeball to get at that part as had been suggested. It meant simply that if one stripped the periosteum from the orbital plate, and held the contents of the orbit aside, one could, with Hartmann's conchotome, get at the

deepest part of it. He got at it from below the bridge. He had two cases quite recently which he had so treated with excellent results, and which amply confirmed Dr. Thomson's contention.

Dr. STCLAIR THOMSON, in reply, said there was a risk in working from below, because of the liability to push upon the eye; and he had heard of a bad result from that in Berlin. It did not matter whether the space was called "fronto-ethmoidal," or "ethmoido-frontal," or "frontal recess." He used the term "orbital-ethmoidal" to indicate that it ran over the orbit. Dr. Westmacott rather questioned whether it should be treated surgically, but that subject must be left for another day. He brought the skulls forward to show that if the frontal sinus and its accessories were to be treated surgically he saw no means of getting at it except by the complete Killian, without the so-called modification of it in any way. He thought the most important cause of disasters in the past was the overlooking of those cells, where suppuration got cut off.

SPECIMEN OF DEGENERATED ETHMOIDS REMOVED FROM A CASE OF MULTI-SINUSITIS.

Shown by Dr. STCLAIR THOMSON. This specimen consisted of the degenerated ethmoid, and, when freed of all blood and liquid at the time of operation, weighed exactly 4 oz. There had been complete obstruction of the nostrils.

CASE OF ADHERENT SOFT PALATE AFTER OPERATION FOR ITS SEPARATION.

Shown by Mr. H. BETHAM ROBINSON. A boy, aged seventeen, came to St. Thomas's Hospital in September, 1906, with complete adhesion of his soft palate to the posterior pharyngeal wall, no nasal-respiration, and absolute deafness. Since early life he had been deaf, and had been troubled with accumulation of mucus in the nasal cavities. He had had the "blight" in his eyes, and now he shows slight corneal opacities due to old keratitis. He had had also discharge from his ears, and the right drum was cicatricial, and the left one had a large perforation. His teeth are bad, but they give no distinctive evidence of congenital syphilis. Congenital syphilis was, however, regarded as the cause of the adherent palate. His condition was so wretched that I determined to give him relief by separating his soft palate.

On October 13 I separated the palate from the pharynx freely from side to side; at its attachment it was a full quarter of an inch thick. The freed palate was prevented from again uniting in the following manner. A piece of lead plate was cut the full breadth of the naso-pharynx, and it was bent so that one arm of it rested on the dorsal surface of the soft palate and the lower on the buccal surface, the cut margin being received between the plates and apposed to the bend, and so kept away from the pharyngeal

wall. Silk threads were fixed to the four corners of the piece of lead; the two from the upper corners passed one through each nostril, and the lower two passed forward across the hard palate between the lateral and central incisors on each side. The upper and lower threads on each side were then tied together in front over the lip, but they were prevented from cutting by being passed through pieces of rubber tubing. After the first day he had comparatively little trouble, being able to swallow fluids and other soft food without any special complaint. Aristol was blown into the nose and over the palate surface daily. The lead plate was not removed for a fortnight, by which time it was considered sufficient healing would have taken place to prevent re-union. Bearing in mind the almost certain specific origin of the mischief he was put on iodide of potash directly after operation to hasten the healing. At the end of eight months there is not the slightest contraction. By Politzerisation and passing the catheter his hearing has been restored to almost normal, and he is able to breathe freely through his nose. To sum up: the lad, by the operation, has become quite bright and intelligent instead of a worry to his relatives from his previous helpless state.

Mr. TILLEY congratulated Mr. Robinson on an excellent result in a very intractable class of case.

Dr. LIEVEN said it was a very good result, but it was necessary to be very careful in those cases. This one was successful because the adhesion was horizontal and was very thick, a slit thus resulting. In many of those cases of adhesion there was atrophy of the velum. Therefore in operating the hole sometimes got too large and the patient might be worse off than he was before, because from that moment they could not eat and drink properly, food and liquid getting into the nose. He had had such a patient, who told him he was much worse after the operation for that reason. There was always the chance that the hearing might be improved if the patient was not too old. It was a very clever idea to pass strings afterwards through the nose. He had heard the same idea spoken of by Professor Hopmann, of Cologne, who used to put india-rubber strings through the nose to hold the velum forwards so that he could get at the naso-pharynx. But he doubted whether a nervous patient would stand those strings for a fortnight. He recommended the use of a little instrument which he brought forward fourteen years ago, an indiarubber tube which led into a ball of the same material. It was put into the nose by a Belloc sound, and the patient himself filled it with air when the ball had arrived at the naso-pharynx, and that exerted active pressure against the cicatricial contraction. It mostly worked in the direction of least resistance, *i. e.* towards the opening which the operator had made. If that were put in at the beginning twice every day for a few hours, and applied less and less as time went on, there would be a very good result.

Mr. ATWOOD THORNE asked how long it was since the operation was done, and how long the appliance was kept in.

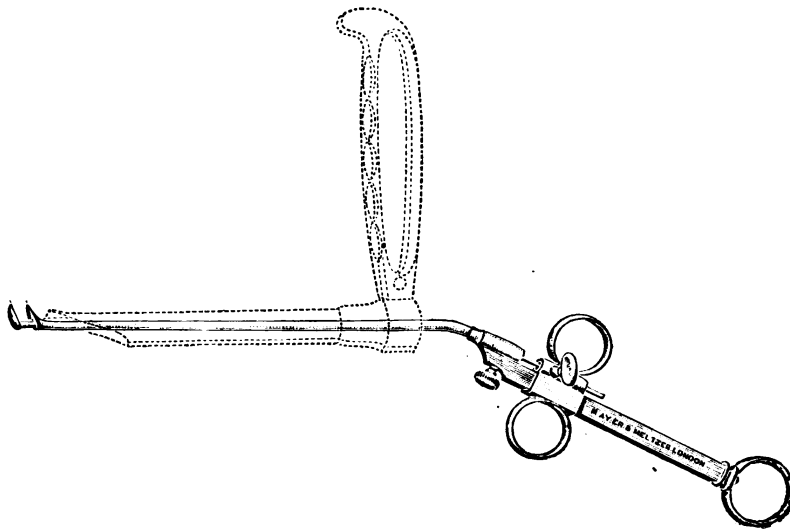
Mr. ROBINSON, in reply, said the operation was done on October 13 last, so he thought it had stood the test of time. The appliance was kept in for a fortnight.

LARYNGEAL FORCEPS FOR USE IN DIRECT LARYNGOSCOPY.

Shown by Dr. STCLAIR THOMSON. These forceps are made with several extremities, which can be attached to the one barrel. The handle is well out of the way and allows of clear vision.

FORCEPS FOR THE REMOVAL OF NEW GROWTHS AND THE EXTRACTION OF FOREIGN BODIES FROM THE LARYNX AND ADJACENT PARTS BY THE DIRECT METHOD.

Shown by Dr. JOBSON HORNE. The instrument is constructed on the rod and cannula principle, the blades closing by traction and not by a joint. It is intended for use, as shown in the drawing, through a tubular spatula. The shaft is placed at an angle to the



handle. The blades are also placed at an angle to the rod, and are made sharp, blunt, or serrated, to meet the requirements of the case, whether it be a growth or a foreign body to be removed, some operators preferring blunt before sharp instruments for removing laryngeal growths of a pedunculated nature. The cannula can be rotated and fixed in any position. The advantages claimed for the forceps are :

(1) That it occupies the minimum amount of space within the tubular spatula and the field of operation ; the line of vision is not obstructed by the instrument used.

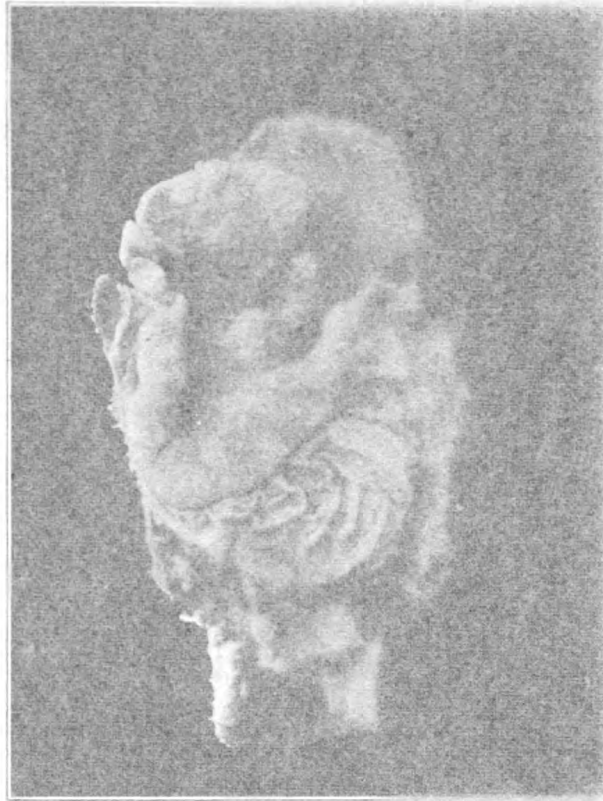
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I. EPITHELIOMA OF THE LARYNX.

Photograph of the posterior aspect of a larynx removed by complete laryngectomy.

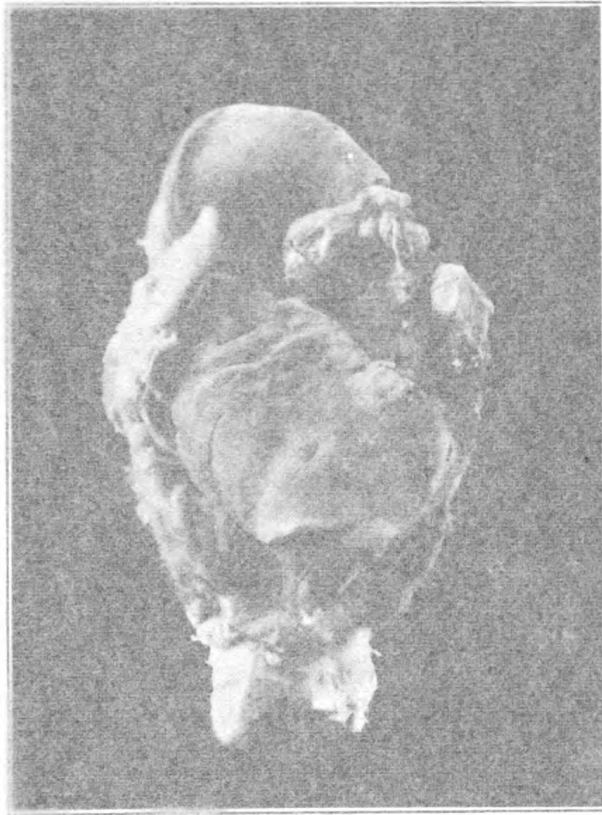
To illustrate a communication to the Laryngological Society of London,
June 7, 1907, by Dr. JOBSON HORNE.



II. EPITHELIOMA OF THE LARYNX

Photograph of the anterior aspect of a larynx after laryngectomy

To illustrate a communication to the Association of Surgeons, June 7, 1907, by J. B. ...



EPI-
PITHELIOMA OF THE LARYNX.

Fig. 1. Posterior aspect of a larynx removed by complete laryngectomy.

Communicated to the Laryngological Society of London, June 7, 1907, by Dr. JOHNSON HORNE.



II. EPITHELIOMA OF THE LARYNX.

Photograph of the posterior aspect of a larynx removed by complete laryngectomy.

To illustrate a communication to the Laryngological Society of London,
June 7, 1907, by Dr. JOBSON HORNE.

THE
JOHN GREER
LIBRARY

(2) The closing of the blades, by traction gets rid of the "kick" occasioned by a forceps closing on the hinge or joint principle.

(3) The small spoon-shaped blades, by being placed at an angle instead of in the same straight line, can be insinuated by the side of foreign bodies and into all parts of the larynx. This is particularly advantageous in removing growths from the anterior commissure and recesses of the ventricles.

The instrument has been made for me by Messrs. Mayer and Meltzer, of Great Portland Street, London.

Dr. PATERSON thought the forceps exhibited were exceedingly useful. There was one used by Edmund Meyer, of Berlin, which closely resembled that shown by Dr. StClair Thomson, and he himself had used it from time to time. On the whole he found his own forceps very adaptable, and, perhaps, more powerful than either of those shown that day.

EPITHELIOMA OF THE LARYNX.

Dr. JOBSON HORNE exhibited two macroscopic specimens of epithelioma of the larynx from patients who had undergone complete laryngectomy. For the specimens he was indebted to Mr. F. G. Harvey, who, as members of the Society knew, was one of the pioneers in the further development of the operation. The operations were performed by Mr. Harvey, at the Throat Hospital, Golden Square, as far back as 1901. In one case the patient was known to be living twelve months after the operation, whilst, in the other case, the patient, after recovering from the operation, died within that period of time. Some account of the first case will be found in the series of cases reported by Mr. Harvey to the *Lancet* in 1901. Dr. Jobson Horne exhibited the preparations—which showed the larynx in each case entire, and the colouring preserved by the formalin method—as instructive pathological specimens illustrating the stage of the disease in which complete laryngectomy is the only operation admissible.

A CASE OF NÆVUS OF THE TONGUE.

Shown by Mr. STUART-LOW. He said that he had shown this case because it was unusual to find such a large nævus of the tongue in such a young patient. The girl was now twelve years of age, and being an orphan, had been in the same institution since she was three years old. The nævus was situated on the right side of the tongue on the anterior third; it was now the size of a florin, but at the age of three it was only as large as a bean.

It was said to have grown rapidly during the last year. Mr. Stuart-Low proposed to incise the whole growth with scissors, and stitch the cut surfaces.

Dr. DAVIS thought electrolysis would cure it.

A CASE OF CHRONIC FRONTAL SINUS DISEASE.

Shown by Mr. STUART-LOW. He said that this young woman was operated upon by him one month ago that day for chronic frontal sinus disease. The disease had existed for quite seven years, and during the past year she had suffered severely from frontal headache and had had much nasal discharge. Having opened the sinus it was discovered to be quite full of mucous polypi, and the partition between the two sides having been partially removed, the opposite sinus was found in a similar condition. It was found necessary to remove a considerable portion of the anterior bony wall of the sinus, and to obviate the deformity usual after this from falling in of the soft structure, Mr. Stuart-Low had inserted a thin, perforated, silver plate over the opening in the bone. The wound was douched with fresh lamb's blood serum, as explained in an article in the *Lancet* on May 7, 1907, which seemed to facilitate the healing process, and a protective shield worn to avoid bandage pressure. The wound healed by first intention, and the silver plate had remained in position well and so prevented any blemish from sinking in of the skin. The patient was only four days in the hospital, and now expressed herself as free from pain and offensive nasal discharge.

TUMOUR OF THE PHARYNGO-GLOSSUS, NOT MALIGNANT; POSSIBLY OF THE NATURE OF A DERMOID OR ACCESSORY THYROID.

Shown by Dr. DUNDAS GRANT. A female patient, aged twenty-three, complains of difficulty of speaking and swallowing which has been marked for one year, although it had been gradually developing for about five years. Her voice has the characteristic thickness associated with pharyngeal obstruction. The pharyngeal portion of the tongue is almost entirely occupied by a rounded swelling of comparatively smooth surface and red tint, and with vascular ramifications under the mucous membrane. It is elastic to the feel as if cystic in nature and there are no enlarged glands. It has not been punctured or incised. It is more probably thyroid than dermoid in view of its projection into the pharynx instead of into the sub-maxillary region. The exhibitor considers it non-

malignant and hopes to be able to extirpate it through the mouth, but will be guided by the degree of accessibility as attained under an anæsthetic.

Mr. CRESSWELL BABER said it reminded him of a case which he showed some time ago, of thyroid tumour at the base of the tongue (*Proceedings of this Society*, vol. ii, p. 1). In his case the tumour was about the size of a walnut, and it was removed with the galvano-cautery snare. It also occurred in a young woman.

Mr. WESTMACOTT said it appeared to be of the nature of a retention cyst in the thyro-glossal duct. Ten years ago he went through all the recorded cases of that character, but in none of the cases which he looked up was there any dermoid tissue found in the thyro-glossal duct of His.

SOFTENING GUMMA ON EXTERNAL SURFACE OF LEFT ALA NASI.

Shown by Mr. HERBERT TILLEY. Patient is a male, aged twenty-five, who had syphilis five years ago. The left side of the nose has increased in size during the past four weeks and produced considerable external deformity. At the present moment almost the whole extent of the left side of the nose is occupied by a red, cedematous, semi-fluctuating, tender swelling the size of half a walnut. No intra-nasal swelling can be seen in the left nasal cavity, neither is the septum deflected to the right in its upper portions. The patient has been put on full doses of iodide of potash.

ANNUAL MEETING

Held Friday, June 7, 1907, at 4 p.m., at 20, Hanover Square.

J. B. BALL, M.D., President, in the Chair.

HENRY J. DAVIS, M.B., }
W. JOBSON HORNE, M.D., } Hon. Secretaries.

The minutes of the last Annual Meeting were read and confirmed.
The Report of the Council was then read and unanimously adopted.

REPORT OF THE COUNCIL FOR THE YEAR ENDING JUNE 7, 1907.

The session now closing has been one of unusual prosperity. The important and instructive communications made to the Society have been almost too numerous to permit of all receiving the attentions they deserved.

The meetings have been well attended—the average attendance of 38 being above that of previous years, if not the largest on record. We have been honoured by many distinguished visitors from amongst our foreign and British *confrères*.

We deeply regret to record the loss to the Society, through death, of Mr. R. W. Stewart, for some years its treasurer, Dr. Willcocks, a vice-president, and Dr. G. Schorstein.

During the past session one honorary and nine ordinary members have been elected.

Congratulatory addresses were forwarded by the Society to Professor Frañkel, of Berlin, and Professor Schroötter, of Vienna, on the occasion of their respective celebrations, and it has given pleasure to learn of the gratification these addresses afforded to the recipients.

The Council has given full consideration to matters connected with the amalgamation scheme, and, in conjunction with the Council of the British Laryngological, Rhinological, and Otological Association, it has arranged the details to the satisfaction of all concerned.

Since the foundation of the Society in February, 1893, 115 ordinary meetings have been held. The number of original members was 45. The Society now consists of 151 ordinary members and 12 honorary members.

It has contributed to medical literature a series of *Transactions*, which will be ever of value to those engaged in the study and research of medical science.

The Society, full of vigour and increasing strength, now ceases to exist as the Laryngological Society of London, in accordance with a resolution which will be submitted to you to-day. In its place the Section of Laryngology of the Royal Society of Medicine will be formed. We hope, and we fully expect, that the Section of Laryngology will carry on the traditions of this Society, and that under the new conditions we shall flourish and prosper even more than in the past.

The Honorary Treasurer's Report was read and unanimously adopted.

BALANCE SHEET.—SESSION 1906-7.

DR.	£ s. d.	CR.	£ s. d.
Balance, June, 1906	83 18 2	Rent	42 0 0
Subscriptions, 1904-5	2 2 0	Electric Lighting (Garcia Celebration)	1 10 0
" 1905-6	29 8 0	Reporting	20 8 6
" 1906-7	137 11 4	Indexing Reports	2 0 0
Entrance Fees	11 11 0	Bale and Danielsson	3 3 0
Sale of <i>Transactions</i>	1 8 6	Pulman	1 16 0
Interest on Deposit	6 1 6	Adlard	73 10 11
		Typewriting	2 8 4
		Library Supply Co.	0 2 4
		Annual Dinner	7 14 0
		Baker—Microscopes	0 17 0
		Martindale	0 12 0
		Rogers	0 13 6
		Methylated spirit	0 1 6
		Mathew (porter)	2 0 0
		Porter's Xmas Boxes	2 0 0
		Secretaries' Expenses	3 10 0
		Treasurer's Expenses	1 7 8
		Bank Charges	1 1 6
		Balance	105 4 3
	<u>£272 0 6</u>		<u>£272 0 6</u>
			£ s. d.
		Amount on Deposit at Bank	150 0 0
		Balance at Bank	105 4 3
		Total to Society's credit	<u>£255 4 3</u>

June, 1907.

H. BETHAM ROBINSON, *Hon. Treasurer.*

The Honorary Librarian's Report was unanimously adopted.

LIBRARIAN'S REPORT.

During the past year our Library has been made fair use of, and most of our exchanges have been maintained. Having a good stock of back numbers I have been able to meet several applications for our *Proceedings*. One gentleman in Paris bought a complete set of four volumes, and I have been able to hand over to the Treasurer a cheque for £1 8s. 6d., as a result of sales effected.

I might remind members that we possess a complete card index, and also a complete set of bound volumes of the *Transactions*.

During the past year the following donations have been made to the Library:

Presented by Dr. F. de Havilland Hall.

1. Krankheits und Behandlungslehre der Nasen-, Mund- und Rachenhöhle sowie des Kehlkopfes und der Luftröhre, von Maximilian Bresgen. 2te Aufl. Wien und Leipzig, 1891.
2. Die Heilbarkeit der Larynxphthise und ihre chirurgische Behandlung, von Theodor Heryng. Stuttgart, 1887.
3. Studies from the Saranac Laboratory for the Study of Tuberculosis. (E. L. Trudeau, M.D., Director.) Boston, 1900-1904.
4. Herr Grossmann und die Frage der Posticuslähmung, von Sir Felix Semon. (Sonder-Abdruck aus dem Archiv für Laryngologie, 6 Bd., 3 Heft.) Berlin, 1897.
5. Étiologie et traitement de certains troubles vocaux. (Extrait de La Parole, No. 5, 1899.) Par Paul Olivier. Paris, 1899.
6. Épistaxis spontanées (a répétition). Relation de cinq cas. (Extrait de La Parole, No. 8, 1899.) Par Marcel Natier. Paris, 1899.
7. Sulle vegetazioni adenoidi in generale e più particolarmente sui loro rapporti colle otopatie. (Estratto dalla Clinica Moderna, Anno X, n° 4, 5, 6, 7. Per Vittorio Grazi. Firenze, 1904.
8. Sputum Examination in Pulmonary Tuberculosis and its Prognostic Value. (Repr. from the Montreal Medical Journal, October, 1901.) By Lawrason Brown.
9. Über Nasensteine im Anschluss an zwei neue Fälle. Inaugural-Dissertation, von Max Seeligmann. Karlsruhe, 1892.
10. Corps étrangers des bronches et bronchoscopie. Par E. J. Moure. Bordeaux, 1906.
11. An Analysis of Fifteen Hundred Cases of Tuberculosis discharged from the Adirondack Cottage Sanatorium from Two to Eighteen Years Ago. (Repr. from the Journal of the American Medical Association, Nov. 21, 1903.) By Lawrason Brown. Chicago, 1903.
12. Autopsy of the Larynx and the Trachea. (Examination without laryngeal mirror.) By Alfred Kirstein.
13. Third Annual Report of the Reception Cottage, Saranac Lake, New York. April, 1904.

Presented by the Author.

14. De behandeling der secundaire ontsteking van het oor-labyrinth. (Overgedrukt nit het Nederl. Tijdschrift voor Geneeskunde, 1906, Tweede Helfte, No. 3.) Door H. Burger.
15. Een kunstmatige dermoidkyste. (Overgedrukt nit het Nederl. Tijdschrift voor Geneeskunde, 1906, Tweede Helfte, No. 4.) Door H. Burger.
16. De kwakzalverij in de oorheekunde. (Overdruk nit het gedenkboek, nitgegeven ter gelegenheid van het vijf-en-twintigjarig bestaan der vereeniging tegen de kwakzalverij.) Door H. Burger.

Presented by H. Burger.

17. Nederlandsche Keel- Nous- en Oorheekundige Vereeniging, Jaarvergadering, Zaterdag, 28, en Zondag, 29 October, 1905, in het Physiologisch Laboratorium te Utrecht.

Presented by the Society.

18. Nederlandse Geselschaft für Hals-, Nasen- und Ohrenheilkunde. XIV Versammlung in Utrecht am 28 und 29 Oktober, 1905, im Physiologischen Laboratorium. (Aus der Monatsschr. für Ohrenheilkunde, 1906, Heft 6.)

The Honorary Curator's Report was read and unanimously adopted.

CURATOR'S REPORT.

Our thanks are due to the members whose names are to be found in the following list, for some forty odd microscopical sections that have been contributed to the collection since my last report in January, 1906. Of those in the supplementary catalogue, I hope many will find their way into that referring to our Proceedings by being exhibited with their clinical histories next session. The majority of the new sections are of unusual interest, but there are a few that are of so much importance that I propose to call special attention to them.

In the *nose and accessory cavities* class we have a good example of the peculiar spiral and knotted threads found in a mucous polypus, and shown by Dr. Hugo Löwy, and a very instructive specimen of lupus of the triangular cartilage, including the cartilage and sub-mucous tissues contributed by Dr. Furniss Potter. The bleeding polypus collection has been augmented by five additional specimens, viz., from Dr. W. H. Kelson, Dr. Hugo Löwy, Dr. Lambert Lack, Mr. C. A. Parker, and myself (exclusive of Dr. H. B. Robinson's, included in the supplement last year). In the *naso-pharynx* section, we have examples of Dr. Fitzgerald Powell's lymphoid tissue mass with giant-cell formation, and a very typical endothelioma of Mr. Stuart-Low's. In the *oro-pharynx* class there are three allied specimens of the peculiar infiltration of that region (as seen in the *uvula*) described by Sir Felix Semon, one contributed by himself, and two by Dr. Brown Kelly; we also have the two sections from a case of spheroidal cell carcinoma respectively before and after *neoformans* inoculation, shown by Dr. Scanes Spicer. The *larynx* collection is enriched by two examples of keratosis of the vocal cords, from Dr. Logan Turner and Dr. Scanes Spicer, the one completing the histological picture and confirming the diagnosis of the other. In conclusion, I may express a hope that the new phase which we are about to enter will not interrupt the expansion of this magnificent collection. It is a lasting record of the histology of numbers of cases that have passed from observation, and a safe harbour for otherwise scattered specimens in danger of destruction.

A. CATALOGUE REFERRING TO *Proceedings*.

I. *Nose and Accessory Cavities.*

1. Bleeding Polypus of Septum (Vascular type of Fibro-angioma), Dr. H. B. Robinson, March, 1906, vol. xiii, p. 68.
2. Bleeding Polypus of Inferior Meatus, March, 1906, vol. xiii, p. 72, Dr. W. H. Kelson and Dr. Pegler.
3. Lupus (Tuberculoma) of Septum, including Basal Cartilage, February, 1907, vol. xiv, p. 43, Dr. Furniss Potter.
4. Nasal Polypus, exhibiting Spiral Mucous Threads, March, 1907, vol. xiv, p. 55.

II. *Naso-pharynx.*

1. Angeio-fibroma, January, 1906, vol. xiii, p. 40, Dr. E. A. Peters.
2. Squamous (Malpighian) Cell Carcinoma, February, 1906, vol. xiii, p. 51, Mr. Stuart Low,

3. Lymphoid Tissue Tumour with Giant Cell Formation, May, 1907, vol. xiv, p. 91, Dr. Fitzgerald Powell.
4. The same case stained for tubercle bacilli.
5. Polypoid growth from same case.

III. Mouth, Tongue, Palate.

1. Lardaceous-looking, variable Infiltration of Uvula, February, 1903, vol. x, p. 11, Sir Felix Semon.
2. Sclerotic Hyperplasia of Uvula, December, 1905, vol. xiii, p. 20, Dr. A. Brown Kelly.
3. Papilloma of Uvula, December, 1905, vol. xiii, p. 22, Dr. E. A. Peters.
4. Hyperplastic Congenital Syphilis of Uvula, March, 1906, vol. xiii, p. 68, Dr. A. Brown Kelly.
5. Endothelioma of Soft Palate, February, 1907, vol. 14, p. 44, Mr. Stuart Low.

IV. Pharynx.

1. Squamous Cell Carcinoma, April, 1906, vol. xiii, p. 88, Mr. H. W. Carson.
2. Spheroidal Cell Carcinoma ("Hunt"), June, 1906, vol. xiii, p. 105, Dr. Scanes Spicer.
3. Spheroidal Cell Carcinoma, same case after injection with bacterial vaccine of *Micrococcus neoformans*, November, 1906, vol. xiv, p. 8, Dr. Scanes Spicer.
4. Squamous Cell Carcinoma, May, 1907, vol. xiv, p. 94, Dr. Dundas Grant.

V. Larynx.

1. Multiple Papilloma of Larynx ("Howard"), November, 1905, vol. xiii, p. 12, Dr. Scanes Spicer.
2. Keratosis of Vocal Cords (Dr. Scanes Spicer), February, 1906, vol. xiii, p. 50.
3. Keratosis of Larynx, April, 1906, vol. xiii, p. 82, Dr. Logan Turner.
4. Squamous Cell Carcinoma in Arytænoid Region, April, 1906, vol. xiii, p. 88, Mr. H. W. Carson.
5. Carcinoma of Arytænoid Region, November and December, 1906, vol. xiv, pp. 11 and 26, and January, 1907, vol. xiv, p. 36, Dr. Watson Williams and Dr. Scanes Spicer.
6. Squamous Cell (Scirrhus) Carcinoma of Vocal Cords, May, 1907, vol. xiv, p. 95, Dr. Lambert Lack.

B. SUPPLEMENTARY CATALOGUE.

I. Nose and Accessory Cavities.

1. Inflammatory Growth from Middle Turbinate, Dr. Wm. Milligan.
2. Inflammatory Growth from Septum, Dr. Wm. Milligan.
3. Cyst of Middle Turbinate, Dr. Lambert Lack.
4. Early Stage of Atrophic Rhinitis, Dr. Lambert Lack.
5. Bleeding Polypus of Septum (Cellular Type of Fibro-angioma), Dr. Hugo Löwy.
6. Bleeding Polypus of Septum (similar type to No. 5), Dr. Pegler.
7. Bleeding Polypus of Septum (Angeio-fibroma Type), Mr. C. A. Parker.
8. Bleeding Polypus of Septum (Edematous Fibro-angioma type), Dr. Lambert Lack.
9. Squamous Cell Carcinoma (Polypoid Growth) of Nose and Maxillary Antrum, Dr. Wyatt Wingrave.
10. Squamous Cell Carcinoma (Polypoid Growth), Dr. Pegler.

II. Naso-Pharynx.

1. Naso-pharyngeal Mucous Polypus, Dr. Scanes Spicer.

III. Mouth, Tongue, and Palate.

1. Lymphangioma of Lower Lip. Dr. Pegler.

IV. *Pharynx.*

1. Polypoid Fibroma of Anterior Pillar, Dr. Alfred Brown.
2. Squamous Cell Carcinoma of Anterior Pillar with Giant Cells, Dr. E. A. Peters.

V. *Larynx.*

1. Squamous (Prickle) Cell Carcinoma of Vocal Cords from Case of Thyrotomy, Dr. Pegler.
2. Myxomatous Fibroma of Vocal Cord, Dr. G. A. Cathcart.
3. Interarytænoid Hypertrophy, Dr. Lambert Lack.

SPECIAL MEETING.

A Special Meeting of the Society was held immediately after the Annual Meeting, for the purpose of submitting the following Resolutions, which were unanimously adopted :

1. *Resolved* : " That, in pursuance of the decision of this Society to unite with other Societies in forming the Royal Society of Medicine, which has now been granted a Royal Charter from His Majesty the King, all the property of every kind whatsoever of this Society be and is hereby transferred to the Royal Society of Medicine, and the Treasurer is hereby directed forthwith to transfer to the Royal Society of Medicine all sums of money in his possession, standing in his name, or at the credit of the Society at its bank."
2. *Resolved* : " That the Laryngological Society of London be discontinued, and is hereby dissolved."

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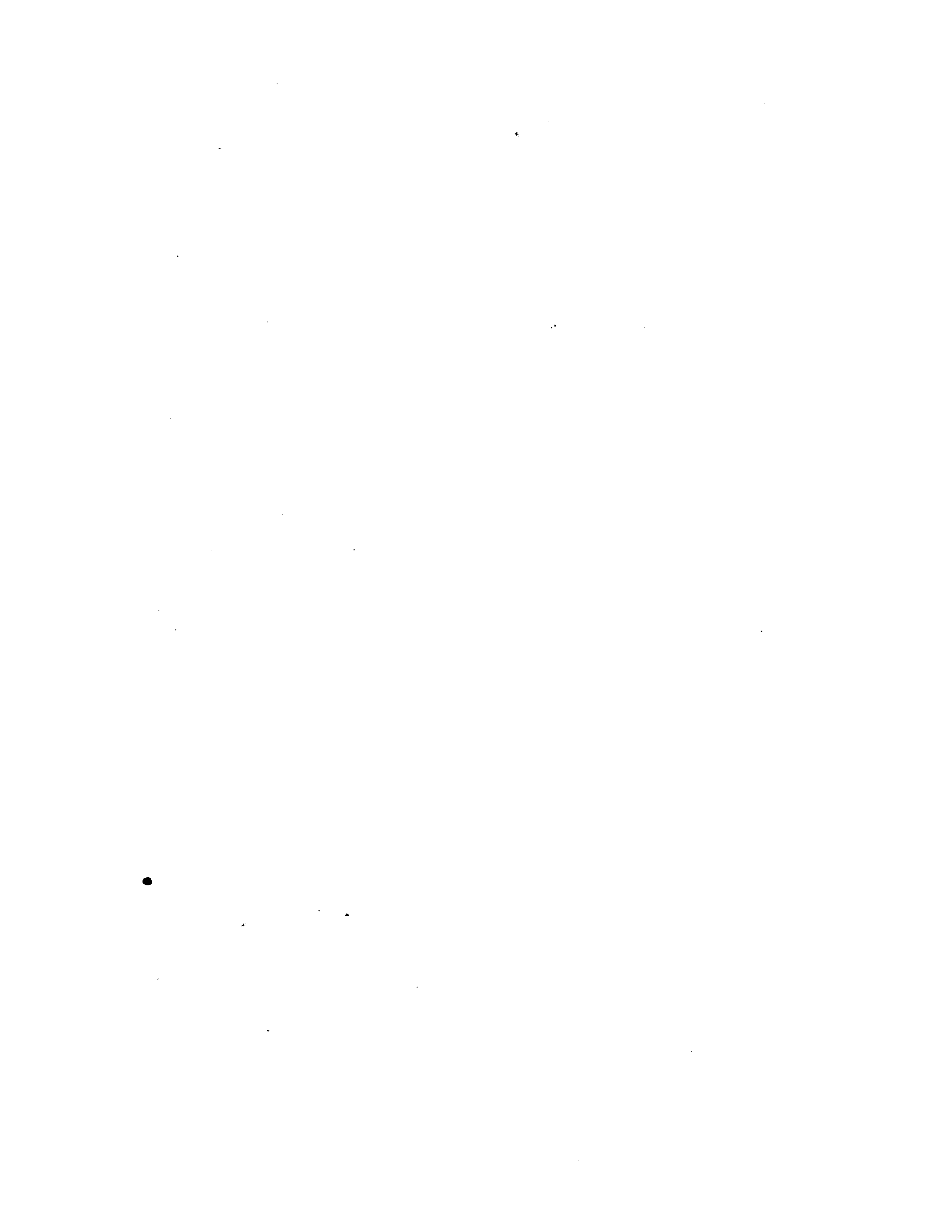
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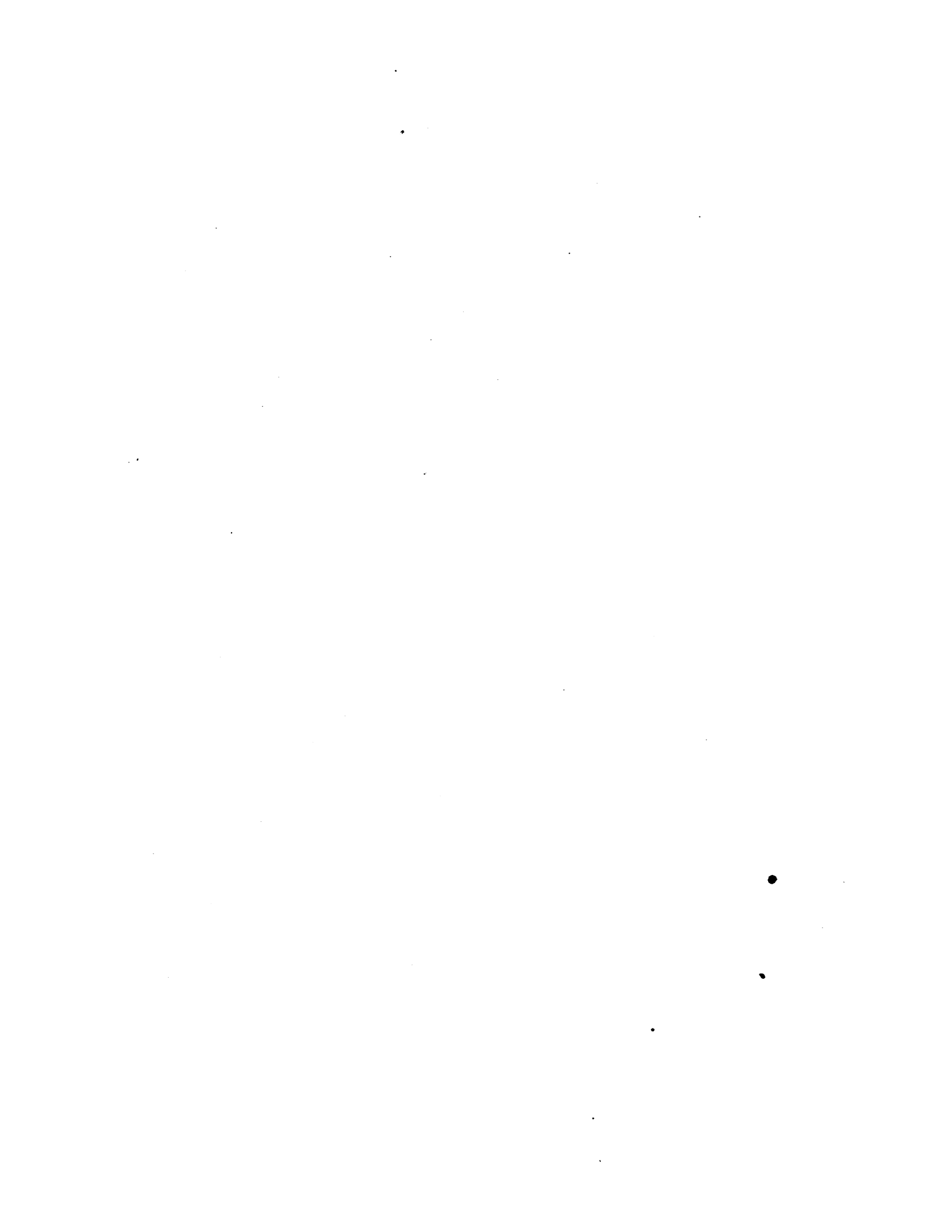
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