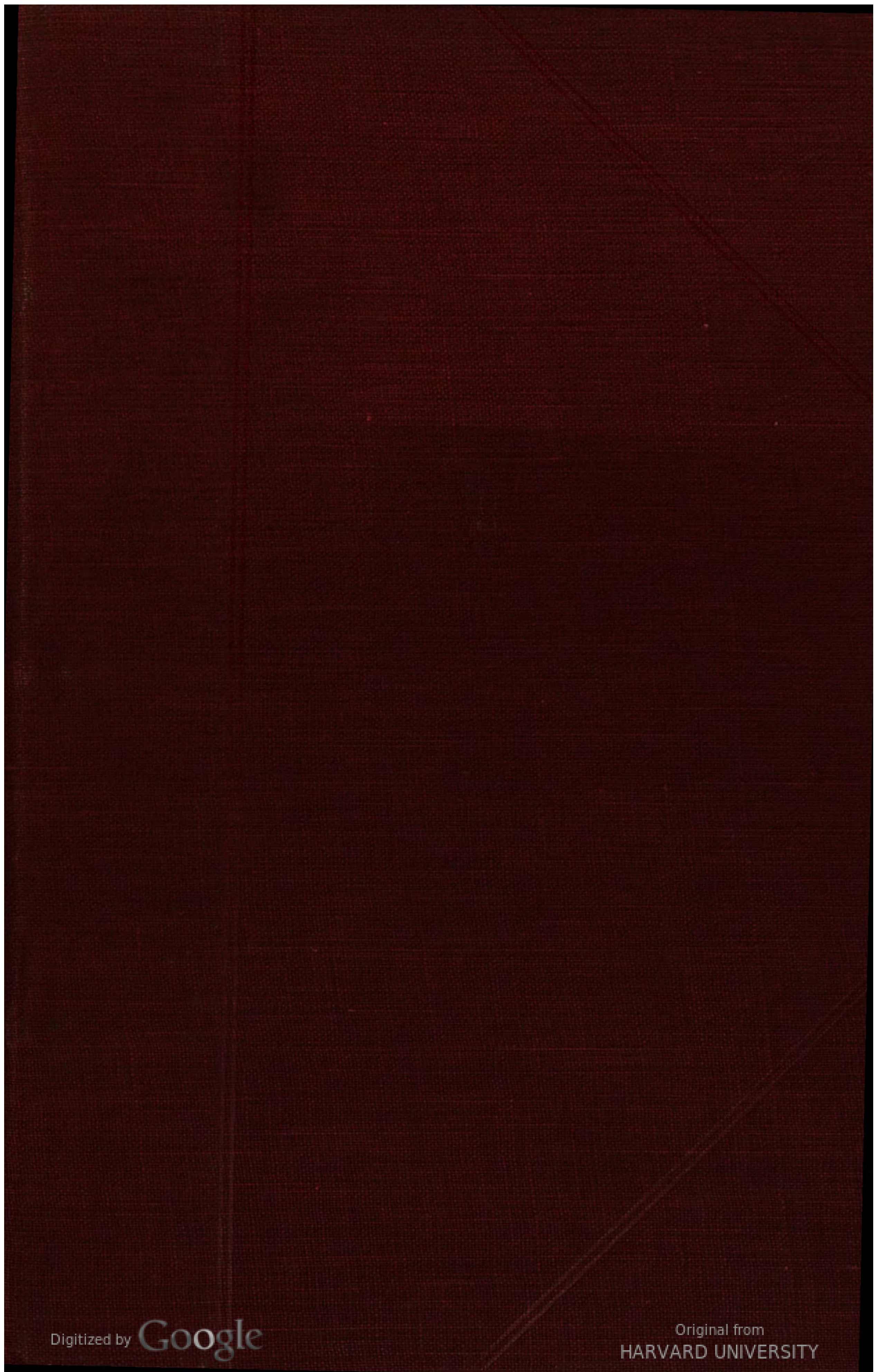
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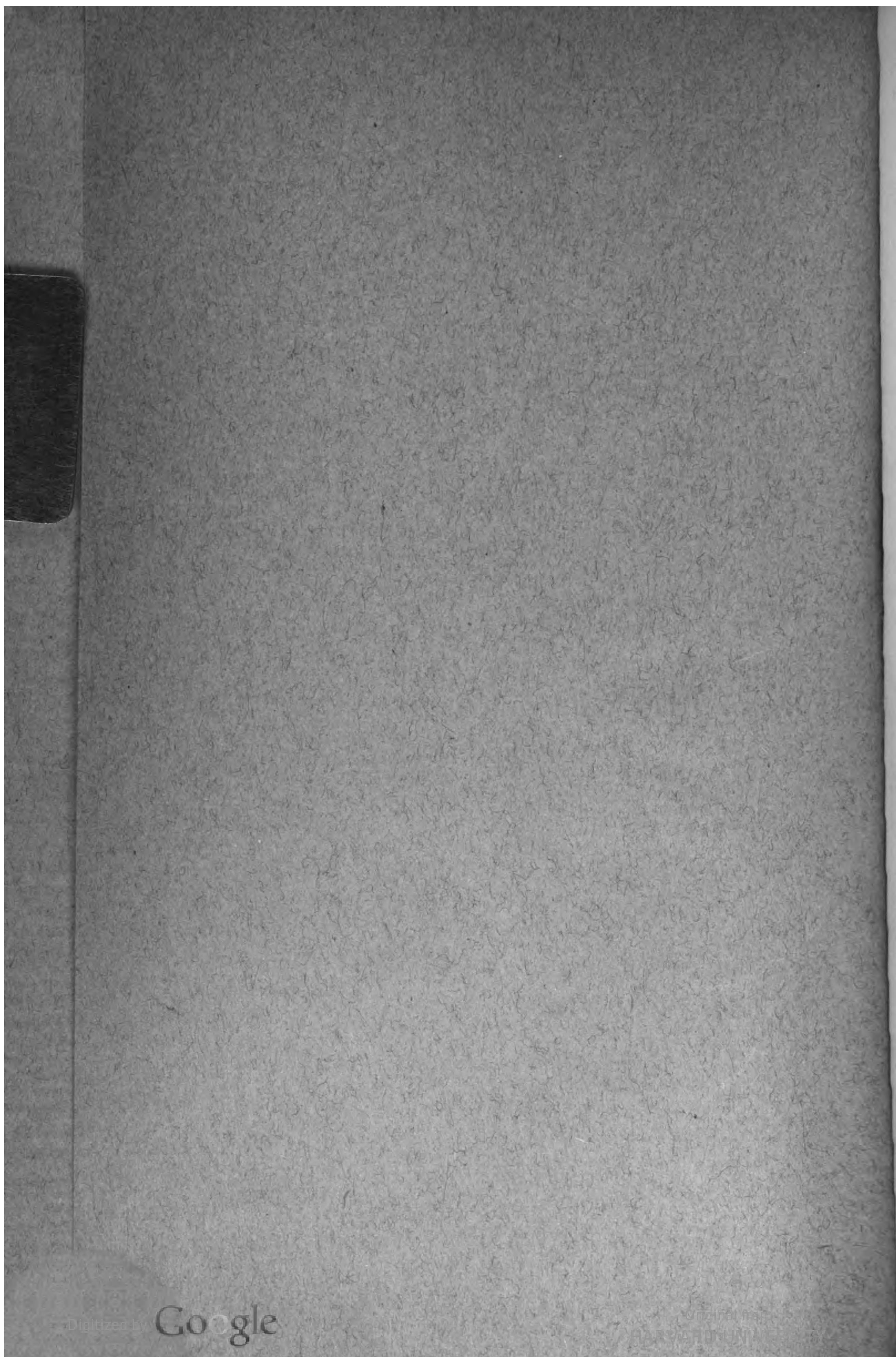

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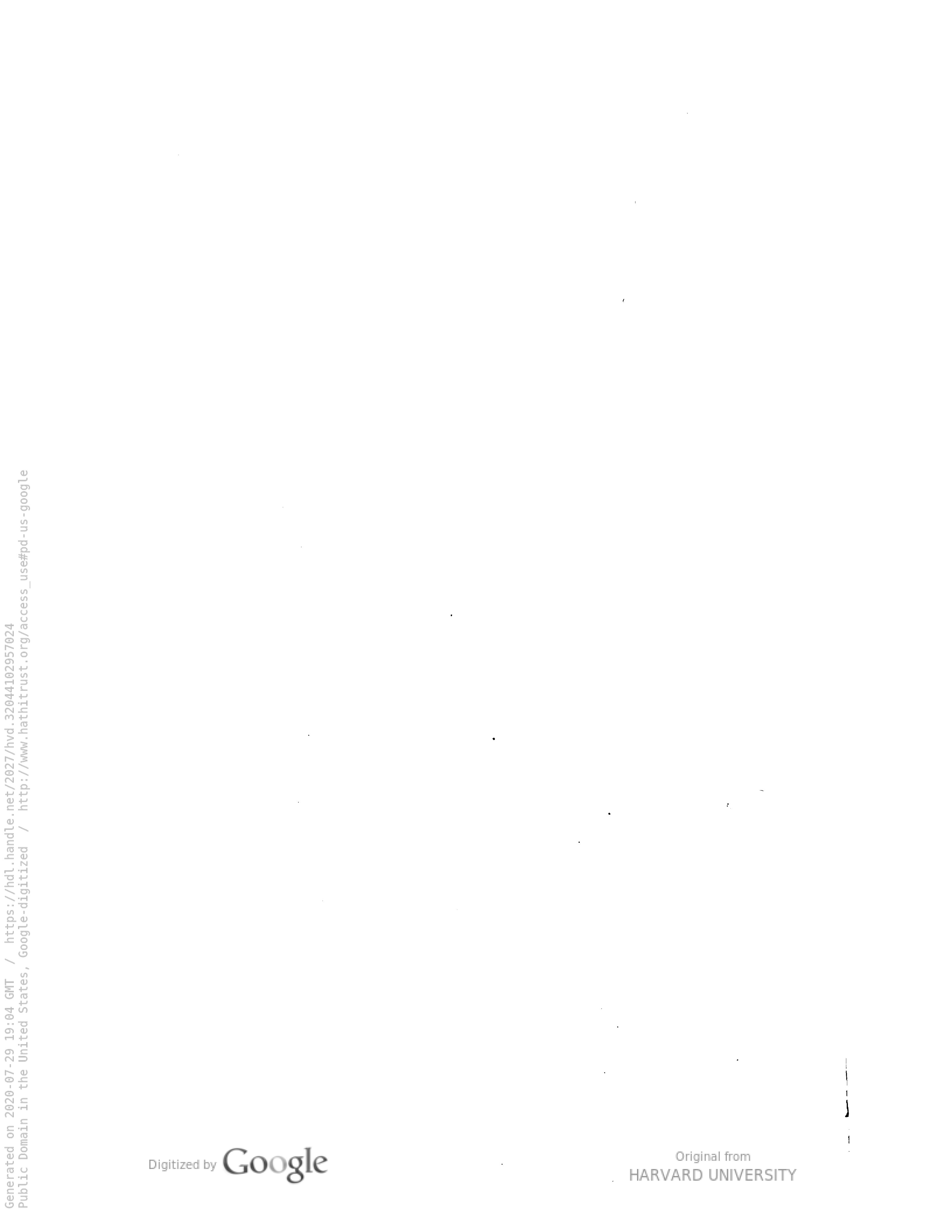
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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY

OF

LONDON.

24403

VOL. IV.

1896—97.

WITH

LISTS OF OFFICERS, MEMBERS, ETC.

LONDON:
PRINTED BY ADLARD AND SON,
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1897.

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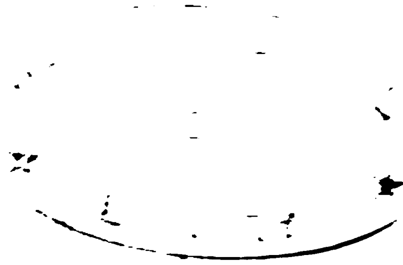

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OFFICERS AND COUNCIL

OF THE

Laryngological Society of London

ELECTED AT

THE ANNUAL GENERAL MEETING,

JANUARY 13TH, 1897.

President.

H. TRENTHAM BUTLIN, F.R.C.S.

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PRESIDENTS OF THE SOCIETY.

(*From its Formation.*)

ELECTED	
1893	Sir George Johnson, M.D., F.R.S.
1894	Sir Felix Semon, M.D., F.R.C.P.
1895	Sir Felix Semon, M.D., F.R.C.P.
1896	Sir Felix Semon, M.D., F.R.C.P.
1897	H. Trentham Butlin, F.R.C.S.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *November* 11*th*, 1896.

FELIX SEMON, M.D., F.R.C.P., President, in the Chair.

W. R. H. STEWART, F.R.C.S., } Secretaries.
STCLAIR THOMSON, M.D., }

Present—37 members and 5 visitors.

Before the ordinary business of the meeting the President alluded in feeling terms to the death of Sir George Johnson, the Society's first President.

The minutes of the previous meeting were read and confirmed.

Dr. Douglas D. Macrae, of Montreal, Canada, was elected a Member of the Society.

The following gentlemen were proposed for election at the next Ordinary Meeting:

Mr. ATWOOD THORNE, M.R.C.S., L.R.C.P., 10, Nottingham Place, W.
Mr. MORLEY AGAR, M.R.C.S., L.R.C.P., 11, Wimpole Street, W.

A SPECIMEN OF THE LARYNX OF THE SOLAN GOOSE AND OF THE CORMORANT.

Shown by DR. FELIX SEMON. The interesting feature about them consisted in the fact that the larynx of both these birds is practically divided into two lateral halves by a thin triangular spur, which originates from the median line of the inner surface of what would correspond in man to the thyroid cartilage, and which touches a corresponding very considerable thickening of the middle part of the inner surface of what would correspond in man to the cricoid car-

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tilage. The front spur is apparently membranous, almost transparent, and of a dark colour; the cricoid thickening represents a mere increase of the substance of the cartilage itself.

One of the first to draw attention to these curious formations was Alexander von Humboldt ('Observations de zoologie,' 1811, though the paper was already written in 1803). The arrangement occurs in various classes of birds; mostly, however, in diving birds. Its physiological purpose is difficult to determine; it might be hypothetically suggested that it is intended to give greater power of resistance to the larynx in the action of diving from a considerable height (as in the Solan goose) or during the act of voracious feeding on very large fishes.

Mr. Stewart, the Conservator of the Hunterian Museum, states that in the penguin the trachea is double throughout.

The President also showed two photographs sent to him by Dr. Max Scheier, of Berlin, illustrating the progress recently made in the employment of the Röntgen rays in laryngology and rhinology. One of them represents a larynx, the outlines of which can be much more clearly distinguished than in any previous skiagraphs known to the demonstrator, while in the other one a foreign body is seen in the antrum, and the frontal sinus is most clearly delineated.

Specimen of Epithelioma of Larynx and Œsophagus following Tubercle and Syphilis.

Shown by Dr. Clifford Beale. The patient was exhibited at the November meeting of the Society in 1893, suffering from stenosis of the larynx, the result of syphilitic laryngitis ('Proceedings,' vol. i, p. 35). Until the latter months of 1895 he had remained free from any fresh symptoms. Indefinite thickening about the larynx then began to be noticed, with some amount of dysphagia in swallowing fluids, but nothing fresh could be detected with the laryngoscope. The thickening gradually increased, and evidently involved the deeper tissues of the neck. Part of the swelling on the right side of the neck became soft and semi-fluctuating, and was incised, a large amount of caseous material being exposed and scraped away, with marked relief to the patient. The swelling on the left side increased, and breaking down on the surface, a fungating growth appeared which was proved by the microscope to be epithelio-

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matous. The patient rapidly failed and died, but until the last week of his life he was able to take solid food with but little inconvenience, and could make himself heard in a hoarse whisper when the tracheotomy tube was closed. The specimen showed that the whole of the upper part of the œsophagus was converted into a cancerous ulcer which had invaded (if it had not originated in) the larynx and destroyed all parts of it except the epiglottis. Calcareous nodules were found in the lungs, and one of the testes was found to be scarred and fibrous.

Case of Arrested Development in a Child.

Shown by Dr. Bond. F. F—, a child 8 years old this month, was brought to Dr. Bond on September 15th. She was only 2 feet 11¾ inches in height, about the size of an average child of 2½ years; her weight was 32¾ lbs.; she was pale, and the pupils large; her speech was so indistinct it could not be understood. She was brought on account of a large swelling in front of neck, which was a greatly enlarged thyroid gland going down to sternum in mid-line; and at sides the gland was greatly enlarged. The thymus was not enlarged. The liver was greatly enlarged, reaching to umbilicus, and the abdominal veins were distended. The face was not unusually large; the tongue did not protrude. The child was accustomed to sit for hours without speaking; would sometimes try to speak, and then could not say what she wished. She knew her letters.

The child was born in the Old Kent Road; was said to have had rickets when young; she cut her first teeth at eighteen months; and could not walk until four years old.

The child has for two months been treated with thyroid extract (thyroidin tabellæ), during which time she has grown 2 inches, *i.e.* ¼ of an inch a week; has got to speak much more distinctly, and has broken out occasionally into laughter, dancing, and singing. The child's movements are altogether brisker, and her aspect brighter. The liver is markedly less, and also the swelling in neck.

The President asked Dr. Bond what he considered the nature of the swelling in the neck.

Dr. Bond, in reply, thought it was an enlarged thyroid, and the case was one of sporadic cretinism complicated with rickets.

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Case of Sarcoma of Nose after Operation on June 12th last.

Shown by Dr. Bond. It is now some five years since this man first had a sarcomatous growth in nose. He was shown to the Society in May last with the left nose in front filled with a fungating, vascular mass of sarcoma attached to the floor, septum, and lower part of outer wall in front.

The operation—performed at Golden Square—consisted in laying the nose open along the left side at junction with cheek, and turning it over to right side of face. The part of septum with growth on it was removed and the floor down to the bone. The site of growth was curetted, and burnt with a Paquelin's cautery. After this the nose was replaced *in situ* and fixed with stitches. The patient made a rapid recovery with trifling deformity. There is at present no sign of growth in nose.

Sections were shown.

Mr. Bowlby remarked that the growth did not seem to be a typical sarcoma. In some respects it closely resembled epithelioma.

Angeioma of Nasal Septum. Case and Microscopical Section.

Shown by Dr. Bond. The patient, a man of 30, in January, 1896, came to Golden Square complaining of great epistaxis from the left nose in front. Dr. Bond found this to be due to a soft vascular polypus, springing from left side of the cartilaginous septum, and about half an inch in diameter. This was removed, but in July had recurred, and was removed again by Dr. Lack. On October 17th the patient returned, stating that for a fortnight he had had severe bleeding of the nose twice a day. The growth was removed by the cold snare, and the site curetted and then burnt with the galvano-cautery. Such cases are very uncommon, and three have been described by Dr. Natier, of Paris, under the title of "Polype saignant de la cloison."

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Mucocele of the Frontal Sinus; Radical Operation; Recovery.

Shown by Mr. Cresswell Baber. The patient, a woman of 52, came to the Brighton Throat and Ear Hospital in October, 1895, suffering with severe left frontal pain, which commenced in the previous May after a severe cold.

At the age of nine she received a severe blow on the nose, and between ten and twelve had scarlatina and measles. In July, 1895, fœtid discharge from the left nostril, and prominence of the left eyeball, were first noticed. When first seen, in October, 1895, these symptoms were well marked, and as the left antrum appeared opaque by trans-illumination, that cavity was punctured by Grimwald's method, but no pus was found. A portion of the enlarged left middle turbinate was subsequently removed, but without relief, and in November the left frontal sinus was opened with the trephine, and was found to contain a quantity of clear viscid mucus and cholesterine crystals. A month later, mucus was still flowing from the frontal fistula, and a communication into the nose was established, working from above downwards with the drill and chisel. A drain-tube was passed through this passage. This failed to form a satisfactory outlet for the discharge, which became purulent, and in June, 1896, the radical operation for the obliteration of the frontal sinus was undertaken. The whole of the anterior bony wall of the sinus, with the exception of a ridge one eighth of an inch in height at the lower border, was removed. The much thickened mucous membrane was cleared away, except that portion overlying a gap in the bony floor of the size of a sixpence, which had permitted bulging into the orbit, and the consequent proptosis. The skin and periosteum were stitched over the cavity, and a drain inserted. In July healing was complete, and at the present time (November) the patient is free from all frontal symptoms, a slight and not very noticeable depression remaining.

Fœtid nasal discharge is still present, due doubtless to disease of the ethmoidal cells, which probably in the first instance gave rise to the blocking of the duct, and the formation of the mucocele of the frontal sinus.

Dr. Bond thought that an operation causing less deformity might possibly have been sufficient, seeing that the case was one of mucocele.

Dr. J. B. Ball noticed that the supra-orbital nerve had been

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[illegible] anaesthesia of the supra-orbital region. He wished to know if this was a necessary part of the operation.

Mr. [illegible] said that in his case no communication from the frontal sinus into the nose could be made with a probe. After an opening had been drilled into the nose the discharge from the sinus became purulent and an attempt to allow the opening in the forehead to close had to be abandoned owing to accumulation of pus in the sinus. He did not see how division of the supra-orbital nerve could be avoided in the radical operation.

Case of Hæmatoma of the Palate (?).

Shown by Dr. E. Law. Patient consulted Dr. Edward Law on [illegible] at her doctor's recommendation on account of "severe pain on the left of the mouth and throat, difficulty and pain in swallowing, swelling and tenderness behind and below angle of the jaw on the left side." Patient stated that whilst eating toast on the previous evening something suddenly broke in her mouth, and she immediately ejected a large clot of peculiar-looking blood, and afterwards nearly a cupful of bright scarlet blood and saliva. She did not cough or vomit, and before the occurrence had absolutely no pain, soreness, discomfort, or feeling of fulness in the mouth or throat. The tonsils had been removed seven years ago after blood-poisoning.

On examination there was seen a large evacuated sac of a blister extending over the left side of the hard and soft palate, almost pear-shaped with the broad end forwards (patient described it as the shape of a pigeon's liver), and giving the aspect of vesication after a burn. An ecchymotic appearance was caused by a number of minute red points beneath the loosened epithelium, and there was increased redness for some distance around. Epiglottis hyperæmic, other portions of mucous membrane of the oro-pharynx normal. Under pastilles of aristol and cocaine, and suitable diet, patient improved greatly.

Sarcoma of Right Tonsil.

Dr. Herbert Tilley showed a man æt. 72, who applied to him at the London Throat Hospital complaining of thickness of speech of three weeks' duration. There was no pain. On examining the throat a large swelling was seen on the right side extending upwards into the soft palate, making it assume an almost vertical position, trans-

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versely almost to the left tonsil, and downwards as far as the finger could reach when the mouth was opened as widely as possible. It was also impossible to pass a catheter more than three inches backwards in the right nostril. A small gland could be felt externally under the angle of the right ramus. The inner surface (which was free from ulceration) gave a distinct sense of fluctuation, but on inserting a bistoury in three places for two inches of its length only free hæmorrhage occurred, and a week afterwards a foul serous discharge came from these punctures when they were pressed on.

Some members considered the swelling inflammatory, but most agreed it was a sarcoma, and Mr. Walsham thought it ought to be left alone.

Case of Syphilitic Laryngitis.

Shown by Dr. H. Tilley. A man æt. 45, whose case was cited at first as tubercular, but Dr. Tilley thought on further examination that it was probably syphilitic. He complained of hoarseness on admission to hospital, but difficulty of inspiration supervened, and was a marked feature of the case at the meeting. Laryngoscopic examination showed œdema of arytænoids, especially the right side. There was marked thickening of the right vocal cord and vocal process, and complete loss of mobility, the cord reaching almost to the middle line. The left vocal cord was apparently normal, but there was marked abductor paralysis.

The President remarked that it probably would turn out to be malignant, and thought he could make out a subglottic swelling. Tracheotomy was advised.

Dr. Beale mentioned that he showed a precisely similar case some two years ago, viz. a case of syphilitic disease in a man with identical laryngoscopic appearances, and which eventually showed malignant degeneration, the post-mortem specimen of which Dr. Beale showed to the meeting.

Mr. Spencer advised immediate tracheotomy and plucking away the growth for microscopic examination. The patient by wearing the tube would be prepared for a radical operation.

Dropping of Cerebro-spinal Fluid from One Side of the Nose.

Shown by Dr. StClair Thomson. The patient was a single woman æt. 23. Two and a half years ago she gradually became aware of an

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Multiple Papillomata of Larynx.

Shown by Dr. Willcocks. Charles L—, æt. 8 years, was admitted into the Evelina Hospital on May 19th, 1896, suffering from considerable dyspnœa and aphonia; scattered patches of broncho-pneumonia in the lungs, with marked indrawing of the lower ribs, were present. Numerous papillomata in the larynx were detected. These are chiefly situated on the cords and on the inter-arytænoid space. They are small, senile bodies, distinctly mammillated, and varying in size from a pin's head to a split pea. No attempt at removal was made while the boy was in the Evelina Hospital, beyond palliative inhalations and treatment of the broncho-pneumonia.

The boy was transferred to Charing Cross Hospital in July, and after consultation with the anæsthetists, Dr. Hewitt and Mr. Gardner, it was decided that an attempt should be made at removal of the growths *per vias naturales*, under chloroform.

Many of the papillomata were removed with Mackenzie's forceps at various times. The curette and forcible brushing were also employed to a slight extent. The boy had no unpleasant symptoms on any occasion after the operations, and his breathing has been considerably improved, but his voice has never properly returned.

Within the last month the growths have commenced to recur; without, however, producing any serious dyspnœa. The voice is hardly audible, and reduced to a whisper.

The case is shown to the Society with a view of eliciting from members their opinions and advice as to the best plan of treatment to be adopted for the future.

(1) Should the growths be removed after thyrotomy?

(2) Should a preliminary tracheotomy be performed and the papillomata removed as before by the mouth, or allowed to atrophy?

(3) Should the plan already adopted be continued—the growths to be removed under chloroform, by forceps, &c., as occasion demands?

Mr. Bellamy Gardner, who gave the anæsthetic, said that he was much assisted by using Hewitt's gag.

The President would not advise thyrotomy in these cases, as it does not prevent recurrence.

Dr. Bond saw no reason why anæsthesia should be again required in treating this case. In even younger children by the use of a tongue depressor put far back, or by using the left forefinger as a

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guide, it was without training easy to remove masses of these growths. In tiny children he advocated tracheotomy, the removal of all post-nasal growths, and not much meddling. In older children careful training, and the removal under cocaine of all growths seen with the mirror, was to be recommended.

Mr. SPENCER would agree that tracheotomy should be done when necessary, and the papillomata removed; the cricoid ring might have to be divided, but certainly not the thyroid.

TWO CASES OF LARYNGEAL CANCER: (1) SPHEROIDAL-CELLED CARCINOMA OF THE VOCAL CORD; (2) PERICHONDRAL SARCOMA OF THE CRICOID CARTILAGE.

Shown by Mr. W. G. SPENCER. These two cases of malignant disease, otherwise widely differing, had one condition in common—the mucous membrane in both was intact, and therefore there was an absence of those symptoms which are caused by ulceration.

CASE 1. *Spheroidal-celled carcinoma of the vocal cord.*—Ten weeks previous to the removal of the growth, the patient, a healthy man æt. 70 came complaining of hoarseness, which he had noticed for the first time three months before. The growth must, therefore, have existed for at least six months before the operation. I found that the left vocal cord was partly fixed, adduction was completely absent, but there was still some abduction in deep inspiration. The cord itself was clearly visible, and slightly red. I could detect nothing else abnormal neither in the larynx nor in the chest. He had had one attack of gonorrhœa forty years before, but nothing more.

Iodide of potassium and mercury were given for six weeks, but in the meantime the disease slowly advanced. The vocal cord became absolutely fixed in abduction, and its outline and colour indistinguishable from the neighbouring mucous membrane. A swelling formed in it, which extended forwards to the middle line, whilst the epiglottis was drawn a little backwards on that side, so that a complete view could only be obtained during deep inspiration. The hoarseness increased, but no fresh symptoms of any kind appeared. No glandular enlargement could at any time be detected.

The patient was kindly seen by Dr. de Havilland Hall, and by Dr. Semon, who concurred with my diagnosis of cancer, and the tumour was excised. Upon thyrotomy and retraction of the alæ, the tumour was seen occupying the position of the left vocal cord. It was

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the size of a horse-bean, hard to the touch, partly attached to the cartilage, and its covering like the mucous membrane around it. It reached to the middle line in front, but not quite back to the arytænoid cartilage. The growth was removed by a wide incision which included the ventricular band, the ventricle, part of the arytænoid cartilage, and the anterior third of the opposite vocal cord. It had to be separated from the cartilage by a raspatory, after which the exposed cartilage was well rubbed with pure carbolic acid. Recovery took place without incident, leaving the patient with a good hoarse voice.

The material removed is exhibited, and it can be seen that there has been no ulceration. A microscopic section made by Dr. Hebb from the deeper part of the tumour shows clumps of small spheroidal epithelial cells, infiltrated by leucocytes, and surrounded by dense fibrous tissue.

The growth may be compared with the slow-growing carcinomata of the skin, in some of which a tumour forms in the deep layers of the skin previous to any ulceration.

Case 2. *Perichondral sarcoma of the cricoid cartilage.*—A single woman, æt. 43, was admitted under Dr. de Havilland Hall for dyspnœa, seven weeks before the excision. She had been well until two months previously, so that there is evidence of the existence of the disease for four months before its removal. She had worked as a paper colourer in hot air and steam, and had had many attacks of tonsillitis. Dr. Hall found that the dyspnœa was due to subglottic obstruction, thickened masses projecting below the vocal cords without impairing the action of the larynx, which was unaltered. There was no swelling to be made out in the neck. The dyspnœa got slowly worse, so that a month after admission she was partly cyanosed and was unable to lie down and sleep. Dr. Hall and I then agreed that tracheotomy had become necessary, which I forthwith did. As soon as we could we again thoroughly examined her, and found the lumen of the tube just below the glottis blocked by bulging mucous membrane, growing especially on the right side; and in the neck on the right side, enlarged glands could now be felt. I thereupon enlarged the tracheotomy wound, and inspected the disease directly. The interior of the cricoid ring was occupied by new growth covered by mucous membrane of normal appearance and free from all ulceration. Whilst the head was hanging down I plucked away the projecting

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The operation—performed at Golden Square—consisted in laying the nose open along the left side at junction with cheek, and turning it over to right side of face. The part of septum with growth on it was removed and the floor down to the bone. The site of growth was curetted, and burnt with a Paquelin's cautery. After this the nose was replaced *in situ* and fixed with stitches. The patient made a rapid recovery with trifling deformity. There is at present no sign of growth in nose.

Sections were shown.

Mr. Bowlby remarked that the growth did not seem to be a typical sarcoma. In some respects it closely resembled epithelioma.

Angeioma of Nasal Septum. Case and Microscopical Section.

Shown by Dr. Bond. The patient, a man of 30, in January, 1896, came to Golden Square complaining of great epistaxis from the left nose in front. Dr. Bond found this to be due to a soft vascular polypus, springing from left side of the cartilaginous septum, and about half an inch in diameter. This was removed, but in July had recurred, and was removed again by Dr. Lack. On October 17th the patient returned, stating that for a fortnight he had had severe bleeding of the nose twice a day. The growth was removed by the cold snare, and the site curetted and then burnt with the galvano-cautery. Such cases are very uncommon, and three have been described by Dr. Natier, of Paris, under the title of "Polype saignant de la cloison."

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MUCOCELE OF THE FRONTAL SINUS; RADICAL OPERATION; RECOVERY.

Shown by Mr. CRESSWELL BABER. The patient, a woman of 52, came to the Brighton Throat and Ear Hospital in October, 1895, suffering with severe left frontal pain, which commenced in the previous May after a severe cold.

At the age of nine she received a severe blow on the nose, and between ten and twelve had scarlatina and measles. In July, 1895, fœtid discharge from the left nostril, and prominence of the left eyeball, were first noticed. When first seen, in October, 1895, these symptoms were well marked, and as the left antrum appeared opaque by trans-illumination, that cavity was punctured by Grimwald's method, but no pus was found. A portion of the enlarged left middle turbinate was subsequently removed, but without relief, and in November the left frontal sinus was opened with the trephine, and was found to contain a quantity of clear viscid mucus and cholesterine crystals. A month later, mucus was still flowing from the frontal fistula, and a communication into the nose was established, working from above downwards with the drill and chisel. A drain-tube was passed through this passage. This failed to form a satisfactory outlet for the discharge, which became purulent, and in June, 1896, the radical operation for the obliteration of the frontal sinus was undertaken. The whole of the anterior bony wall of the sinus, with the exception of a ridge one eighth of an inch in height at the lower border, was removed. The much thickened mucous membrane was cleared away, except that portion overlying a gap in the bony floor of the size of a sixpence, which had permitted bulging into the orbit, and the consequent proptosis. The skin and periosteum were stitched over the cavity, and a drain inserted. In July healing was complete, and at the present time (November) the patient is free from all frontal symptoms, a slight and not very noticeable depression remaining.

Fœtid nasal discharge is still present, due doubtless to disease of the ethmoidal cells, which probably in the first instance gave rise to the blocking of the duct, and the formation of the mucocele of the frontal sinus.

Dr. BOND thought that an operation causing less deformity might possibly have been sufficient, seeing that the case was one of mucocele.

Dr. J. B. BALL noticed that the supra-orbital nerve had been

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divided, producing anæsthesia of the supra-orbital region. He wished to know if this was a necessary part of the operation.

Mr. C. BABER said that in his case no communication from the frontal sinus into the nose could be made with a probe. After an opening had been drilled into the nose the discharge from the sinus became purulent, and an attempt to allow the opening in the forehead to close, had to be abandoned owing to accumulation of pus in the sinus. He did not see how division of the supra-orbital nerve could be avoided in the radical operation.

CASE OF HÆMATOMA OF THE PALATE (?).

Shown by Dr. E. LAW. Patient consulted Dr. Edward Law on October 28th at her doctor's recommendation on account of "severe pain on the left of the mouth and throat, difficulty and pain in swallowing, swelling and tenderness behind and below angle of the jaw on the left side." Patient stated that whilst eating toast on the previous evening something suddenly broke in her mouth, and she immediately ejected a large clot of peculiar-looking blood, and afterwards nearly a cupful of bright scarlet blood and saliva. She did not cough or vomit, and before the occurrence had absolutely no pain, soreness, discomfort, or feeling of fulness in the mouth or throat. The tonsils had been removed seven years ago after blood-poisoning.

On examination there was seen a large evacuated sac of a blister extending over the left side of the hard and soft palate, almost pear-shaped with the broad end forwards (patient described it as the shape of a pigeon's liver), and giving the aspect of vesication after a burn. An ecchymotic appearance was caused by a number of minute red points beneath the loosened epithelium, and there was increased redness for some distance around. Epiglottis hyperæmic, other portions of mucous membrane of the oro-pharynx normal. Under pastilles of aristol and cocaine, and suitable diet, patient improved greatly.

SARCOMA OF RIGHT TONSIL.

Dr. HERBERT TILLEY showed a man æt. 72, who applied to him at the London Throat Hospital complaining of thickness of speech of three weeks' duration. There was no pain. On examining the throat a large swelling was seen on the right side extending upwards into the soft palate, making it assume an almost vertical position, trans-

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versely almost to the left tonsil, and downwards as far as the finger could reach when the mouth was opened as widely as possible. It was also impossible to pass a catheter more than three inches backwards in the right nostril. A small gland could be felt externally under the angle of the right ramus. The inner surface (which was free from ulceration) gave a distinct sense of fluctuation, but on inserting a bistoury in three places for two inches of its length only free hæmorrhage occurred, and a week afterwards a foul serous discharge came from these punctures when they were pressed on.

Some members considered the swelling inflammatory, but most agreed it was a sarcoma, and Mr. Walsham thought it ought to be left alone.

Case of Syphilitic Laryngitis.

Shown by Dr. H. Tilley. A man æt. 45, whose case was cited at first as tubercular, but Dr. Tilley thought on further examination that it was probably syphilitic. He complained of hoarseness on admission to hospital, but difficulty of inspiration supervened, and was a marked feature of the case at the meeting. Laryngoscopic examination showed œdema of arytænoids, especially the right side. There was marked thickening of the right vocal cord and vocal process, and complete loss of mobility, the cord reaching almost to the middle line. The left vocal cord was apparently normal, but there was marked abductor paralysis.

The President remarked that it probably would turn out to be malignant, and thought he could make out a subglottic swelling. Tracheotomy was advised.

Dr. Beale mentioned that he showed a precisely similar case some two years ago, viz. a case of syphilitic disease in a man with identical laryngoscopic appearances, and which eventually showed malignant degeneration, the post-mortem specimen of which Dr. Beale showed to the meeting.

Mr. Spencer advised immediate tracheotomy and plucking away the growth for microscopic examination. The patient by wearing the tube would be prepared for a radical operation.

Dropping of Cerebro-spinal Fluid from One Side of the Nose.

Shown by Dr. StClair Thomson. The patient was a single woman æt. 23. Two and a half years ago she gradually became aware of an

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increasing tendency to drip from the left nostril. This would occasionally stop for a week or a month at a time, but since Christmas, 1895, it has been continuous day and night. As a rule the fluid runs forwards, causing her to continually hold a handkerchief in her hand to prevent it from dropping from her nose. If her head is inclined backwards the liquid runs into the back of her throat, and she swallows it. By inclining her head forwards about half a drachm was collected in five minutes, which was shown to the Society. It was seen to be perfectly clean, like water, and free from odour. On two occasions it had been analysed by Dr. Hewlett, the Pathologist of the Throat Hospital, and his conclusions were that in its reactions it resembles cerebro-spinal fluid rather than nasal mucus.

The patient had been subject to headaches ever since childhood; these were always relieved when the dripping of fluid set in, and since the flow had become continuous they have been only slight and occasional. The examination of the nasal and accessory cavities was negative. Her sense of smell is unaffected, and the fluid is free from disagreeable taste or odour. There is no history of accident, nor of fits at any time, and she has otherwise been considered healthy. She only applies now for advice because of the discomfort of the continual running from her nose.

Referring to previous publications of somewhat similar conditions, Dr. Thomson was inclined to think that many of them had really been cases of escape of cerebro-spinal fluid *viâ* the nose, and had been wrongly attributed to local nasal conditions. In most of them, as in this case, brain symptoms were present, and there appeared to be a distinct connection between the headaches or other cerebral symptoms, and the cessation of the flow of fluid. Another noteworthy point was that in a large number of similar conditions, atrophy of the optic disc was present. In the present case there was neither optic atrophy nor optic neuritis, and the examination of the eyes showed them to be quite normal. This interesting case had occurred at the Throat Hospital in the clinic of Dr. Bond, to whom Dr. Thomson wished to express his indebtedness for kindly permitting him to investigate and exhibit it.

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Multiple Papillomata of Larynx.

Shown by Dr. Willcocks. Charles L—, æt. 8 years, was admitted into the Evelina Hospital on May 19th, 1896, suffering from considerable dyspnœa and aphonia; scattered patches of broncho-pneumonia in the lungs, with marked indrawing of the lower ribs, were present. Numerous papillomata in the larynx were detected. These are chiefly situated on the cords and on the inter-arytænoid space. They are small, senile bodies, distinctly mammillated, and varying in size from a pin's head to a split pea. No attempt at removal was made while the boy was in the Evelina Hospital, beyond palliative inhalations and treatment of the broncho-pneumonia.

The boy was transferred to Charing Cross Hospital in July, and after consultation with the anæsthetists, Dr. Hewitt and Mr. Gardner, it was decided that an attempt should be made at removal of the growths *per vias naturales*, under chloroform.

Many of the papillomata were removed with Mackenzie's forceps at various times. The curette and forcible brushing were also employed to a slight extent. The boy had no unpleasant symptoms on any occasion after the operations, and his breathing has been considerably improved, but his voice has never properly returned.

Within the last month the growths have commenced to recur; without, however, producing any serious dyspnœa. The voice is hardly audible, and reduced to a whisper.

The case is shown to the Society with a view of eliciting from members their opinions and advice as to the best plan of treatment to be adopted for the future.

(1) Should the growths be removed after thyrotomy?

(2) Should a preliminary tracheotomy be performed and the papillomata removed as before by the mouth, or allowed to atrophy?

(3) Should the plan already adopted be continued—the growths to be removed under chloroform, by forceps, &c., as occasion demands?

Mr. Bellamy Gardner, who gave the anæsthetic, said that he was much assisted by using Hewitt's gag.

The President would not advise thyrotomy in these cases, as it does not prevent recurrence.

Dr. Bond saw no reason why anæsthesia should be again required in treating this case. In even younger children by the use of a tongue depressor put far back, or by using the left forefinger as a

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guide, it was without training easy to remove masses of these growths. In tiny children he advocated tracheotomy, the removal of all post-nasal growths, and not much meddling. In older children careful training, and the removal under cocaine of all growths seen with the mirror, was to be recommended.

Mr. SPENCER would agree that tracheotomy should be done when necessary, and the papillomata removed; the cricoid ring might have to be divided, but certainly not the thyroid.

TWO CASES OF LARYNGEAL CANCER: (1) SPHEROIDAL-CELLED CARCINOMA OF THE VOCAL CORD; (2) PERICHONDRAL SARCOMA OF THE CRICOID CARTILAGE.

Shown by Mr. W. G. SPENCER. These two cases of malignant disease, otherwise widely differing, had one condition in common—the mucous membrane in both was intact, and therefore there was an absence of those symptoms which are caused by ulceration.

CASE 1. *Spheroidal-celled carcinoma of the vocal cord.*—Ten weeks previous to the removal of the growth, the patient, a healthy man æt. 70 came complaining of hoarseness, which he had noticed for the first time three months before. The growth must, therefore, have existed for at least six months before the operation. I found that the left vocal cord was partly fixed, adduction was completely absent, but there was still some abduction in deep inspiration. The cord itself was clearly visible, and slightly red. I could detect nothing else abnormal neither in the larynx nor in the chest. He had had one attack of gonorrhœa forty years before, but nothing more.

Iodide of potassium and mercury were given for six weeks, but in the meantime the disease slowly advanced. The vocal cord became absolutely fixed in abduction, and its outline and colour indistinguishable from the neighbouring mucous membrane. A swelling formed in it, which extended forwards to the middle line, whilst the epiglottis was drawn a little backwards on that side, so that a complete view could only be obtained during deep inspiration. The hoarseness increased, but no fresh symptoms of any kind appeared. No glandular enlargement could at any time be detected.

The patient was kindly seen by Dr. de Havilland Hall, and by Dr. Semon, who concurred with my diagnosis of cancer, and the tumour was excised. Upon thyrotomy and retraction of the alæ, the tumour was seen occupying the position of the left vocal cord. It was

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the size of a horse-bean, hard to the touch, partly attached to the cartilage, and its covering like the mucous membrane around it. It reached to the middle line in front, but not quite back to the arytænoid cartilage. The growth was removed by a wide incision which included the ventricular band, the ventricle, part of the arytænoid cartilage, and the anterior third of the opposite vocal cord. It had to be separated from the cartilage by a raspatory, after which the exposed cartilage was well rubbed with pure carbolic acid. Recovery took place without incident, leaving the patient with a good hoarse voice.

The material removed is exhibited, and it can be seen that there has been no ulceration. A microscopic section made by Dr. Hebb from the deeper part of the tumour shows clumps of small spheroidal epithelial cells, infiltrated by leucocytes, and surrounded by dense fibrous tissue.

The growth may be compared with the slow-growing carcinomata of the skin, in some of which a tumour forms in the deep layers of the skin previous to any ulceration.

Case 2. *Perichondral sarcoma of the cricoid cartilage.*—A single woman, æt. 43, was admitted under Dr. de Havilland Hall for dyspnœa, seven weeks before the excision. She had been well until two months previously, so that there is evidence of the existence of the disease for four months before its removal. She had worked as a paper colourer in hot air and steam, and had had many attacks of tonsillitis. Dr. Hall found that the dyspnœa was due to subglottic obstruction, thickened masses projecting below the vocal cords without impairing the action of the larynx, which was unaltered. There was no swelling to be made out in the neck. The dyspnœa got slowly worse, so that a month after admission she was partly cyanosed and was unable to lie down and sleep. Dr. Hall and I then agreed that tracheotomy had become necessary, which I forthwith did. As soon as we could we again thoroughly examined her, and found the lumen of the tube just below the glottis blocked by bulging mucous membrane, growing especially on the right side; and in the neck on the right side, enlarged glands could now be felt. I thereupon enlarged the tracheotomy wound, and inspected the disease directly. The interior of the cricoid ring was occupied by new growth covered by mucous membrane of normal appearance and free from all ulceration. Whilst the head was hanging down I plucked away the projecting

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mass with punch forceps until the interior of the ring was clear. The patient was sent back to bed breathing freely through the larynx without a trachea tube. Dr. Hebb examined the pieces plucked away, and reported that they all consisted of sarcomatous new growth, and this diagnosis was confirmed by the rapid enlargement of the glands in the neck, and by the refilling of the cricoid ring with growth.

The larynx, the upper two rings of the trachea, and the enlarged glands were therefore removed through the one incision. No trachea tube was employed. The glands on the right side, five in number, the largest one inch and a half in diameter, were closely adherent to the internal jugular vein for the length of two inches, from which they were separated without wounding it. The trachea was cut across below the tracheotomy wound, to which the growth seemed to have extended. The lower end of the pharynx behind the cricoid was free from the growth, except a piece on the right. The wound was sewn up by stages, and has healed; the neck is quite soft and free from all enlarged glands; the patient can swallow well, and speaks in a good whisper. The only complication was a leakage through the upper end of the wound close to the hyoid bone, which formed when the stitches were taken out, but this has now practically closed.

The patient's work in hot steam, and the repeated attacks of tonsillitis, were in favour of the diagnosis of subglottic inflammation; on the other hand, the larynx was not affected. When we saw that the disease was not an inflammatory one, we thought that it might be an infiltrating thyroid adenoma; and on that hypothesis, combined with the wish for a microscopical examination, the masses filling up the cricoid ring were plucked away.

The larynx is exhibited as removed, except that the infiltrated glands and extrinsic muscles have been cleared off. The interior of the cricoid cartilage is partly filled by new growth, which is now ulcerated on the surface owing to the original growth having been plucked away shortly before. The posterior surface of the arytenoidei postici looks normal; the growth had not extended through them to the pharynx, nor paralysed the vocal cords by infiltrating the recurrent nerves. A microscopic section is also shown. The original growth and the glands removed all consist of the same material—round-celled sarcoma. It is plain that the disease originated beneath the mucous membrane lining the interior of the cricoid cartilage, and that excision of the larynx was the only possible treatment. The growth was

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evidently of a malignant type, and recurrence may be thought likely in spite of the wide removal of the disease and of the enlarged glands; yet there is perhaps more uncertainty about the prognosis in sarcoma than in carcinoma, which may afford some prospect of cure.

The President hoped Mr. Spencer would let the Society see the patients again. He thought both rare cases.

Mr. Bowlby suggested that the specimens should be referred to the Morbid Growths Committee.

Laryngeal Case for Diagnosis. ? Bilateral Malignant Disease.

Shown by Mr. E. C. Stabb. Female, æt. 56, married; large family of healthy children. No family history of malignant disease or phthisis. No history or evidence of syphilis. Loss of voice gradually increasing for twelve months, and slight difficulty of breathing for six months. No pain. On laryngoscopic examination six weeks ago, when she first came under observation at St. Thomas's Hospital, both ventricular bands were much swollen, and nearly touching in the mid-line. The surface was red and swollen, giving the appearance of bilateral malignant infiltration. No ulceration. True cords not seen, being hidden by the swellings above. Right side of larynx almost completely fixed; left side moved slightly on attempted phonation. No glandular enlargement to be detected. Chest normal.

Patient has been treated with increasing doses of iodide of potassium (up to gr. 30 t. d. s. during the last fortnight), but the condition has not altered perceptibly till to-day, when ulceration is present upon the mesial surface of each mass replacing the ventricular band.

Dr. W. Hill had a case of adeno-fibroma of larynx in an old gentleman that looked exactly like this one.

Mr. Bowlby thought it was a case of malignant disease.

Ulceration of the Mouth of Doubtful Origin.

Dr. Ball showed the case of S. M—, æt. 25, a sister of charity. She came under observation on July 21st, complaining of soreness of the mouth which had existed for eleven months. At the back part of the inner aspect of each cheek was an eroded patch, about three-quarters of an inch to an inch in diameter, with a reddish surface and

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an irregular, sinuous edge, formed by a thin line of detached macerated epithelium. The history was that the soreness began first on the right side, and about two months later the left side became sore. At times the places felt very sore, and it hurt her a good deal in eating. This generally lasted a week or so, and then they would feel better for a week or two. During the three or four months she has been under observation the patches have varied a little in size, being sometimes a little larger, sometimes a little smaller; otherwise there has been no change. Mouth-washes of borax, chlorate of potash, and boracic acid have been used, and the patches have been painted with chromic acid solution (10 grains to the ounce), and touched with nitrate of silver. Some affection of a herpetic or pemphigoid nature has been suggested. Nothing, however, of the nature of vesicles or bullæ have been observed. It is intended to try internal administration of arsenic. The patient's tongue exhibits, in a well-marked form, the ordinary features of the so-called geographical tongue. This condition of the tongue appears from the history to have existed since childhood.

The PRESIDENT had shown a similar case at the Clinical Society, when no definite diagnosis was given.

Mr. SPENCER suggested the possibility of slight scurvy from low diet.

Disease of the Tonsil, Soft Palate, Pharynx, and Larynx on the Left Side, Syphilitic in Appearance, occurring in the Course of Pulmonary Tuberculosis.

Dr. JOBSON HORNE showed this case. The patient, a married woman æt. 28, had suffered for four or five months with throat symptoms. The left tonsil was eaten out by a process that was still active, and attacking adjacent structures. There was paresis of the left half of the soft palate, which was intensely inflamed. Ulceration was spreading upwards and downwards on the posterior wall of the pharynx. The left half of the larynx was infiltrated, and the cord fixed. A purulent secretion trickled from the posterior nares, the right was completely obstructed (polypus), and the left partially so.

The points in the woman's history material to her case were these. She came from a tubercular stock,—she was herself tuberculous,—and she had bred a child that had died from tuberculosis. The thorax

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yielded signs of active tuberculosis in the right upper lobe. She had been married eleven years, and had had two children. Eighteen months since she had a miscarriage, and since then her hair had been falling out. During the past two years there had been a nearly constant cough, occasionally slight hæmoptyses, and the general health had deteriorated.

To say that the tonsillar condition was due to syphilis, Dr. Horne considered was not open to an absolute denial, but he thought that tuberculosis was mainly responsible for the laryngeal lesion. He showed the case in the hope that the diagnosis would be better defined before treatment was initiated.

Dr. Clifford Beale thought it was of a tubercular nature.

A Case of Malignant Disease of the Thyroid Gland.

Shown by Dr. Dundas Grant. The patient was a lady æt. 57, who for about two months had suffered from fulness in the throat and embarrassment in breathing, on exertion paroxysms of coughing, and for four weeks huskiness of voice. There was an intensely dense enlargement of the thyroid gland, especially the right lobe, which although it moved slightly in swallowing, did so in considerably less degree than the larynx. Behind each external mastoid there was an enlarged gland. The larynx was displaced considerably to the left.

Laryngoscopic examination showed both vocal cords to be normal in appearance and in movement, and the absence of any definite plugging of the walls of the trachea.

She had been under the exhibitor's observation about four weeks, during which time she had taken iodide of potassium, and applied Leiter's cold coil to the swelling. She thought she was slightly relieved by the use of the cold coil, but in reality there was no diminution in the size of the gland.

She has developed a very slight degree of tracheal stridor, and the enlargement of the lymphatic glands has become more marked, thus confirming the original diagnosis.

Mr. Bowlby had seen two cases like this. There was no doubt about the diagnosis. He considered an operation impossible.

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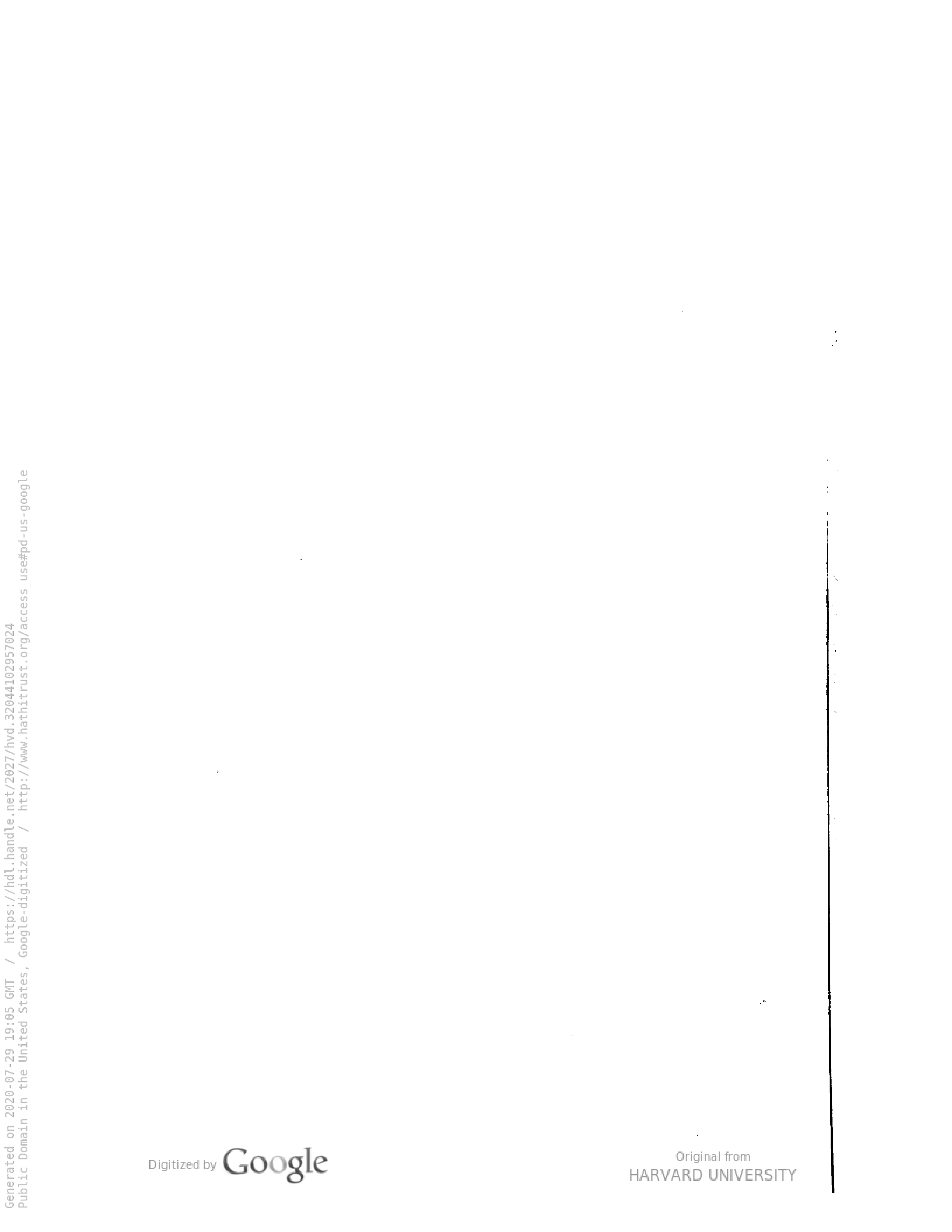
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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *December 9th*, 1896.

FELIX SEMON, M.D., F.R.C.P., President, in the Chair.

W. R. H. STEWART, F.R.C.S., } Secretaries.
STCLAIR THOMSON, M.D., }

Present—30 members and 8 visitors.

The minutes of the previous meeting were read and confirmed.

Mr. Morley Agar, 11, Wimpole Street, W., and Mr. Atwood Thorne, 10, Nottingham Place, W., were elected members of the Society.

Dr. W. Hill and Mr. Waggett were nominated as auditors.

SPECIMEN OF FATTY TUMOUR FROM EPIGLOTTIS.

Shown by Dr. P. MCBRIDE. M. W—, æt. 41, was first seen in July, 1887. About six months before the patient found that he made a peculiar sound in breathing. Eventually this symptom became troublesome when he lay down, and finally he began to have some difficulty in swallowing; there was no pain, but deglutition required a distinct effort, and was accompanied by an audible sound.

On examining the throat, a pale pink rounded tumour was seen behind the tongue. The laryngoscope and probe showed that it was attached to the epiglottis. A Jarvis snare with a bent shaft was passed over the mass and tightened. It was found that the cold wire could not be made to cut through the growth, so that the part seized had eventually to be cut off with scissors; the remainder of the

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tumour was removed by means of the galvano-caustic snare adjusted by the aid of the laryngoscope. The first portion of the growth removed was handed over to Dr. Alexander Bruce, who described it as a fibro-lipoma. The stump which was left had a broad attachment to the right valleculæ. At first the sloughing resulting from the electric cautery produced a bad taste in the mouth. These symptoms soon yielded to the use of a boracic gargle. On the 26th December, 1887, the condition of parts was as follows:—" Only a rounded fulness filling up right vallecula and evidently attached to the epiglottis and adjacent part of the tongue." On the 3rd December, 1888, the patient was again brought, and the tumour had not only recurred, but reached a size equal to that it had attained when first seen. The second recurrence was removed by means of the galvano-caustic snare while traction was made on the tumour with forceps; this had the effect of enucleating the mass ('Transactions of Edinburgh Med.-Chir. Soc.,' 1888).

After this immunity was enjoyed for eight years, subsequent to which uneasy breathing and choky feelings seem to have been noticed. Six or eight months ago he began to have a difficulty in swallowing, and the food occasionally returned into the mouth. He stated that he never had any real dyspnœa, even on exertion. On depressing the tongue, a rounded mass with a yellowish appearance in parts was seen; the bulk of the growth, however, was pinkish, and a good many dilated vessels crossed it. When touched by the finger, the tumour felt firm and elastic; with the mirror, a large rounded growth was seen completely obscuring the larynx. On the 25th of October, the electric cautery snare was passed over it, while traction was made by means of a vulsellum, and, as a result, this specimen was removed. The wire has only cut through the capsule, while the deeper portion of the tumour has evidently been enucleated by traction. Dr. McBride believes that traction should always be exercised in these fatty tumours while the capsule is being cut through.

Photographs of a Case of Rapid Destruction of the Nose and Face.

Shown by Dr. P. McBride. A. P—, æt. 28, house painter. History of gonorrhœa three years before, but no evidence of syphilis.

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He never had anything to do with horses. In December, 1895, he scratched his nose on the inside of left ala with his finger. This became itchy and sore; in a week the skin began to swell. During January matters remained the same, only the left side of the nose and corresponding cheek were swollen and painful, and there was some discharge from the nostril. He was examined in the beginning of January, 1896, when an ulcer was seen on the inner side of the left ala about as large as a sixpence, covered by a dirty white slough; some of this was removed and examined for tubercle bacilli with a negative result. Syphilis then suggested itself, and the patient was put on iodide and boracic syringing. He, however, returned on the 6th March, worse rather than better, and was admitted to the wards.

The case then presented the following features, viz.: erysipelatous-looking swelling of the left ala, cheek, and lower eyelid, a pustule beginning to form on the exterior of the left ala, much pus partly inspissated within the nostril, and bare bone in the middle turbinated region. Gradually the pustule changed into a fistula, and from this onward gradual destruction of the surrounding parts followed. On the 5th April Dr. Semon saw the patient, and suggested the possibility of the case being one of primary syphilis. Mercurial inunctions were then tried without effect.

Dr. Milligan also saw the case, and kindly made an inoculation, but the result as regards tubercle was negative; indeed, the guinea-pig when killed five weeks after presented no evidence of disease. After this, destructive and caustic agents were used, with the hope of destroying what seemed to be a virulent and rapidly destructive organism. Thus acid nitrate of mercury, Potassa Fusa, Paquelin's cautery, and removal of the diseased edges with the knife were tried. Mercurial inunctions were again employed, but without effect. The progress of the case was characterised by great rises of temperature (of a septicæmic type) associated with marked œdema of the face and eyelids, which at first lasted a few days and then disappeared. Latterly, however, the temperature was more constantly up, but still showed marked fluctuations. In July, Dr. Unna, of Hamburg, kindly saw the patient. Both of his suggestions had already been considered, viz. malignant tertiary syphilis and glanders. On his recommendation iodide and quinine were given, and peroxide of hydrogen was used locally. At this time two tubes of agar were kindly inoculated by Dr. Fortune, and cultivation

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experiments carried out. The patient had a hydrocele, and from this the fluid was drawn off. Guinea-pigs were inoculated both with the hydrocele fluid and with secretion from the ulcer. Several hemorrhages had meanwhile occurred from the ulcerated surface, and one necessitated plugging. The cultivations gave no definite results as far as they were carried; that is to say, there were no glanders organisms but numerous cocci and bacilli. The guinea-pigs died, one (that inoculated with hydrocele fluid) in a few days, and the other in a month. Neither presented any evidence of orchitis—the characteristic change produced in these animals by glanders. The destructive ulceration continued, and the patient died on the 18th September.

Post-mortem revealed nothing, as the organs, excepting the heart and right testicle, which were atrophic, were normal. The destruction of the face was very extensive, the bone being exposed from malar to malar (3½ inches) while the whole external nose and most of the upper lip were destroyed.

Sections taken from margins of the ulcer were kindly examined by some pathological friends; owing to the presence of marked endo-arteritis, some were of opinion that the microscope, at least, pointed to tertiary syphilis. Against the view of syphilis there is an absence of definite history and corroborative evidence. On the other hand, French writers have described as "destructive farcy of the face," a variety of glanders having similar results, but all the facts of the case point to the absence of this disease. Dr. Muir, pathologist to the Royal Infirmary, has been good enough to examine sections, and is strongly of opinion that the disease does not correspond to any type with which we are familiar.

Dr. SEMON said he had seen the case in Edinburgh. Might it be caused by a phagedænic chancre?

Mr. SPENCER suggested that the condition was akin to the noma of children, similar to the cases described by Sir James Paget as "carbuncle of the lip," occurring in adults. A primary phagedænic syphilitic sore seems to be excluded by the absence of enlarged glands.

Dr. BRONNER said he had seen a somewhat similar condition attack the eyelids of children.

Dr. W. HILL asked if the patient lived long enough to develop secondary symptoms, on the assumption that the case might have been, as suggested, a primary syphilitic phagedæna of a very malignant type which would be unlikely to be influenced by mercurial treatment.

Dr. McBRIDE, in reply, stated that noma and syphilis had been thoroughly considered, and negatived.

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Case of Foreign Body in Nose.

Shown by Dr. P. McBride. Miss M—, æt. 32, came on December 4th complaining of a discomfort in the right nostril. There was no pain, but she felt as if something were moving. On examining the nostril, a whitish-brown mass was seen with a sharp edge, and on touching this with a probe it was felt to be hard. By means of a blunt hook it was pulled forward, but was too large to permit of its removal; with forceps some pieces were broken off, and then the main mass was extracted, measuring roughly $1\frac{1}{2} \times 1 \times 1$ inches. Patient had complained of feeling something in that side of the nose for ten years. Even previously, however, there had been some discomfort; there was also a history at 11 years of age of nasal discharge with smell, and she had all her life had a bad breath. After the substance was removed there was no ulceration and no evident loss of substance or cicatrisation. The mass was slightly fœtid, but the remarkable feature of the case was the absence of all purulent secretion. The substance, as you see it, is a rhinolith, but whether the nucleus be a foreign body or a piece of dead bone cannot of course be said.

Specimen of Papilloma of Septum Nasi.

Dr. Logan Turner showed macroscopic and microscopic preparations of a tumour removed from the right nasal fossa. Patient was a man, J. B—, æt. 52, who was seen on September 1st, 1896, complaining of complete obstruction of both nostrils, a protrusion from right nostril, and a swelling of right side of nose and adjacent cheek. Symptoms commenced in right nostril three years before, and were slowly progressive, the external swelling of nose and cheek being first noticed eleven months ago.

On examination, the right nostril was found completely occluded by a growth projecting beyond the alar margin. The external swelling of nose was of soft consistence, semi-fluctuating. The left nostril was occluded by a deviated septum. Nothing could be felt in the naso-pharynx on digital examination. The nasal bones were not

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expanded, there was no protrusion of right eyeball, no bulging of hard palate or anterior wall of right antrum. There was no glandular enlargement. The age of patient, the recent more rapid growth, the soft consistence, the occasional attacks of hæmorrhage, even with the absence of glandular enlargement, favoured a diagnosis of malignant tumour, probably suitable for complete removal.

Professor Annandale, through an external incision, completely removed the tumour growing from the septum, by dissecting off all the mucous membrane from the right side of the septum and by removing a portion of the bone.

Three months after operation there is no trace of disease, and the patient breathes freely through the nose.

The tumour, a cauliflower mass, measured 6½ inches in circumference, with a broad attachment.

Microscopical examination showed a papilloma consisting of a branching connective-tissue framework, containing blood-vessels, and covered everywhere with many layers of epithelial cells, distinctly demarcated from the stroma, but here and there the epithelium shows evidence of invading the subjacent fibrous stroma.

Case for Diagnosis.

Shown by Dr. Ball. A man, æt. 33, came to the West London Hospital, on November 28th, complaining of soreness of left side of throat and dysphagia. He attributed his symptoms to having swallowed a haddock bone about ten months previously. This had stuck in his throat, and had troubled him for a day or two, but he had felt nothing more of it till about three months ago, since when his throat had gradually got more painful. The left faucial pillars are thickened, and the left half of the soft palate does not move. In the left tonsillar region is a small ulcerated area, leading to a cavity about a quarter of an inch deep. All this region feels somewhat indurated to the finger. The epiglottis is red and much thickened, especially towards the left side. The left ary-epiglottic fold and left arytænoid are markedly œdematous and swollen, and the corresponding parts on the right side less so. The glands below the angle of the jaw on the left side are swollen, and slightly tender. There is a strong tubercular family history, but there are no physical signs of disease of the lungs.

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Dr. DE HAVILLAND HALL remarked that, having regard to the appearance of the larynx, he had no doubt that the pharyngeal ulceration was tubercular in origin.

Dr. DUNDAS GRANT thought at first, from the hardness, it was epitheliomatous, but that the examination of the larynx dispelled this idea.

Dr. BALL, in reply, agreed that the appearance of the larynx was indicative of tuberculosis, but thought the case interesting from the condition of the pharynx, and from the fact that the patient attributed his trouble to the impaction of a fish bone.

CASE OF SUBGLOTTIC STENOSIS.

Shown by Dr. HERBERT TILLEY. A female æt. 38, who had complained of difficulty of breathing for two months. She had no pain. Hoarseness supervened about three weeks after commencement of dyspnœa. No history of syphilis could be obtained.

Laryngoscopic examination showed a normal larynx, but in the subglottic cavity a marked constriction was visible, lined by dry green mucus. Patient had a marked depression of nasal bones, and had a distinct general syphilitic appearance.

CASE OF ULCERATION OF PHARYNX.

Shown by Mr. C. A. PARKER. Jane L—, æt. 23, came on the 31st of December, 1895, with a history of having for years past suffered frequently from acute sore throat. A month previously had an attack lasting fourteen days, after which a discharge from the left ear commenced, unaccompanied by pain.

Examination showed much muco-purulent discharge from left ear. Chronic rhinitis. Tonsils considerably enlarged and uniformly red, except that here and there there were small bluish-grey patches. She also had considerable swelling of the post-nasal adenoid tissue. Larynx normal.

No other signs of syphilis and no history obtainable. Chest normal.

In five weeks the condition had much improved, and the tonsils, which were uncomfortably big, were amputated. The wounds healed up quickly.

On April 21st she came as her throat felt uncomfortable. On

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examination some ulceration was found in the naso-pharynx, and on what was left of the tonsils. A week later there was marked ulceration in naso-pharynx, especially round the right Eustachian tube, right tonsil, and right side of the soft palate. Operation on post-nasal growths was deemed inadvisable on account of the active ulceration. The ulceration was at this time so suggestive of late secondary or early tertiary syphilis that she was treated with mercury and iodide of potassium.

On May 26th the post-nasal growth was removed. Following on this the throat got rapidly worse, the ulceration spread rapidly over the right side of the pharynx, soft palate, and uvula, and there was a great deal of pus running down from the naso-pharynx—a good view of which could no longer be obtained.

She now had frequent severe headaches, was often delirious at nights, and her evening temperature was raised to about 101° F. This could not be accounted for by the ear trouble, which was practically well.

She was now treated with the compound syrup of hypophosp. internally and lactic acid locally, and at one time seemed to improve and at another got worse; but on the whole the condition of the right tonsil and palate improved, whilst the naso-pharynx got worse.

At the present time great destruction of the palate and uvula can be seen; the right posterior pillar of the fauces is much thickened and œdematous, and studded with yellowish spots, and there is a thickened red mass coming down from the posterior nares immediately behind it. The left posterior pillar and left tonsil are also swollen. The swollen mass on the right side extends down to the glosso-epiglottidean fold, and there is active ulceration proceeding in the naso-pharynx.

Yesterday was noticed for the first time a small ulcer surrounded by œdematous tissue on the left side of the septum nasi, just opposite the lower border of the middle turbinated body.

Dr. McBride thought it might be a case of tertiary syphilis.

Dr. Grant pointed out the œdematous condition of the middle turbinal mucous membrane, and thought there might be empyæma of the nasal sinuses; the fact that the patient had suffered from delirium supported this idea.

Mr. Parker, in reply, stated that the nose condition being quite recent, it could not account for the temperature and delirium. He looked upon it as of tubercular origin.

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Case of Œdema of Arytænoids.

Shown by Dr. de Havilland Hall. A. S—, æt. 47. Present illness dates from October 24th, when the patient complained of a sore throat and cough. Suffered from winter cough for seven years. No history of syphilis.

Admitted into Westminster Hospital on October 30th. On November 1st the fauces, tonsils, and pharynx were stated to be hyperæmic; the ary-epiglottic folds swollen, the right more than the left. Epiglottis red and swollen. Vocal cords not visible. Nares normal.

When first seen on November 2nd, the epiglottis was swollen, the right arytænoid so swollen as to conceal the corresponding cord almost entirely. The left arytænoid only slightly swollen. The swelling of the epiglottis has now almost entirely disappeared, and the right arytænoid is almost two thirds of the size it was. No rise of temperature.

Dr. Tilley said the symptoms were identical with the early stages of the patient he showed last meeting, in which tracheotomy was advised.

Dr. Newman asked if there was any albumen, as it had the aspect of the throats that occurred in Bright's disease.

Dr. McBride said it was very like cases of a rheumatic origin, but it differed from them in colour.

Dr. Semon suggested pilocarpin injections.

Dr. H. Hall, in reply, stated there was no albumen.

A Case of Pre-epiglottic Cyst, with Specimen and Microscopical Section.

Shown by Dr. Dundas Grant and Mr. Richard Lake. The patient, a married woman æt. 30, came under Dr. Grant's care on September 10th, 1896, complaining of recurring attacks of pain in the throat, with absolute loss of voice, taste, and power of swallowing. These functional symptoms had occurred suddenly at frequent intervals during the last three or four years, and lasted for two or three days at a time. During them the voice disappeared so completely that not even a whisper could be produced. The bolus of food on attempts at swallowing seemed to stick at the root of the tongue, and had to be rejected. The pain started in the throat and ran down the thyroid

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and supra-sternal towards the mammary regions. The attacks first came on at a time when she was the victim of severe mental worry, and were afterwards excited by very slight causes, such as exposure to dust or tobacco smoke.

Examination showed on the lingual aspect of the right half of the epiglottis a rough, reddish, sessile growth like a mass of granulations, on the apex of which there was a shiny yellowish spot. The whole was nearly buried in the exuberant lymphoid tissue of the hypertrophied lingual tonsil, but was found by means of the probe to be growing from, or at all events attached to, the epiglottis. Cocaine was applied, and with Mackenzie's forceps a complete cyst of the size of a small sultana raisin was pulled away, which was handed over to Mr. Lake for examination.

Next day the patient experienced a slight soreness, but a great feeling of relief as if a large obstructing body had been removed. Has enjoyed the freedom from discomfort ever since.

The case seems to illustrate the extraordinary disturbance produced in a neurotic subject by a comparatively insignificant growth touching the epiglottis.

Report by Mr. Lake.—"The cyst is collapsed and folded on itself, and measured in its long diameter $\frac{1}{2}$ inch, in its short diameter $\frac{3}{16}$ inch.

"Under the microscope the specimen has the following characters:—An outer fibrous sheath, an inner epithelial lining, and a middle lymphoid layer. The inner layer is of ordinary stratified epithelium, the innermost layers of which are cloudy and ill defined, and in the rete there is a total absence of papillæ.

"The lymphoid layer consists of ordinary lymphatic tissue, with follicles similar to those found in all tonsillar strictures and lymphatic glands. There are also traces of muciparous glands in one part of the capsule.

"I am not inclined to think that there was more than one cyst, but the branch-like cavity is due to corrugation of the collapsed walls.

"I consider the growth to be a retention-cyst of a crypt of the lingual tonsil, which as it filled more and more rotated in the line of least resistance, stretching the occluded neck until it became practically a free cyst."

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Case of Thickening of Hard Palate.

Shown by Dr. Bond. The patient, a girl æt. 28, noticed at junction of hard and soft palate and the mid-line a swelling which ached "like toothache." The growth began nine months ago; has certainly grown during the last three weeks, and consists of three rounded divisions—paler on surface than the rest of mucous membrane, and tender to the touch. It extends for about three-quarters of an inch from before back. Its nature is doubtful, and suggestions as to this were invited. Probably it is an exostosis, and it is proposed to remove it.

Case of Growth springing from Top of Œsophagus.

Shown by Dr. Bond. The patient, a woman of 30, was seen in October last. She complained of sore throat for the preceding nine months, and of marked and increasing difficulty in swallowing. She looked very ill, was constantly retching and trying to swallow the abundant mucus present.

On examining fauces a large, sloughing, cauliflower-like mass was seen filling all lower pharynx, behind epiglottis, and covering over larynx. On palpation it could be traced down to brim of œsophagus. It was about the size of a couple of walnuts. It was removed with a cold snare. Two large sloughing masses were first removed whilst depressing tongue. The base of growth was caught in snare with a little help from left forefinger, and the mass twisted off, not cut through. There was no hæmorrhage. The next day patient could eat soft food. On microscopic examination Dr. Hewitt found it to be a fibroma.

At present one can see behind and to right of right arytænoid, a fungating granular mass of *quasi*-malignant aspect.

Case of Excision of Larynx and Upper Two Rings of the Trachea for Perichondral Sarcoma of the Cricoid Cartilage. (Specimen shown at last meeting.)

Shown by Mr. W. G. Spencer.

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Case of Excision of Vocal Cord for Spheroidal-celled Carcinoma (Specimen shown at last Meeting).

Shown by Mr. W. G. Spencer.

Total Extirpation of Larynx for Squamous-celled Epithelioma (Patient and Specimen).

Shown by Mr. Lambert Lack. The patient, a man æt. 58, had suffered from horseness for about two years. The growth involved the right ventricular band and vocal cord, the anterior two thirds of left vocal cord, and extended downwards to the first tracheal ring.

The operation was performed on August 15th last. No preliminary tracheotomy. The larynx was exposed by the usual vertical median incision, and two transverse incisions, one along the lower border of the hyoid bone, and one about an inch above the sternum, both reaching from sterno-mastoid to sterno-mastoid. The larynx and trachea were then freed all round and separated from the œsophagus behind. The trachea was then cut across and sutured to the skin all round in the lower transverse incision. By this means the trachea was completely shut off from the wound, and there was no danger of any blood, &c., entering it during the subsequent steps of the operation. The larynx was now cut away from the pharynx and removed entire.

The hole left in the pharynx was now very carefully closed by a closely set series of sutures of fine catgut, uniting mucous membrane to mucous membrane. Over these a similar series of sutures was placed uniting the muscular and membranous walls of the gullet, but not piercing the mucous membrane. To strengthen these, other layers of sutures were inserted, bringing all the tags of divided muscles together in the middle line. In this way the wound was obliterated, and a strong wall built up, completely shutting off the pharynx, and able to resist the strain of swallowing. The skin was then brought together, except for a small triangular space at the upper corner. The entire wound, with the exception of this space, healed by first intention. The patient was from the first day and throughout able to swallow without pain or difficulty. There was no

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danger of fluids passing from the pharynx into the wound, exciting inflammatory secretions there, and passing thence down the trachea. Thus the danger of septic lung infection was minimised. The case ran an aseptic and afebrile course, and the patient was walking about in fourteen days, having suffered no more than after a simple tracheotomy. Thus also the tedious and painful after-treatment involving frequent dressings and packing of the wound, and the constant passage of the œsophageal sound, were done away with. Unfortunately, in the first instance the cut was too close to the lower limit of the disease, and later two more rings of the trachea had to be removed.

The patient has no voice, but can whisper distinctly, and is gaining power. He is otherwise quite well, and is able to dispense with a tracheotomy tube.

Total Extirpation of Larynx with Part of Anterior Wall of Pharynx, of Posterior Part of Tongue, and Glands in Neck, for Squamous-celled Epithelioma.

Shown by Mr. Lambert Lack. The patient, a man æt. 45, complaining for about eighteen months of increasing pain and trouble in swallowing, and for the last four months of repeated and occasionally severe hæmorrhages. The tumour involved the epiglottis, arytæno-epiglottic folds, anterior parts of ventricular bands and adjacent parts of tongue and pharynx, with some small hard moveable glands in the left anterior triangle. The laryngoscopic appearances were peculiar. The transformed epiglottis, as large as a hen's egg—a purple, ulcerated tumour mass—seemed to project up out of the cavity of the larynx, which it concealed from view; and the sharply defined raised edge of the growth on the tongue was by many mistaken for the ulcerated, thickened, partly destroyed epiglottis.

The larynx was removed on September 5th, the glands some five weeks later. The operation was performed in essentially the same way as in the last case, but preceded by a preliminary pharyngotomy to determine its practicability. Owing to the large size of the gap left in the pharynx, the stitching up afterwards was a very difficult matter, and there was considerable tension on the upper stitches (those uniting tongue to pharynx). These held, however, for five days, during which time the patient could swallow perfectly well, and the greater part of the wound healed. A small fistula then formed at the upper part of the wound, and liquids came through on swallowing.

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This could be prevented by packing, but the patient was now fed by the œsophagus tube. The stitches had held long enough to serve their main purpose, the whole wound with the exception of this sinus healed by first intention. The after course was quite afebrile, and there was never a risk of septic products from pharynx or wound entering the air-passages. The sinus slowly contracted, and causes the patient no trouble in swallowing either solids or liquids, although it still exists and will probably require closing. The patient seems now in good health, and has put on a great deal of flesh. He had been previously refused operation at three other hospitals.

The President thought that these cases opened a new era for the operation. The results as a rule, however, left the patient in such a terrible state that it made it necessary for laryngologists to make as early a diagnosis as possible.

Dr. Newman agreed with Dr. Semon that unless the disease was recognised early the case had better be left alone.

Dr. Hall stated that in the case of the woman (Mr. Spencer's case), the patient had greatly improved in general condition since the operation. In view of the fact that the growth was entirely subglottic, an early diagnosis was out of the question. At the time the operation was performed, extirpation of the larynx was the only practicable procedure.

Mr. Spencer said that his patient, in which the whole larynx had been excised, had recovered good general health, could swallow easily, and hold conversations with the nurses and patients in the hospital. He had not done the operation with any other view than that of palliation, but that in any case the patient's life would be prolonged and rendered comfortable for months.

Mr. Lack said he did not see what else could have been done. There was no alternative to the operation, and there was always a chance of cure. He thought the operation justifiable.

The President stated that he hoped it was quite understood that he did not go so far as to say that the operation was unjustifiable.

Microscopic Specimens of a Pedunculated Tubercular Growth of the Vocal Cords.

Shown by Dr. Adolph Bronner. The larynx was in other respects apparently normal. The patient had been suffering from pulmonary phthisis for over two years, and had been hoarse for a few months. There was a small, red, regular, pedunculated growth on the edge of the left vocal cord. This was removed by forceps. The patient died about a year later. There was no further history

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of hoarseness, and the larynx apparently remained normal up to death.

The Clinical Research Association reported as follows:

"The growth is composed of vascular connective tissue like granulation tissue, in which are embedded the acini of mucous glands. There are one or two giant cells beneath the mucous membrane, which are probably indicative of the tuberculous nature of the affection."

Dr. McBride referred to the German literature, where these were mentioned as tubercular tumours simulating fibromata and papillomata, by Avellis and others.

Fibroma of Right Nasal Cavity, together with Microscopic Specimen of the Same, Prepared by an Old Histological Method for Rapid Diagnosis.

Dr. Jobson Horne showed this case. A woman, æt. 70, on the 23rd of June last met with a fall, injuring the right side. A week after epistaxis commenced, and had persisted; at times it had been of daily recurrence, the loss of blood frequently copious. A month after the epistaxis commenced the right nasal cavity was noticed to be obstructed, and it was on this account the patient eventually sought relief. There was no localised pain, but frontal headache.

About one month ago, examination of the nose found the right nasal cavity occupied by an irregularly rounded, opaque, dusky-grey tumour, with blood-vessels coursing near its surface; the free margin was in contact with the septum, which bulged towards the left. There was complete stenosis. Gentle manipulation showed firm consistency with a sessile attachment; some thick purulent matter escaped, and the growth bled readily. No bleeding point was detected in any other part of the nasal cavities. No extension of growth to the naso-pharyngeal region.

On trans-illumination a rim of brightness appeared immediately beneath the right lower eyelid, absent on the left side. Light was transmitted through the right wing of the nose, but not through the left. In other respects the limits of trans-illumination were symmetrical.

A portion of the growth was then removed with Krause's snare for microscopic examination.

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The piece of tissue was treated by a method to which Dr. Kanthack has recently drawn attention. It was placed in a test-tube with water and boiled; boiling for a minute and a half sufficed for the size of the tissue. It was then ready for cutting on a freezing microtome. The sections were stained in hæmatin and mounted in the usual way, the entire process requiring from fifteen minutes to half an hour. The water being sterilised by boiling, the tissue could have been safely left corked in the test-tube for twenty-four or thirty-six hours. Tissues hardened by this rapid method can be preserved for longer periods, in alcohol or Müller's fluid, or treated by the paraffin method.

Under the microscope the growth presented the appearances of a fibroma; no evidence of malignancy.

Since the removal of a portion the epistaxis had ceased, and the stenosis had been reduced.

Case of Congenital Nasal Stenosis.

Shown by Dr. Watson Williams. A man, æt. 28, in whom the right nostril was occluded by a congenital web of skin, situated at the junction of the vestibule with the nasal passage proper. The web practically occluded the right nostril, for although in the centre there was a minute valvular opening which just admitted a probe, the patient was unable to blow out or inspire any air. No syphilis or any illness, or any disease of the nose, but at the age of three or four had a severe blow on the nose from a fall, which had produced a deviation to the sound side. There was a deviation of the septal cartilage at its anterior extremity, with the convex side towards the occluded nostril, and a not very marked horizontal similar deflection of the middle of the septum. There was no enlargement of the inferior turbinated body, and no defective development of the superior maxillary or nasal bones on the occluded side. The eyes were bilaterally symmetrical in position. Moreover, there was no crowding of the teeth or deformity of the palate.

The patient was shown as a clinical instance in which nature had imitated the experiments of Ziem in occluding the nasal passages on one side in young animals with results on which considerable stress had been laid in support of the view that septal deviation was very frequently due to partial nasal obstruction; for though septal deviation

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existed in this patient, probably resulting from the blow which also caused external deformity of the nose, none of the other associated deformities described by Ziem were present.

Specimens of Angeio-fibroma of Pharynx illustrating the Effects of Pressure on the Superior Maxillary Bones.

Shown by Mr. A. A. Bowlby.

Case of Pharyngeal Tumour.

Shown by Mr. A. A. Bowlby.

Dr. Scanes Spicer considered the tumour a cyst.

Dr. Newman had a very similar case two years ago, which proved to be an enchondroma arising from the intervertebral discs.

Mr. Lambert Lack thought it might be an adenoma.

Dr. Semon considered it too hard for a cyst.

Mr. Bowlby, in reply, said he would operate after Christmas; at present he looked upon it as being a fibroma.

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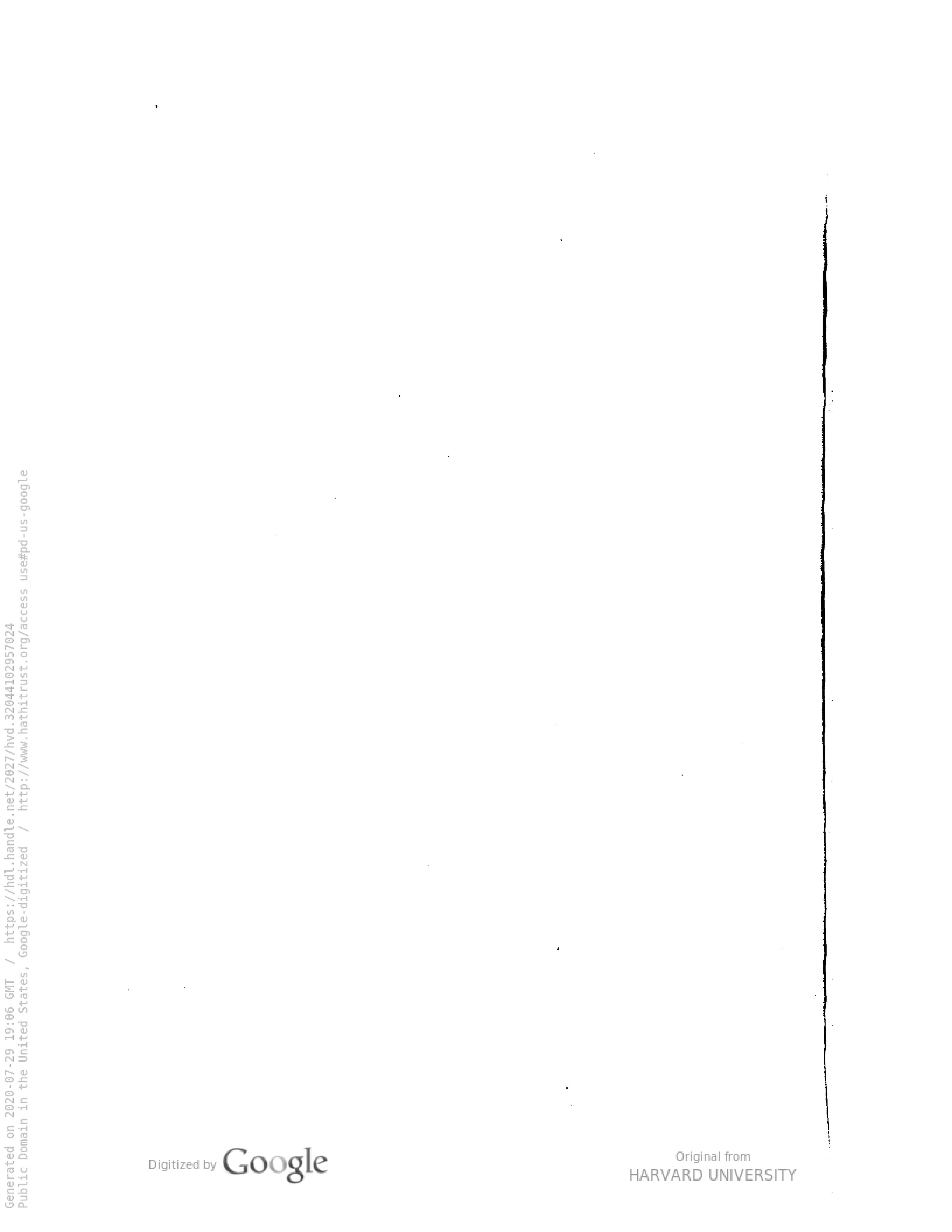

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ANNUAL GENERAL MEETING, *January 13th*, 1897.

FELIX SEMON, M.D., F.R.C.P., President, in the Chair.

W. R. H. STEWART, F.R.C.S., } Secretaries.
STCLAIR THOMSON, M.D., }

Present—35 members and 10 visitors.

The minutes of the Fourth Annual General Meeting were read and confirmed.

Dr. E. Law and Mr. Waggett were appointed Scrutineers of the ballot for the election of Officers and Council for the ensuing year, and they reported the result of the ballot as follows:

President.—H. Trentham Butlin, F.R.C.S.
Vice-Presidents.—E. Cresswell Baber, M.B.; J. W. Bond, M.D.; A. Bronner, M.D.; Scanes Spicer, M.D.; Charters Symonds, F.R.C.S.
Treasurer.—W. J. Walsham, F.R.C.S.
Librarian.—J. Dundas Grant, M.D.
Secretaries.—StClair Thomson, M.D.; H. Tilley, M.D.
Council.—J. B. Ball, M.D.; R. M'Kenzie Johnston, M.D.; F. Semon, M.D.; W. R. H. Stewart, F.R.C.S.; P. Watson Williams, M.D.

The Report of the Council was read as follows:

Your Council is glad to be able to report the continued prosperity of the Society during the past year. It now consists of 8 honorary and 106 ordinary members. We are sorry to announce that owing to

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distance from London, duties in other branches of the profession, or ill-health, three of our ordinary members have felt themselves compelled to sever their connection with the Society, and it is with the deepest regret we have to report the loss British laryngology in general, and this Society in particular, has sustained by the death of the late Sir George Johnson, the Society's first President, and one of its honorary members.

The meetings have all been well attended, the average number of members being about thirty, and we have been honoured by many distinguished visitors, both British and foreign. During the session the number of interesting cases and specimens have been almost too numerous, and two most instructive general discussions were held, one on the "Laryngeal Complications of Typhoid Fever," introduced by Drs. Kanthack and Drysdale, and the other on "Foreign Bodies in the Upper Air and Food Passages," introduced by Mr. Charters Symonds. During the course of the latter the application of the Röntgen rays to laryngology was kindly demonstrated by Messrs. Waggett and Rowlands.

The usefulness of the Society has been greatly increased by the appointment of a small Sub-committee for examining and reporting on morbid specimens of special interest, and your Council would also call attention to the fact that a collection of microscopical specimens has now been inaugurated in connection with the Sub-committee, and would invite members to contribute specimens, so as to assist in making this a thoroughly useful and representative collection.

The Treasurer's Report and Balance-sheet were then presented as follows, and adopted.

The actual receipts for the year 1896 have amounted to £119 7*s.* This amount includes two subscriptions already paid for 1897 (£2 2*s.*). There are still a few subscriptions and one entrance fee unpaid; these will appear in the balance-sheet of 1897.

The actual expenditure has been £76 4*s.* 3*d.*, leaving a balance for the year of £43 2*s.* 9*d.* This with the balance of £68 19*s.* 10*d.* handed over by the past Treasurer, Mr. Butlin, leaves in the Treasurer's hands the sum of £112 2*s.* 7*d.*

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BALANCE-SHEET, 1896.

Income.

	£	s.	d.
Balance from 1895 per former Treasurer, Mr. Butlin . .	68	19	10
Subscriptions—			
85 members at £1 1*s*.	89	5	0
14 members at £2 2*s*.	29	8	0
Sale of odd numbers of 'Proceedings' and bound copies per Librarian, Dr. Beale .	0	13	6
Excess over subscription in cheque	0	0	6
Total . .	£188	6	10

The income for the year is £119 7 0

Expenditure.

		£	s.	d.
Rent and Electric Light (20, Hanover Square). . . .		31	10	0
Adlard for Printing and Postage, December 26th, 1895, to June 17th, 1896 .		39	11	1
Petty Cash—				
Creswick (Receipt Book)	0 6 6			
Baker (Slide Boxes) .	0 9 0			
Rogers (Carbolic Acid and Spirit). . . .	0 4 6			
Secretarial Expenses: Mr. Stewart £1 0 0; Dr. St.Clair Thomson . 0 14 0	1 14 0			
Postage and Receipts: Stamps, Treasurer .	0 11 0			
Doughton, attendance	0 10 0			
Bank Charges: Cheque Book £0 8 4; Scotch and Irish cheques 0 1 10	0 10 2			
Indexing volume, 1896	0 18 0			
		5	3	2
Balance in Treasurer's hands, Jan. 1, 1897		112	2	7
Total . .		£188	6	10

The expenditure for the year is . . £76 4 3

Audited and found correct, *January* 6, 1897.

ERNEST WAGGETT.
WILLIAM HILL.

The Librarian's Report was then read and adopted. During the past year there have been but few additions to the Society's Library. A list of these is appended. The supply of foreign and home periodicals taken in exchange for the 'Proceedings' has been steadily maintained. The sets of some of those received during previous years have been bound. An important series of microscopic specimens has been presented to the Society, and placed in the care of the Librarian, by Dr. Pegler, together with two cases capable of holding 100 specimens each. A list of the first series of specimens has been added to the Library catalogue.

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The following works have been added to the Library during the year 1896.

Presented by Dr. E. J. Moure, of Bordeaux.

De Quelques Anomalies de la Région Mastoidienne.
Empyème du Sinus Maxillaire chez les Enfants.
Pathogene et Traitement des Deviations et Éperous de la Cloison du Nez chez les Jeunes Enfants, with translation.

Presented by Dr. Gouguenheim, of Paris.

Sequestres Énormes de la Fosse Nasale Gauche.
Angine Couenneuse a Streptocoques.

Presented by Dr. J. A. Wilkens, of Amsterdam.

Ueber die Bedeutung der Durchleuchtung für die Diagnose der Kieferhöhlen eiterung.

Presented by Dr. Brindel, of Bordeaux.

Résultats de l'Examen Histologique de 64 Vegetations Adenoides.

Presented by Dr. Simon Dunogier, of Bordeaux.

De la Prothèse appliquée au Traitement des Empyèmes de l'Antre d'Highmore.

Presented by Dr. Ludwig Polyák, Secretary.

Jahrbücher der Gesellschaft der Ungar, Ohren und Kehlkopfœrzte, Bd. I, 1894–95.

Presented by Dr. Burger, of Amsterdam.

Dritte Jahresversammlung der Niederländischen Gesellschaft für Hals, Nasen und Ohrenheilkunde.

Presented by the Publisher.

Transactions of the British Laryngological, Rhinological, and Otological Association, Summer Meeting, 1895.

Presented by Dr. Vittorio Grazzi.

Atti del Secundo Congresso della Societa Italiana di Laringologia, d'Otologia e di Rhinologia.

Presented by the Hon. Secretaries.

Brighton and Sussex Medico-Chirurgical Society. Proceedings, 1895–96.

Lists of works previously presented to the Library will be found in 'Proceedings,' vol. i, p. 55, and vol. iii, p. 37.

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The following gentlemen were elected to serve on the Morbid Growths Committee for the ensuing year:

Mr. Bowlby, Dr. Kanthack, Dr. Pegler, Mr. Spencer, Mr. Waggett, Dr. StClair Thomson.

A vote of thanks to the retiring officers was then proposed by Dr. W. Hill and seconded by Mr. Bowlby, and carried unanimously. The retiring President, Dr. F. Semon, returned thanks.

The Ordinary Meeting of the Society was subsequently held, Dr. F. Semon in the Chair.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were proposed for election at the next Ordinary Meeting:

As an Honorary Member—Professor D. Moritz Schmidt, Frankfort-on-the-Main, proposed by the Council.
As Ordinary Members—Mr. Herbert E. Durham, M.B., B.C.Cantab., F.R.C.S.Eng., 82, Brook Street, proposed by Dr. F. Semon, Mr. C. Symonds, Dr. Kanthack.
Mr. Henry Secker Walker, F.R.C.S.Eng., 44A, Park Square, Leeds, proposed by Dr. Scanes Spicer, Dr. W. Hill, Mr. Waggett.

Report of the Morbid Growths Committee on the following cases was read.

Mr. W. G. Spencer. (1) "Sarcoma of Cricoid Cartilage." (For notes of this case see 'Proceedings,' November 11th, 1896, p. 11.)

"The specimen is a carcinoma with large cell-masses, many of which show degeneration in the centre. The cells are polyhedral and small in type, but there are no squamous cells."

Mr. W. G. Spencer. (2) "Spheroidal-celled Carcinoma of Vocal Cord." (For notes of this case see 'Proceedings,' November 11th 1896, p. 10.)

"The growth is a carcinoma with abundant fibrous matrix enclosing alveoli filled up by large masses of cells. The cells themselves are both polygonal and columnar, and it is evident that the growth has originated in the columnar cells of the ducts, passing into the ventricle just outside the vocal cord."

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Dr. BOND's case of "Sarcoma of the Nose." (For notes of this case see 'Proceedings,' November 11th, 1896, p. 4.)

"The specimen is a typical carcinoma of the villous or papillary variety. The connective tissue is delicate, and the cells extremely polymorphous. There are no squamous cells or horny cell-nests, and the growth is certainly not a squamous epithelium, but is probably derived from columnar epithelium."

Dr. LOGAN TURNER's "Section of Papilloma Nasi." (For notes of this case see 'Proceedings,' December 9th, 1896, p. 21.)

"We agree with the author's description of this specimen, except as regards the invasion of the mucosa by the epithelium, and believe it to be a papilloma, non-malignant. The section does not include any of the submucous tissue. It is suggested to examine deeper parts of the specimen to test whether or no there is invasion by the epithelium."

Dr. MCBRIDE's case. (For notes of this case see 'Proceedings,' December 9th, 1896, p. 18.)

"The section shows ordinary inflammatory changes, and we are unable to detect any appearances of new growth or any known forms of bacteria.

Dr. F. SEMON presented to the Society, on behalf of Dr. Lefferts, of New York, a photographic album of views of his clinic in New York, and on his own behalf the bound volumes of the 'International Centralblatt für Laryngologie.'

Dr. Betz's plaster-of-Paris models of the nose and its accessory cavities were demonstrated by Dr. SEMON.

Dr. CRESSWELL BABER thought the models rather coarse, and preferred the skulls prepared in France, and obtainable from Messrs. Meyer and Meltzer.

SERIES OF X RAY PHOTOS, BY DR. MACINTYRE, F.R.S.E.

Demonstrated by Dr. SEMON. One of the large photographs shows the thorax, arms, &c., of a man æt. 30. The second (in which two spots representing the buttons of the clothing will be seen), is the thorax with the upper extremities of a young man æt. 20. In both photographs some of the viscera are faintly outlined.

The third photograph is not of interest from the laryngological

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stand-point, but was made a test of penetration when experimenting in the thoracic region. It represents a case of hip-joint disease, and in it you will see the spine, pelvis, &c.

The case of the heart is from the living subject, and was the first photograph of this organ obtained by Dr. MacIntyre. Since then he has photographed many abnormal conditions, mostly in the direction of hypertrophy, and in one case an aneurism in the thorax. One of these abnormal conditions of the heart will be seen in the photograph marked "enlargement of the heart in a case of pneumonia." At the time the photograph was taken the heart was beating rapidly, and respiration was very quick. These movements in taking a picture had to be contended with, and as it was at an early date of the work the exposure took five minutes.

The larynx is just the same as the one in the small album, but it is interesting in the sense that it was photographed through the whole thickness of the neck, showing the base of the tongue, hyoid, arytænoid, epiglottis, pharyngeal space, spine, &c.

The photograph of an anatomical specimen of the larynx has a pin which has been placed therein purely for experimental purposes.

The photograph of the coin in the œsophagus is the one referred to by Sir Joseph Lister in his address at Liverpool.

The instantaneous photograph representing the bones of the fingers, was taken in the fraction of a second by means of a mercury interrupter, as described in the 'Lancet' this year.

All these photographs were taken with a ten-inch spark coil and the focus tube.

Notes of a Case of Bilateral Abductor Paralysis in a Child.

Read by Dr. Permewan. L. S—, æt. 5, was admitted into the Liverpool Children's Infirmary on December 16th, 1895, complaining of loud breathing at night, and occasional spasm. Enlarged tonsil and post-nasal adenoids were removed with no improvement. On February 4th, 1896, paralysis of abductors of both cords was found. On May 10th, urgent dyspnœa supervened and necessitated tracheotomy; and she has worn the tube ever since. The condition of the cord is still the same, and the voice remains normal. There are no signs of disease in neck or chest. There was no history of diphtheria or sore throat, and no signs or symptoms of brain disease.

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The cause of the paralysis is not clear; probably there has been some affection of lymphatic glands, which has implicated both recurrent laryngeal nerves. Niegel's case was due to implication of the nerves in inflammatory tissue.

Drawing of a Case of Tubercular Ulceration of the Larynx.

Shown by Dr. Permewan. This shows a case of rapid cure under lactic acid.

Case of Laryngeal Obstruction.

Shown by Mr. W. R. H. Stewart. Patient, a female æt. 44, kindly sent by Dr. Scott Gibson. Breathing had been bad for eight or nine months, had become rapidly worse, the last two months especially when lying down. Was confined of her tenth child five weeks ago, nine children living, all exceptionally healthy; one died from pneumonia. Patient is very anæmic, and has progressive muscular atrophy of one hand. There is no obtainable history of tubercle, malignancy, syphilis, or injury.

Mr. Bowlby thought it was simple inflammatory subglottic swelling.

Dr. F. Semon said there was fixation of the left vocal cord, a good deal of subglottic swelling, and he thought there was a foreign body of some kind subglottic, it might be only inspissated mucus. He mentioned a case he had some years ago at St. Thomas's, where a ventriloquist had "swallowed his call" sometime before, and had forgotten the fact. He asked Mr. Stewart to let the Society hear of the further history of the case.

Dr. StClair Thomson suggested the albuminuria might be the cause.

Dr. Permewan suggested syphilis.

Dr. Jobson Horne asked if it might be tubercular.

Mr. Stewart said he would certainly let the Society know of the further development of the case. He did not think albuminuria had anything to do with it, as the dyspnœa had been gradually getting worse for eight or nine months, and the urine was free from albumen a week ago. He thought the fact of there being nine healthy children and no history was against the theory of syphilis, and there was also no history of tubercle. The patient had been on arsenic for a week, and seemed greatly improved in her general health.

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Case of Curious Malformation of the Nose.

Shown by Mr. W. R. H. Stewart. Patient, a man æt. 25, was sent to Mr. Stewart at the Great Northern Central Hospital, with a wish for something to be done, if possible, to relieve him of what to all appearances was a bifid nose. He stated that when quite a baby a tumour was removed from the nose, and he never remembers being any different from what he is at present.

Dr. Semon suggested that a woodcut should be procured for insertion in the 'Proceedings,' as it seemed to be an unique case.

Mr. Waggett pointed out that the case was not one of duplication of part of the organ. The mesial nasal process in the embryo was bilateral in character, consisting of two prominent lateral portions separated by a mesial groove. Normally this groove was obliterated by the approximation and coalescence of the lateral portions, which were ultimately represented by the philtrum columella nasi and internal boundary of each anterior naris. In the negro type the mesial groove in a measure persisted at the tip of the nose. In the present case an operation scar corroborated the history of the removal of a tumour in infancy. Dermoid inclusion cysts, though rare, were found in the middle line of the nose. The speaker suggested that at an early date in fœtal life such an inclusion cyst was formed, and that this presented a mechanical obstacle to the normal coalescence of the prominent extremities of the globular processes, *i. e.* the lateral portions of the mesial nasal process.

Case of Nasal Obstruction.

Shown by Dr. Bennett. Miss M—, æt. 19, has suffered from obstruction of the left nostril since last summer. There have been no other symptoms. She came under observation last October, and a growth was found on the septum, the floor of the nose, and on the inferior turbinal. The growth was supposed to be of a tuberculous nature. A portion of the growth from the septum was removed at the end of the year, and examined microscopically, with the report that the growth was a squamous epithelioma. The appearance of the growth still makes one hesitate to accept the diagnosis, and further microscopical examination will be made.

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Case of Pharyngeal Pouch.

Shown by Mr. P. de Santi. A man, æt. 33, was sent up by Dr. Eliot, of Southampton, for a swelling in the right submaxillary region.

The patient had had a swelling in the neck since the age of fifteen, but it had never caused him much trouble. He has twice had some hæmorrhage from the mouth, the last time being six months ago; the bleeding occurred at night, but was not severe. He does not know where it came from. At one time there was some swelling on the left side of the neck, but never anything like that on the right side.

On examination there is a visible swelling beneath the right half of the inferior mandible in practically the digastric triangle. On the patient taking a deep breath and blowing out his cheeks, the "pouch-like swelling" in the neck becomes tightly distended like a bladder blown up. The filling up of the pouch is instantaneous, and the size thereof that of a moderate-sized fist. On percussion, when the swelling is distended, the note is quite dull. On examination of the mouth no opening whatever can be found into the apparent pouch. On examination with the finger there seems a good deal of loose tissue between the floor of the mouth and the external surface of the swelling.

At no time has there been any entry of food or liquids into the swelling.

Mr. de Santi stated that the case was one of great rarity, and he was desirous of a diagnosis. In no way did the swelling resemble a real pharyngocele. In the only case he had ever seen of pharyngocele the swelling was on the left side, commenced at the beginning of the œsophagus, and contained food-stuff which could be squeezed out.

The swelling in the man exhibited was in all probability of congenital origin, and possibly connected with a branchial cleft or some fœtal structure. All he could compare it to was the pouch found in much the same region in some monkeys.

Mr. Bowlby suggested that it was not a pouch containing air, but veins.

Mr. Waggett suggested that Mr. Bowlby's view of the case might be tested by trans-illumination. With a small lamp in the mouth the patient would be able to distend the tumour in the usual manner. If it was of a venous character the increased amount of blood traversed by the light would cause a deepening of the shadow as the tumour

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increased in size. Conversely, the stretching and thinning of the walls of a true air pouch on distension would diminish the opacity of the tumour.

Pathological Specimens.

Shown by Dr. Kanthack.

1. Tubercular Ulcers of Larynx and Trachea.

2. Diphtheria.—Hardened and fixed in formalin.

3. Larynx from Case of Hæmorrhagic Diphtheria.—Hardened and fixed in formalin.

4. Epithelioma of Larynx (see microsection No. 2).—The interest of this specimen is the circumstance that it occurred in a tuberculous patient, and was not diagnosed during life.

5. Singer's Nodule.—Hardened and fixed in formalin (see microsection No. 3.) This specimen shows marked interstitial myositis, and disproves the glandular origin of those nodules.

6. A curious Intra-laryngeal Growth, removed from a woman aged 67 years.—The growth was attached by a broad base on the left side in the subglottic region, and the case will be published *in extenso* at a future date.

The President stated that as Dr. Kanthack had specially asked for his own views concerning singers' nodules, he could summarise his own experience, which in this class of cases had been considerable, to the effect that he had not the slightest doubt that the affection was of an inflammatory character. The mere fact that almost all his patients had recovered without any local treatment, under the influence of prolonged and complete vocal rest, was positive proof in favour of this. He had, however, not been aware that the inflammation actually extended to the musculus vocalis, and Dr. Kanthack's contribution certainly taught something quite new. It was not a little remarkable that most of the patients he had seen had been taught the "coup de glotte," and it seemed very probable that this method of bringing the cords together with a snap was in many cases to some extent, if not entirely, responsible for the production of the nodules. He had not dared to treat the nodules by operative interference except in one case in which, by the application of the galvano-cautery, the high falsetto voice of a clergyman had been changed into a deep basso. He congratulated himself that this had not happened in the case of a soprano singer.

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Case of Black Tongue.

Shown by Dr. Semon. The patient was a gentleman æt. about 40. A fortnight before the case had been most characteristic. There had been a large patch of enormously elongated, hair-like, inky black papillæ in the region of the papillæ circumvallatæ. Under the local use of a 5 per cent. ethereal solution of salicylic acid, mixed with a 5 per cent collodion solution, and followed by an application of peroxide of hydrogen by means of a plug of cotton wool applied to the affected region several times a day, so much improvement had resulted that only the traces of the affection were still visible. This plan had been recommended by Unna, of Hamburg.

Mr. Waggett inquired if it was not usual for this rare condition to run in cycles with alternating appearance and disappearance, the latter being spontaneous. The apparent striking success of the treatment mentioned might be explained in this way.

A New Nasal Snare.

Shown by Dr. StClair Thomson for Dr. Ernest Brown (Montreal). The chief features were that the instrument has no springs or ratchets. The rack, which forms one side of a triangle upon which a pulley runs, gives a loop of considerable length. The wire can be drawn home with great rapidity or, if desired, the loop could be taken in very slowly by using the screw and fly nut. The instrument is made of metal and simply constructed.

Dr. Thomson drew attention to the great strength of the snare, and the advantage over some others of working noiselessly.

A Wrist-easel with Tracing Tablets for Laryngoscopic and other similar Drawings.

Shown by Dr. Dundas Grant. Consists of a small metal frame about 2 by 3 inches, fixed to left wrist by a metal clip, which is easily attached. In the frame can be placed drawings of the conventional outlines of the normal larynx, the tympanic membrane, the nasal cavities, &c. Over the drawing is placed a sheet of semi-transparent tracing paper, held firmly by means of a metal frame.

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The observer, even if comparatively unskilled in drawing, can thus trace a representation of the diseased condition without the trouble of laying down his instruments. The remaining outlines can either be traced at once or at a later period. By means of this apparatus, drawings may be made with the least possible inconvenience to the patient or the observer, and with the minimum tax upon the artistic skill of the latter.

A Microscopic Specimen of an Early Epithelioma of the Vocal Cord, and a Drawing of the Laryngoscopic Appearances before Operation.

Shown by Dr. J. Middlemas Hunt. The patient, a man of 56, had been slightly hoarse for about a year. Laryngoscopic examination showed marked congestion of left vocal cord, and on its edge, in the anterior third, was a small, white, flat papilloma, which seemed to invade rather than grow from the surface of the cord. There was perfect movement of both cords in phonation and inspiration. The growth was diagnosed as malignant from (1) its white colour, (2) its invasion of the substance of the cord, (3) the soft ulcerated appearance of its surface, (4) the congestion of the cord on which it was situated, (5) the age of the patient. Thyrotomy was performed after a course of iodide of potassium, and the left cord excised. The growth, which was no larger than a millet seed, presented the microscopic characters of an early epithelioma. The patient is now well, and has an excellent voice, six months after the operation.

A Case of Unilateral Paresis of the Vocal Cord.

Shown by Dr. P. Watson Williams (Bristol). The patient, first seen on November 12th, 1896, had a slight sore throat about three weeks before, and about two weeks before this he had lost his voice for one day, when it apparently got right again. In September he had had a severe and typical attack of acute lacunar tonsillitis, but the voice was quite unaffected.

The patient, a medical student, had been seeing cases of diphtheria, but was in good general health.

The voice was a little squeaky when the patient was first seen, and

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the laryngoscope showed that the left abductor was paralysed and the adductor paretic, the healthy cord passing across the middle line in phonation. He was improved by local faradisation and the administration of strychnine and salicylate of soda, so that in six days time there was only a pure left abductor paralysis. By December 5th the abductor was only paretic, and since then the paresis had become still less marked.

Dr. Williams attributed the lesion to rheumatic neuritis, the patient having a history of subacute rheumatism in childhood, and some years ago he had a first attack of lacunar tonsillitis. There was not the slightest evidence of any intra-thoracic lesion, nor of syphilis, alcoholism, &c.

It was an interesting fact that the adductor recovered first, and Dr. Williams recalled another instance of this tendency to the early recovery of the adductor as compared with the abductor, viz. that of a child whose right vagus had been divided during an operation on the neck (the cut ends being sutured immediately), and in whom the adductor recovered in a few months, leaving only a pure abductor paralysis. The President had demonstrated the proneness of the abductors to succumb earlier than the adductors; these cases afforded clinical evidence of the converse sequence of events in recovery, viz. that the adductors exhibit a decided tendency to recover sooner than the abductors.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *February* 10*th*, 1897.

HENRY T. BUTLIN, ESQ., F.R.C.S., President, in the Chair.

STCLAIR THOMSON, M.D., } Secretaries.
HERBERT TILLEY, M.D., }

Present—33 members and 4 visitors.

The minutes of the previous meeting were read and confirmed.

Professor Moritz Schmidt was elected an honorary member of the Society.

Mr. Herbert Durham, M.B., C.M., F.R.C.S.Eng., London, Mr. H. Secker Walker, F.R.C.S.Eng., Leeds, were elected as ordinary members.

The following candidates were proposed for election:

Dr. Ernest Brown, Montreal.
Ronald Herdman, M.B., C.M., London.

CASE OF CLEFT PALATE WITH HYPERTROPHY OF THE POSTERIOR EXTREMITIES OF THE INFERIOR TURBINATES AND ADENOIDS.

Shown by Dr. EDWARD LAW. Patient, a boy æt. 16, complains of difficulty in breathing through the nose, slight deafness, defective mode of speaking, and formerly the passage of liquids through the nose. Patient was operated upon when ten months old, but the result was

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not successful. A second operation was performed eight years later with great advantage, but the fissure appeared again during an attack of influenza two years ago, and seems to be still increasing.

On examination, a cicatrix is seen in the middle line of the hard palate which terminates in a fissure passing through the soft palate. The posterior rhinoscopic image shows the enlarged bluish-grey posterior extremities of the inferior turbinates, which touch the septum and each other, and a small quantity of adenoid growths still remaining on the posterior wall of the naso-pharynx.

Case of Cleft Palate with Great Hypertrophy of the Inferior Turbinates.

Shown by Dr. Edward Law. Patient, æt. 22, came to the hospital complaining of a serious impediment to distinct articulation.

On examining the oro-pharynx, a longitudinal fissure is seen passing through the soft and hard palate in the middle line as far as the alveolus. The anterior portion of the cleft is filled up by the apposition of the wrinkled, dark, purplish-grey, greatly hypertrophied lower border of the inferior turbinates. The rhinoscope shows the Eustachian orifices to be small and contracted, and, under ordinary conditions, covered or seriously encroached upon by the hypertrophied tissue of the inferior turbinates. There is no deafness or other aural symptoms, although the tympanic membranes are opaque and retracted. The parts are much changed on the application of cocain. The cavernous structure of the two bodies shrinks and separates, giving a distinct view of the middle turbinal bodies, also enlarged, and of the nasal septum, which apparently is incomplete in the posterior and inferior segment, running upwards and backwards until it coalesces with the posterior wall of the vault of the pharynx.

The cases are shown because such enlarged turbinal masses are not sufficiently described or depicted in surgical treatises, and to ask for opinions as to the advisability of operative interference. The hypertrophied structures probably perform a conservative process by blocking up the gap and so acting as an imperfect obturator.

Mr. Cresswell Baber said he had frequently seen enlarged inferior turbinated bodies and adenoid vegetations in the cleft palate, and attributed them to irritation of the air passing direct into the

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naso-pharynx through the mouth. It might be necessary on operating to remove the hypertrophies and adenoids. Nasal obstruction is also sometimes increased in these cases by deflection of the septum, which is adherent to one edge of a cleft in the hard palate.

Dr. Scanes Spicer suggested that the greatly hypertrophied inferior turbinated bodies should be removed in these cases in order to give comfortable nasal respiration after the cleft palates were operated on and closed. He asked the general surgeons present whether such a previous procedure would not have a favorable influence on the palate operations, as nasal respiration lessened the tension of the soft palate, whereas buccal respiration increased it.

Dr. Grant pointed out the value of the pad formed by the enlarged inferior turbinates in aiding the patient to drink, and therefore should hesitate in advising their removal.

Dr. Hill thought the extreme hypertrophy of the inferior turbinates might be due to the irritation caused by direct contact of food. He had removed the posterior extremities in other cases previous to the operation for cleft palate.

Mr. Bowlby stated that in two cases he had found it necessary to remove masses of adenoids previous to operating for cleft palate, as their presence hindered the closing of the gap.

Mr. Charters Symonds had sometimes found a pad of adenoids give support to palate after operation, but suggested removal in Dr. Law's first case.

Mr. Spencer, referring to Case 2, said that the arch of the palate was flat, and the muco-periosteum very thin, therefore the case was not a favorable one for another attempt at union. The patient requires an upper tooth plate to set out the sunken upper lip and replace carious and absent teeth. The plate can at the same time be made to act as an obturator.

Mr. de Santi thought that the age of the patient was no contra-indication to an operation to remedy the cleft palate. He had known a lady of thirty-five who had been operated on for a very extensive cleft palate. It was most successful. He pointed out that the voice often remained much the same after even a successful operation on account of the shape of the hard palate.

Dr. Law, in reply, stated that he did not consider the age in either case an absolute contra-indication; at the same time one must remember that both patients only complained of indistinct nasal speech with some obstruction. Closure of the cleft (such a successful result of operative measures is by no means certain) may in no way remedy the defective articulation, even after a long course of training. The thin cicatrix and tension in the first case and the low palate and broad fissure in the second, are not favorable features. These considerations, with the slight mortality, rather point to leaving matters alone, and placing the patients in the hands of the dental surgeon. The removal of the enlarged turbinal masses before closing the fissure might be followed by regurgitation of liquids through the nose and other disagreeable symptoms if the subsequent operation was not successful.

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A METHOD OF EXAMINING THE LARYNX IN INFANTS.

Shown by Dr. LACK. The method is an extremely simple one, and no special instruments are necessary. The infant is supported in the usual position for laryngoscopy. The index finger of the left hand is passed well into the mouth, and the terminal phalanx hooked round the hyoid bone, which is pulled forwards. The rest of the finger acts as a tongue depressor, and the knuckle as a gag. The left thumb placed under the chin serves to steady the head. If a small laryngeal mirror be now introduced in the usual way, the larynx can be quite easily seen. The method causes no pain, no anæsthetic is required, and it is applicable to every case. For some months I have examined the larynx of every infant coming under my care, and have almost invariably succeeded at the first attempt. In older infants, those with teeth, I have used a curved tongue-depressor, a copper spatula suitably bent, instead of the finger, and this method may be preferred by those laryngologists whose fingers occupy an inconvenient amount of the space afforded by an infant's mouth. It is not quite so easy, and some means of opening the mouth may be necessary. The younger the infant the less is the resistance, and the easier the examination.

The method seems to cause no more trouble than an examination of the fauces, and is consequently applicable as a routine practice. It is much easier than Kirstein's method, with which I have rarely succeeded, and which causes great inconvenience. Eseat's method, which has just been brought out, seems to be founded on a false principle, and to be quite impracticable without an anæsthetic.

The infant on whom I propose to demonstrate is 1 year 9 months old, and is a typical case of congenital laryngeal stridor. The pathology of these cases remains undecided, but in this case the stridor is seen to be due to lateral approximation of the soft parts forming the upper aperture of the larynx, which flap together and vibrate on inspiration, and separate again slightly on expiration.

Dr. BOND, who had used the method in several cases, spoke highly of it.

Dr. WAGGETT pointed out that a tongue depressor ending in a slightly curved, forked extremity was in use in France, and was used on the same principle as Lack's method.

Dr. BEALE asked what were the limits of age for which Dr. Lack advocated this method.

Dr. SPICER said that hitherto in children he preferred general

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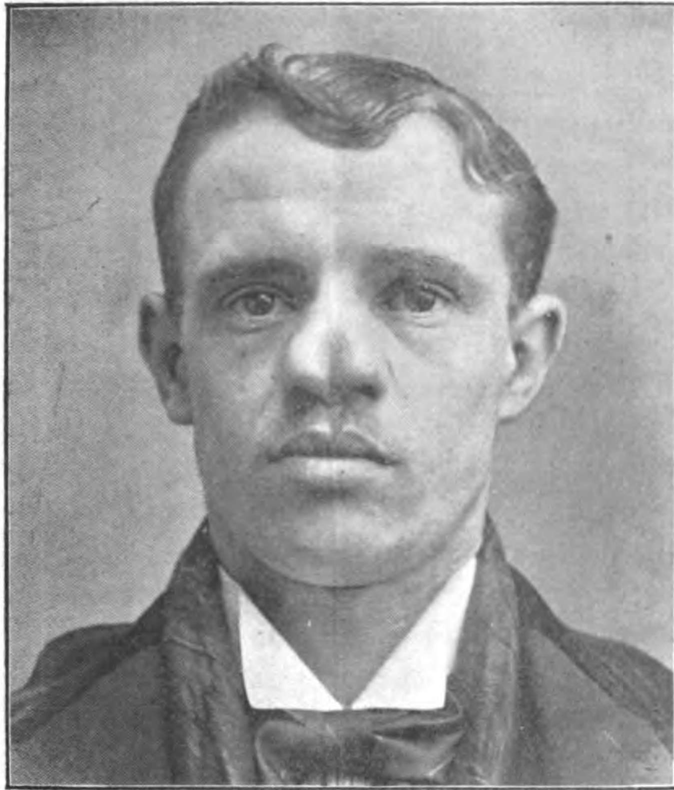

Mr. W. R. H. Stewart's case of Malformation of the Nose,
See p. 43.

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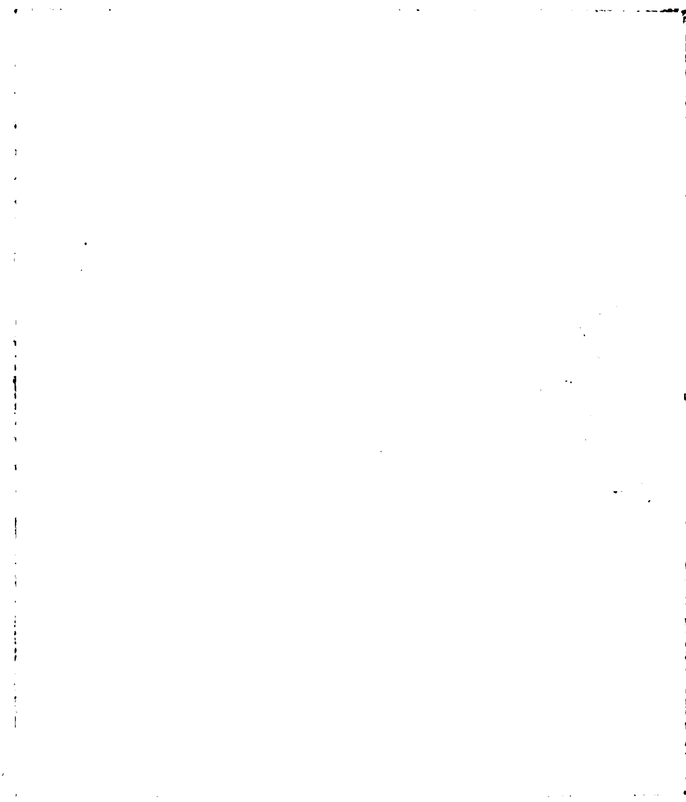

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chloroform anæsthesia combined with local application of cocaine, as the patients were otherwise unmanagable. He proposed, however, to try Dr. Lack's method.

Dr. Lack, in reply, stated that the method he advocated was especially suitable for very young children, because in older ones he found no difficulty, as a rule, in using the ordinary method of laryngoscopic examination.

Case of Bilateral Abductor Paralysis with Unilateral Paresis of Soft Palate and Pharynx.

Shown by Dr. Lack. L. C—, female, æt. 28, a school teacher. For about seven months she has noticed impairment of the voice, and speaking required an unusual effort towards the end of the day. Three months ago she noticed a peculiar sound on inspiration when talking or on any exertion. This noise continued during sleep. At times she has had some difficulty in inspiration. The patient has always been anæmic, but has improved lately. She has always been very nervous. The family and previous history are unimportant.

Present condition.—The patient is somewhat anæmic and extremely neurotic. There is stridor on talking or on any exertion, and it continues and is usually much louder during sleep. She has had one severe attack of dyspnœa in the last two days, brought on by emotion. She has no trouble in swallowing.

On examination of the larynx there is seen to be bilateral abductor paralysis, complete on the right side, but the left cord seems to have slight movement. Both cords are much congested. The right half of the soft palate and pharynx are paretic, but not entirely paralysed. The tongue is much wasted, and the intrinsic muscles are paralysed. She cannot raise the tip.

There is slight nystagmus on extreme outward rotation, more especially to the right, probably due to weakness of the external rectus. There is possibly also some wasting of the hypothenar eminence and of the interossei in the left hand, but it is very slight, and there is no apparent loss of power.

Dr. James Taylor thinks the lesion is probably in the medulla. At his suggestion the patient has been treated with large and increasing doses of strychnine.

The condition has remained stationary for the last two months.

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Tuberculosis of Larynx.

Dr. Watson Williams (Bristol) showed a coloured drawing of a case of laryngeal tuberculosis of the right vocal cord and the ventricular bands, which he had treated by curettement and the local application of concentrated lactic acid, pure guaiacol, &c. He drew attention to the sedative effect of strong guaiacol applications adding much value to its germicidal action in tubercular lesions. He remarked on the advantage of combining phenazenum and cocaine with lactic acid in the form of a watery spray solution in these affections of the upper respiratory tract.

Dr. Clifford Beale called attention to the fact that the case described and figured by Dr. Watson Williams showed no signs of tubercular infiltration. The lesion appeared to be superficial only, and as such was amenable to successful treatment by scraping and the application of lactic acid, whereas in the cases of actual submucous infiltration the results of "curettement" were but rarely successful. A great distinction ought to be made, in describing cases of cured tubercular laryngitis, between those cases where infiltration was present, and those in which the lesion was superficial. The latter sometimes recovered without local treatment, or were improved by the application of simple astringents.

Dr. Watson Williams, in reply, stated that cases of tumefaction had in his experience done well with curettement and lactic acid applications.

Lupus of the Larynx and Tuberculosis of the Lungs.

Shown by Dr. StClair Thomson. This patient was shown in order to elicit from the Society its opinion as to the association of these two conditions. Between lupus of the skin and phthisis there is acknowledged to be a close relationship, but in one of his most recent publications Bosworth states that he finds but a single case, viz. that of Thoma, in which lupus of the throat occurred in an individual showing evidence of tuberculous deposit in other regions ('Twentieth Century Practice,' vol. vi, 1896). Now, in this case a man aged 21 presented lupus of the epiglottis, while there were phthisical symptoms in both lungs, with tubercle bacilli in the sputum. There was also some lupus on the skin of the nose, as well as inside the left nostril, but the history of the case (it commenced with epistaxis) indicated that the lupus had first attacked the mucous membrane of the left nostril, then the skin over the tip of the nose, and lastly

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the epiglottis. As regards the lungs, there were neither fever, night sweats, nor hæmoptysis, and the patient had gained in weight.

Mr. Stewart said that he thought the case looked more like one of tubercular laryngitis than lupus.

Dr. Lack had seen two cases of lupus in the upper air tract ending in phthisis after some years.

Dr. Bond had had a somewhat similar experience.

Perichondritis of Larynx arising in the Secondary Stage of Syphilis.

Mr. Symonds showed a man, æt. 35, who applied at Guy's Hospital fourteen months ago with a phagedænic chancre of fourteen days' duration. While still progressing, and while the rash was present, hoarseness developed. This was about two and a half months from inoculation. Congestion of the left cord was first noticed; then it became fixed, and lost in the surrounding swelling. The voice for a time was reduced to a whisper. Subsequently ulceration of the septum nasi appeared. When exhibited, the left half of the larynx shows a hard infiltration, with immobility of the cord. There was no ulceration, nor had there ever been any, and at no time was there expectoration. The epiglottis was somewhat curved, and obstructed the view. The patient had been regularly under mercury during the whole time. The voice has improved of late.

Ulceration of the Right Ventricular Band with Impaired Mobility of the Cord.

Mr. Symonds showed the case of S—, æt. 54, who when seen on October 16th, 1896, complained of dryness of the throat, pain in the right side in swallowing, occasional loss of voice; symptoms had existed for six weeks. The right cord was red, and moved less freely than the left; no ulceration visible; the ventricular band was swollen and red. There was no sign of old syphilis, or gout or tubercle. The family history was excellent (eight living out of fourteen). There was no ataxy.

On October 30th the right cord was almost motionless. He was given mercury with potassium iodide.

November 26th.—Though still red, the cord was thought to be more moveable, and on two occasions his voice had returned. There

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was some ulceration of the ventricular band to be seen at this time, and Dr. Greville Macdonald, who saw the patient, thought the appearance indicated tubercle. The lungs gave no evidence, and no bacilli were found in the sputum. He has not lost flesh and has never spat blood. He was ordered cod-liver oil and malt.

January 29th, 1897.—The movement of the cord had improved, but the ulceration in the fore part of the ventricular band was more marked, was sharply defined in front with a raised border. No other part of the larynx had become affected. His health otherwise remained good, and his weight was maintained.

Opinions were asked as to the nature of the case, which seemed to lie between a chronic tubercular ulcer, and early malignant disease. The congestion and impaired mobility of the cord suggested malignancy, and the raised edge of the ulcer pointed somewhat in the same direction, while the improvement in movement was opposed to this view.

Mr. Baber thought that the case was either tubercular or syphilitic.

Dr. Bennett thought the case was one of tubercle, but remarked that the immobility of the cord was rather contrary to this view.

Dr. Watson Williams thought that the general aspect of the infiltration, the tendency to pallor rather than hyperæmia, and the apparently superficial narrow ulceration along the margin of the ventricular band, were in favour of the lesion being tubercular rather than malignant disease.

Tubercular Ulceration of the Septum.

Mr. Symonds showed this lad, who was exhibited at the Society in 1895, with a swelling on the right side of the septum, of which various opinions were given. Subsequently Mr. Symonds reported that the mass removed was proved to be tubercular. For a time the disease was kept under by curetting; then in July, 1897, he received a blow on the nose, when rapid progress of the disease ensued, and in a fortnight the columella was destroyed, and the alæ affected. On many occasions the nose has been scraped and lactic acid applied.

When shown the interior of the nose could be well seen; the whole of the cartilage was destroyed, granulations were seen on both inferior turbinals, and there was ulceration of the skin. A small spot had appeared on the palate, but was better. The boy was otherwise in

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good health, and had much improved of late. He has been treated of late with lactic acid locally, and curetting from time to time.

Mr. Cresswell Baber asked if the growth had been freely curetted and treated with lactic acid at the early stage, as he had several times found that arrest the disease.

Mr. Bowlby said that in some cases, in spite of treatment, destruction was very rapid, and that in one case he had seen the whole nose entirely destroyed in three months.

Dr. Hill thought that trichloracetic acid 25 per cent. more suitable in these cases, as lactic acid was not strong enough.

Mr. Symonds said the case had been freely curetted at first, and commenced healing, but then rapidly recurred.

Case of Frontal Sinus Suppuration.

Shown by Dr. Bennett. Mrs. L—, æt. 39, had influenza in the early part of 1894, and from that time suffered severely with right frontal pain and a discharge from the nose. She came to the Leicester Infirmary in October, 1894, with an abscess over the right frontal region as large as a walnut, and a smaller one under the right eyebrow. In the right nostril there was a polypus and a considerable enlargement of the anterior end of the middle turbinal. She was at once admitted. Before opening externally, it was thought desirable to clear away all obstruction to the escape of pus from the sinus, and the polypus and the anterior portion of the turbinal were removed. Pressure on the abscesses caused a large quantity of pus to escape, and openings in the bone of considerable size could be felt through the skin. To secure still freer escape for the pus, the bone was cautiously chipped away from the neighbourhood of the infundibulum. So much relief was experienced, and the amount of pus so materially diminished, that opening from without was postponed. After a few weeks, all pain and all external swelling had disappeared. The patient now felt so well that for some months the only treatment adopted was the use of a cleansing spray. The patient then discontinued coming to the infirmary, as she felt quite well. In December, 1896, at my request, she came for examination, and granulation tissue was removed from the aperture, from which a small quantity of pus was exuding. The former openings in the bone were scarcely to be detected, having become closed with new bony material. The treatment proposed is to keep the nose clear of all granulation tissue which could in any way

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impede the escape of pus. The patient feels as well as she ever did before the influenza. The case was shown to illustrate the importance of commencing treatment in these cases by thoroughly clearing away all impediments to the escape of pus; and also to invite the opinion of members as to the wisdom of continuing to watch the case, or whether it is advisable even now to open the sinus externally.

Mr. SPENCER said that a case under his care had suffered from septic-inflammation of the eye, and the loss of acute vision, because of the delay before operating upon an empyema of the frontal sinus.

Mr. CRESSWELL BABER thought that in this case the discharge would probably not stop without further treatment, and that the slight risk of leaving it alone should be placed before the patient. He advocated, in these cases, obtaining a free access to the duct of the frontal sinus by removing any growths, and the anterior end of the middle turbinated body before opening the sinus from without, but deprecated any forcible entry into the sinus from the nose.

Dr. SCANES SPICER thought that Dr. Bennett had done the best in attacking the frontal sinus empyema through the nose by resecting the anterior extremity of the middle turbinated body. He thought that there was also disease of the ethmoid cells here, and that cautious curetting followed by passage of a Grünwald's frontal sinus cannula, and gentle washing out, *might* lead to further improvement.

Dr. HERBERT TILLEY said that the question of operating or not on these cases of chronic frontal sinus suppuration was one for careful consideration, and weighing of the merits of the individual case. Intra-nasal treatment gave great relief but rarely cure, and some patients preferred the inconvenience of a slight flow of pus, with its comparatively small risk, to the uncertain results of an external operation, where the chances of a recurrence, an external fistula, and a scar had to be borne in mind, and should be laid before the patient. Dr. Tilley had recently operated successfully on a case of long standing, where both sinuses and antra were diseased, and had adopted Luc's method, which consisted of establishing a free communication between the sinuses and the nose, and inserting a self-retaining tube for some days (in his Case 5) after the operation.

Dr. HILL thought the case should be treated surgically with a view to radical cure.

Dr. SPICER and Mr. CHARTERS SYMONDS also made remarks on the case, the latter recalling a case in which he had found the dura mater exposed in the sinus.

CASE OF TUMOUR OF THE UVULA.

Shown by Dr. BENNETT. The specimen shown was removed by Mr. Bond, of Leicester, from the palate of a child æt. 6. It had pro-

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bably existed for years, but no certain information could be obtained. The only troublesome effect was the interference with distinct speech. On examination a tumour about the size of a walnut was seen, apparently confined to the uvula, but digital examination showed that it extended upward towards the hard palate. It was removed by dividing the mucous membrane, and shelling it out except for the strands of tissue which passed up, but the exact point of origin could not be determined. The microscopical report was in favour of the growth being of a simple nature.

Case for Diagnosis: an Affection of the Mouth and Lower Jaw.

Mr. Lawrence showed the patient, a female æt. 25, married five years, never pregnant. She was well till four months ago, when she noticed a swelling of the gum over inner right alveolus. Then there appeared a lump over the left cheek, which got larger and broke, giving exit to "matter." Next a swelling arose on the right side over the lower jaw. Her present condition shows: (*a*) enlargement of gum over right inner alveolar border, (*b*) superficial ulceration over right half of palate, (*c*) an abscess on right side of lower jaw, (*d*) on left cheek a very large granulating surface, and below it a breaking down glandular mass. During the last two or three days a mass has developed in the right groin following one which appeared some weeks ago. There has never been a rash or history of syphilis.

Dr. Herbert Tilley suggested that the fluctuating swellings should be opened and the pus examined for actinomycotic fungi, and cited a somewhat similar case which was described by Israel.

Mr. de Santi was of opinion that this was not a case of actinomycosis. He had seen six or seven cases, and in all the course of the disease had been very chronic, and the appearance of the granulations quite different to that shown by Mr. Lawrence. There was an absence of the peculiar yellow points seen in actinomycosis, and also of any indentation. He thought it possibly a mixture of tubercle and syphilis.

Mr. Bowlby thought the rapidity of the growth and acuteness of the suppuration, and the extent of the glandular infection, were unlike actinomycosis. He thought the ulceration of the palate was syphilitic, and the ulcerating growth on cheek with suppurating glands more like tubercle, these latter conditions suggesting tubercle as the cause of the whole process.

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Dr. LIEVEN (Aix-la-Chapelle) also considered the palate ulceration syphilitic, and the swellings tubercular, an opinion also shared by Dr. ST CLAIR THOMSON.

Mr. SPENCER thought the lesions on the cheeks tubercular, and advised erasion. He thought actinomycosis unlikely owing to the lack of infiltration and brawny swelling.

CASE OF PERICHONDRITIS OF LARYNX WITH APPEARANCES SIMULATING PARALYSIS OF CORDS.

Shown by Dr. HERBERT TILLEY. (Kindly lent by Mr. Barker, of University College Hospital.) Patient is a man æt. 35, who complained of hoarseness and pain on swallowing. He has had syphilis, and a bad attack of rheumatic fever twelve months ago. There are no chest lesions. His symptoms commenced nine months ago with difficulty of breathing and pain on swallowing. The difficulty has disappeared, but the pain slowly increases, and radiates now from his throat over the side of his head, and there is great tenderness and pain when external pressure is applied to the larynx.

1. The right vocal cord is fixed in the cadaveric position as in complete abductor paralysis.
2. The left cord is only slightly moveable.
3. The arytænoids move very slightly on phonation.
4. There is a curious lobster-tailed swelling of the mucous membrane of the left arytænoid cartilage.

CASE OF DOUBTFUL EARLY MALIGNANT DISEASE OF LARYNX.

Dr. SCANES SPICER showed a male patient æt. 58, who had suffered from hoarseness, which commenced four months ago, and had gradually increased. This was associated with a feeling of lump in the throat, and some little difficulty in swallowing.

Laryngoscopic examination showed the right vocal cord to be immobile, and in the cadaveric position; there was slight general thickening above and below, but no distinct tumour or ulceration; the right arytænoid pyramid was slightly displaced backwards. There had been no pain or hæmorrhage; no history or evidence of syphilis or tuberculosis. The patient had taken 15 gr. doses of iodide thrice daily for a month with no change.

The appearances and character of voice suggested early malignant

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disease, and as the pathological changes were intrinsic and unilateral, and there was no glandular enlargement, Dr. Scanes Spicer thought the case a favorable one for radical operation, but before proposing this he would like the opinion of the Society on the case.

Mr. de Santi thought the appearances of the larynx were suggestive of early malignant disease.

Hypertrophic Pharyngitis and Tonsillitis with Chronic Enlargement of Parotids and Submaxillary Glands.

Shown by Mr. Spencer. A man æt. 25, had some superficial tubercular lesions which healed after erasion, also various acne patches and blepharitis. He next had a febrile temperature for some time without any definite cause being found. He has the last two months suffered from inflammation of the pharynx, tonsils, &c., and the parotids and submaxillary glands have become much enlarged, and are hard but painless. The mouth is somewhat dry, but no crusts have been seen.

Dr. Lack thought the case possibly syphilitic, and Dr. Bennett suggested that arsenic should be administered.

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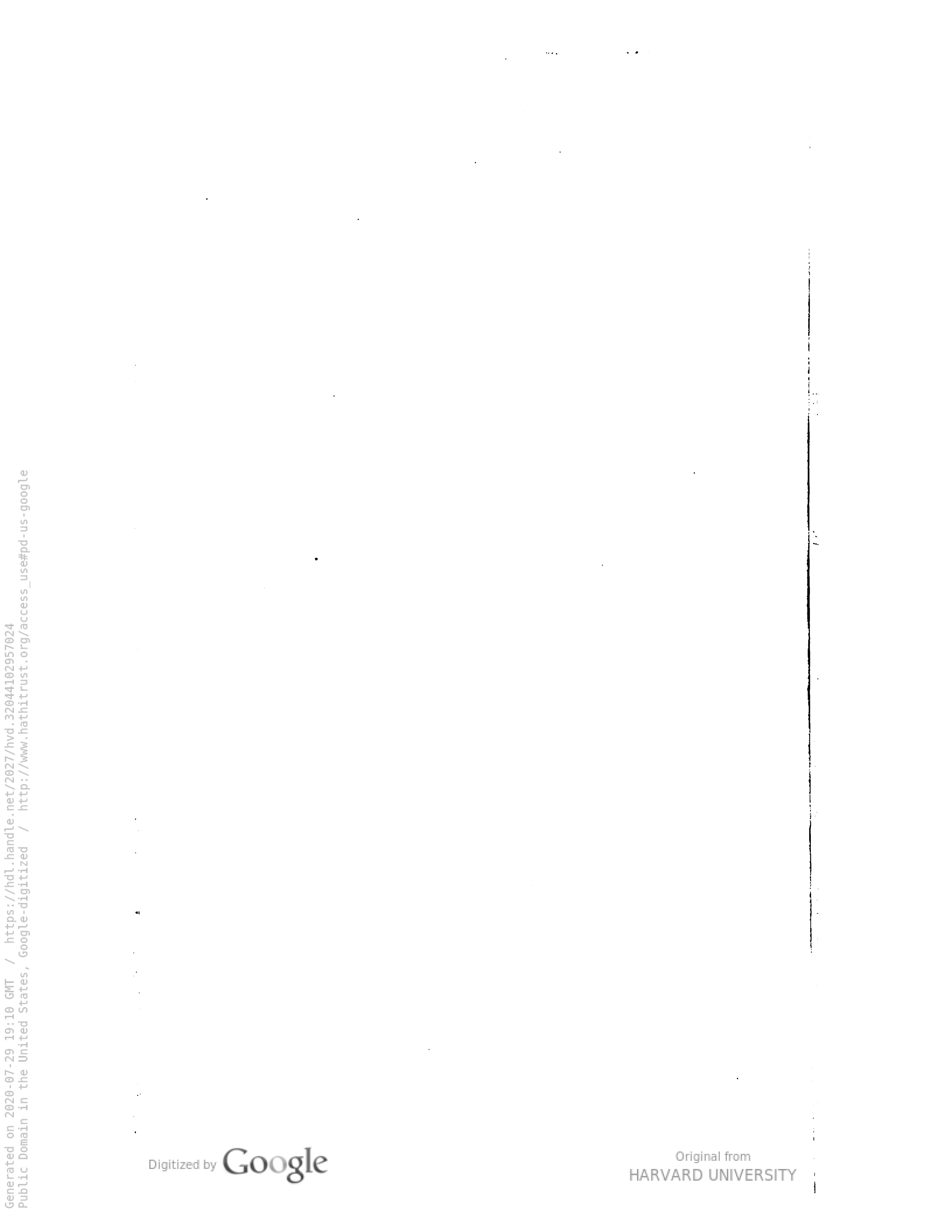

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *March* 10*th*, 1897.

HENRY T. BUTLIN, ESQ., F.R.C.S., President, in the Chair.

STCLAIR THOMSON, M.D., } Secretaries.
HERBERT TILLEY, M.D., }

Present—31 members and 4 visitors.

The minutes of the previous meeting were read and confirmed.

A letter was read by the President from Dr. Moritz Schmidt, of Frankfort, thanking the Society for the honour they had conferred on him in electing him an honorary member, and asking their acceptance of the last edition of his work, 'Die Krankheiten der oberen Luftwaege' for the Library of the Society.

PHARYNX FROM A CASE OF SCARLET FEVER, FATAL ON THE NINTH DAY OF DISEASE, THAT HAD BEEN TREATED WITH ANTI-STREPTOCOCCIC SERUM.

Shown by Mr. KNYVETT GORDON. The specimen showed sloughing of both tonsils, and ulceration of the uvula. There was a chain of small ulcers extending from the tip of the epiglottis to the pyriform fossa on each side; the naso-pharynx had been full of sloughing adenoid tissue.

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He stated that, in his opinion, the serum was not of much value in cases of scarlet fever where the septic symptoms appeared late, and were due to absorption from a sloughing throat or neck, but he had obtained a strikingly good result when there was septicæmia at the onset, and the serum was given early.

Cases Shown by H. Lambert Lack.

Case 1.—Man æt. 65, nearly two years after operation for sarcoma of nose.

The patient was treated for eighteen months for nasal polypi of the left nostril only, when, in February, 1895, for the first time, an ill-defined swelling was noticed in the middle fossa on the right side. In April, 1895, the man was again seen; the right nostril was then almost blocked by a soft, easily-bleeding, superficially necrotic mass, springing apparently from the middle turbinate.

Removal of pieces with the snare was accompanied by severe hæmorrhage, and the mass increased rapidly. Microscopical examination of these pieces confirmed the diagnosis of sarcoma. The patient was admitted into hospital for operation in May, 1895. Under chloroform the posterior nares were securely plugged with a roll of lint held in position by tapes passing through the nose and tied round the head. The right ala nasi was detached to permit freer access. The mass was seized with polypus forceps and torn out. Then by vigorous use of a Meyer's ring knife, the greater part of the lateral mass of the ethmoid was scraped away, the inner walls of the maxillary antrum and of the orbit being almost entirely removed. The roof of the cavity was also very freely scraped away. The large cavity was packed with iodoform gauze, and the post-nasal plug withdrawn. The operation was followed by considerable ecchymosis of the eyelids and cheek, but the patient made an otherwise uneventful recovery, and left the hospital in fourteen days. There is now, nearly two years later, no sign of recurrence of the disease, and there is no deformity of the nose.

The case is an illustration of the mild malignancy possessed by these growths, and of the success which in consequence often attends vigorous intra-nasal treatment.

Case 2.—" Man æt. 45, with cyst of epiglottis and black tongue." The patient complains of a lump in the throat and of choking sen-

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sations, causing great discomfort, especially on swallowing. Examination shows two rare conditions. There is a cyst about the size of a horse-bean in contact with the epiglottis, but apparently springing from the right side of the glosso-epiglottic ligament. This probably gives rise to the above symptoms. There is also the typical condition of black tongue. The papillæ lying immediately in front of the circumvallate papillæ and extending forwards in the centre of the dorsum are greatly elongated, furry-looking, and sooty-black.

This condition has persisted some years, varying much in amount and extent, and apparently gives rise to no symptoms.

Dr. StClair Thomson asked for, and Mr. Butlin suggested the advisability of a microscopic examination of the "black tongue" fungus.

Case of Anterior Turbinotomy in an Elderly Man.

Shown by Dr. Grant. This patient complained of discomfort in the throat with congestion of the fauces, pharynx, and larynx. He had almost complete nasal obstruction, and as the application of topical remedies failed to produce any effect upon the throat, I decided to remove the nasal obstruction.

The anterior extremities of both inferior turbinated bodies were removed. A cut was made by means of the scissors, obliquely upwards and backwards along the attachment of the turbinated body. A cold wire snare was then passed around the peninsula thus left, and the portion ensnared was easily cut through. An opening was thus made into the wide part of the inferior meatus, and breathing through the nostril became very easy.

The loss of blood was quite insignificant. The patient had no signs of constitutional reaction, and as far as the nasal obstruction was concerned, was completely relieved. The discomfort in the throat was also considerably diminished.

Case of Anterior Turbinotomy in a Female.

Shown by Dr. Grant. Patient is a vocalist, and suffered from nasal obstruction. This was greatest in the left nostril, and I removed the anterior extremity of the inferior turbinate by the same

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method as in the preceding case. The bleeding was slight, and the breathing room thus afforded was ample. The other nostril now seemed by contrast to be obstructed, and I removed the anterior extremity of the right inferior turbinate.

The appearance after recovery is that of a double passage, the posterior half of the turbinated body forming an imperfect vertical septum, while the amount of the turbinate left is presumably sufficient for all purposes.

In many cases it might be substituted for the complete turbinectomy.

Dr. William Hill thought that there was still some obstruction, and suggested complete turbinectomy. In this Dr. Scanes Spicer supported him.

Dr. Hall and Mr. Baber pointed out the advisability of only doing as much as was necessary, especially when the obstruction was confined to the anterior extremity of the turbinate. The hæmorrhage in the anterior operation is slight, in the complete turbinectomy often severe.

Case of Functional Aphonia with Ventricular Band Phonation.

Shown by Dr. Grant. Miss ——, æt. 36, has suffered from hoarseness since December, 1890. She lost her voice suddenly, and for four or five months could only speak in a whisper. Then she consulted a doctor, who cauterised her throat on several occasions. The voice returned partially, but it was very gruff, and has remained so since.

She has had purulent rhinitis affecting various sinuses—ethmoidal particular,—accompanied by frontal, post-ocular, and occipital pain. Both frontal sinuses were explored by me, but with comparatively negative results, and no pronounced benefit from the exploration.

The ethmoidal sinuses have been opened, but the nasal trouble is still under treatment, and likely to continue so for some time.

The vocal trouble depends upon an incomplete approximation of the vocal chords—especially in the posterior third, while the ventricular bands come into apposition in the anterior three fourths of their length.

Sounds produced on phonation are extremely gruff and low pitched. After vigorous faradisation of the interior of the larynx, and a con-

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siderable effort at imitating normal sounds, the patient can utter vocal sounds of some purity, and the laryngoscope shows the vocal cords approximated, while the ventricular bands retain their normal position. This soon passes off. Under daily stimulation the acquisition of the normal tone becomes more easy, and its disappearance less quick.

There is slight deafness on the right side. The field of vision is reduced, and there is complete hæmianæsthesia of the right side.

The hysterical nature of the affection is probably unquestionable.

Dr. SPICER thought that phonation was damped by the contraction of the pharyngeal muscles.

Mr. SPENCER said that expiration did not coincide with adduction in this case.

Dr. THOMSON noticed that the patient could cough without the vocal processes coming together, and thought that some of the "gruffness" might be due to thickening of one of the vocal cords.

CASE OF DOUBLE ABDUCTOR AND TENSOR PARESIS IN A TABETIC SUBJECT.

Shown by Dr. GRANT. The patient, an elderly man with marked tabes, has suffered from hoarseness for two years, followed after five months by the occurrence of slight inspiratory stridor.

When seen two years ago his vocal cords were, during inspiration, hardly abducted at all, but they were slightly more open than during phonation. His palate, during phonation, was drawn up to the left, and there was no dimple on the right side. The orbicular muscle of the mouth was feeble; he could neither whistle nor spit, but his tongue moved fairly well, and he could make a channel with it.

His swallowing and his pharyngeal reflexes were normal. He was known to make considerable noise in his sleep.

He has frequently had diplopia; his knee-jerks are gone; he has shooting pains in his legs; is unable to chew owing to want of power and pain in the process, and food accumulates between the teeth and the cheek.

Now he complains of a tightness in the throat, and the stridor in inspiration is very little worse than it was two years ago, although his ataxy has increased very considerably.

His epiglottis is very pendulous, and he appears to have no power of lifting it, so that the movements of the vocal cords are hardly perceptible until Mount Bleyer's epiglottis lifter is used; then during inspiration the vocal cords adhere together in their anterior fourth. There is a very wide elliptical opening from this point to the vocal process. These projections are separated by two or three millimetres, and behind them the cartilaginous glottis is very angular in shape.

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The outward movement of the cartilages of Santorini is very slight in phonation, the vocal processes coming close together, and the elliptical opening between the vocal cords becoming somewhat narrower.

The sensibility of the larynx is slightly diminished, and the voice is monotone.

There appears to be paralysis of the abductors and of the tensors of the vocal cords, both internal and external. Were it not for the latter element the dyspnœa would be considerably greater than it is, and tracheotomy would have been more urged than has been the case.

Dr. SEMON related the details of a similar case of tabes where double abductor paralysis, without any warning, suddenly placed the patient in a condition of almost complete asphyxiation, and only a rapid tracheotomy with three hours' artificial respiration rescued the patient from death; and this case had been the main cause of his advising tracheotomy in similar cases before such acute symptoms appeared. He now thought, however, that in some cases where the paralysis was not so complete, the risks should be clearly laid before the patient, and that tracheotomy might sometimes be deferred.

Mr. CRESSWELL BABER asked if there was any hyperæsthesia of the pharynx and larynx, as he had under his care a case of abductor paralysis in locomotor ataxia in which there was hyperæsthesia together with attacks of spasm of the adductors.

Dr. GRANT also showed a case of chronic œdema of larynx in a boy aged fifteen, and a case of complete occlusion of the right posterior naris.

CASE OF CHRONIC LARYNGITIS.

Dr. BALL showed the case of a clergyman, æt. 26, otherwise healthy, who had suffered from hoarseness and weakness of voice for about five years. The voice is more husky when speaking in a low tone than when he raises his voice. The vocal cords are congested, and on phonation they are not completely approximated, an elliptical opening remaining between them in front of the vocal processes. He has derived no benefit from treatment hitherto, and the question is what is the cause of the condition of chronic laryngitis and defective tension, and what treatment would be most likely to benefit him.

Dr. HALL said that the patient complained of a dry throat and that there was inefficient nasal respiration, which if corrected might tend to relieve the laryngeal condition. This suggestion was supported by Dr. SPICER, who considered the nasal obstruction very complete.

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Dr. Ball, in reply, said that the galvano-cautery had been applied to relieve the obstruction, and possibly more would be done, *e. g.* anterior turbinotomy. There was imperfect action of the internal tensors, and Dr. Semon had suggested internal faradisation; but it was a lengthy and tedious treatment, and he (Dr. Ball) thought that massage and voice training might be of advantage by exercising the muscles.

Double Abductor Paralysis with New Growth at Base of Tongue.

Shown by Dr. StClair Thomson.—This man, æt. 57, was a patient of Dr. Bond's, who had kindly lent the case. The patient had attended the Throat Hospital twenty-seven years ago, under Morell Mackenzie, for noisy breathing consequent on being stabbed about the neck, and at first it was thought that the patient's description of his case probably referred to the commencement of this double paralysis, which would in that case have existed for twenty-seven years. But it appears that the case was published in the 'British Medical Journal,' December 24th, 1870, p. 682, and a reference to that journal shows that at that date the affection was limited to one side, and was recovered from. The following is the description of his condition in 1870 six weeks after being stabbed:

"Four nearly healed wounds were found in the following situations: one just below the prominence of the occiput; a second over the right side of the second cervical vertebra; a third just below and a quarter of an inch behind the mastoid process (this wound was stated in evidence to have been one inch and three-quarters deep); a fourth wound was situated about midway between the second and third. On examination further, there was seen to be paralysis of the right side of the tongue, and slight paralysis of the muscles of the upper jaw on the right side. There were diminished sensibility and loss of power of the abductors and adductors of the right side of the larynx, and considerable enlargement of the thyroid body. No special treatment was adopted, and the patient is now nearly well. Dr. Morell Mackenzie observed that in this case the loss of sensibility of the mucous membrane, the impaired action of the muscles on the right side of the larynx, and the dysphagia, all pointed to an injury of some fibres of the pneumogastric, as it is only by injury of the trunk itself that both the motor and sensory branches could be affected. The paralysis of the right side of the tongue clearly showed injury of the hypoglossal nerve. It was difficult to account for the apparent paralysis of the temporal and masseter muscles, unless it were that this condition had been caused by some tumefaction and stiffness of the articulation of the jaw. As

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the man had not been seen by Dr. Mackenzie at the time of the accident, the account as to heat of the face could not be entirely relied on, and might possibly have been due to inflammatory hyperæmia. There did not appear to have been any affection of the pupil, though the eyes had been suffused with tears. The sudden enlargement of the thyroid body did, however, in conjunction with the other symptoms, seem to imply that there had been injury of some branches of the superior cervical ganglion."

Although the above report states that the patient was "nearly well," he himself asserts that since the year 1870 he has never been free from stridor on the slightest exertion; he cannot lift a weight or hurry without dyspnœa. This is now found to be dependent on very complete double abductor paralysis. The cords, indeed, are so flaccid that on deep inspiration they fall together, while on expiration they flap apart. Is this paralysis in any way connected with his condition as published in 1870, or is it not rather a separate process caused by syphilis, which he contracted about two years previously to the stabbing accident. The pupils are equal and react normally; the patellar reflexes are normal. The patient says his breathing has been better in the last ten years than it had been formerly, and he does not now apply for this, but because of pain in the throat and a lump at the angle of the jaw. There is a small, hard, ulcerated infiltration at the right base of the tongue and on the neighbouring surface of the anterior faucial pillar. There is an enlarged and tender gland at the angle of the jaw. He has been put on iodide of potassium, but the condition of the tongue is suspicious of malignant disease.

Mr. Butlin said that the tumour at the base of the tongue did not look like carcinoma, and was possibly a tertiary lesion.

Dr. Semon pointed out that the late Sir Morell Mackenzie in his description of this case had only spoken of paralysis on the *right* side of the larynx, whilst at present there could be no doubt that there was *bi*lateral, and indeed very complete, abductor paralysis. The explanation, probably, was this: according to Mackenzie's description the *pneumogastric* nerve had been injured; hence, probably, an ascending neuritis had occurred, the affection had extended from the vagus nucleus to the nucleus of the spinal accessory in the medulla, from the latter through the commissural fibres, which according to Lockhart Clarke connected the two accessory nerves, to the left accessory nucleus, and had then travelled downwards the trunk of that nerve, causing abductor paralysis on the left side as well. (Sir George Johnson's theory.) In view of the fact, however, now communicated by Dr. StClair Thomson, that the patient had had syphilis prior to the infliction of the injuries, it was, of course, also

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possible that all the various nerve lesions met with in this case might be the result of cerebral syphilis.

Case of Subglottic Tumour with a History of Aphonia of Twenty-two Years.

Shown by Dr. Donelan. The patient, a woman æt. 33, was seen on December 18th, 1896. When eleven years old she had an attack of acute laryngitis, and her voice, previously clear, became the rough whisper it is at present. She has enjoyed good health, and even when she has had severe colds there has been no dyspnœa.

On examination a subglottic growth, probably a soft fibroma, was found to be the chief cause of the aphonia. The left arytænoid body passes slightly in front of the right in adduction, and to such an extent that the left capitulum completely crosses its fellow, especially when any extra attempt at phonation is made. The difficulty in approximating the right cord to the middle line would appear to be partially due to this condition.

The growth itself is about the size of a large pea, with the longer diameter antero-posteriorly. It is not pedunculated, but is so far mobile as to float up between the cords on any attempt at phonation. No removal has been made as yet. He thought the case of interest to the Society as showing how long growths of this class may exist without causing serious symptoms.

Dr. Herbert Tilley said that he considered it a case of soft fibroma, and that it should be removed endo-laryngeally.

Mr. Butlin suggested that the appearance seemed more like a papilloma, and advised removal of a portion of it at any rate.

Dr. Hall suggested the intra-laryngeal snare for its removal, Dr. Law, Stoerk's guillotine, while Dr. Spicer thought the growth had too large a base for the snare.

Mucocele of Left Frontal Sinus after Operation.

Shown by Dr. Bond. Patient is a female who had a swelling in the left frontal region for some years, with much pain in it on stooping forward, also pain in the left side of the nose and the left eye. There was tenderness on pressure and some "pitting" and redness where the swelling was most prominent. There was a history of a blow. The operation consisted of a vertical cut over the middle

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of the swelling, avoiding the supra-orbital nerve. A crown of bone was removed with the trephine, and the sinus opened with a chisel. It was full of thick mucus, and the nasal passage was blocked. This was made patent, the crown of bone replaced and the skin sewn up, the wound healing by first intention. The site of operation was selected where the bony thickening was most prominent. The patient has now no pain or deformity from operation.

Dr. StClair Thomson would like to have the opinion of members with regard to the occurrence of mucoceles in the accessory sinuses. Giraldès and Virchow had both shown that the term dropsy of the antrum was inappropriate, as it implied a false notion of the pathological condition. The fluid which distended the maxillary or frontal sinus was contained in a vesicle or cyst, and the mucus or "dropsy" was the contents of the distended and thin-walled cyst. Had any one had experience of a sinus being simply distended by retention of the mucus normally secreted by its surface?

Dr. Grant related a case of cystic distension of the antrum under his care.

Mr. Baber reminded the Society of the case of mucocele which he had shown earlier in the Session, in which he operated radically, but granulations returned and filled the front nasal passage so that symptoms returned, and he then removed the whole of the front wall of the sinus and the mucous membrane lining it. This cured the patient, but, of course, produced a considerable deformity.

Case of Rhinitis Caseosa and Rhinolith.

Shown by Dr. Wm. Hill. Mrs. C. M—, æt. 42, came on February 4th of this year complaining of a blocked right nostril of five years' duration, accompanied by fœtor, headache, and deafness of the right ear; the condition had come on gradually, and there was no history of an acute rhinitis or of syphilis. On examination the right nasal cavity was seen to be filled with a putty-like mass, which, on removal with a scoop, was found to be of the consistence of bird-lime; the nose was cleared of the caseous material, and it was then found that the septum was perforated, and that the nasal wall of the antrum, together with the inferior turbinal body, were absent, and that the caseous matter extended into the antrum. The floor of the inferior meatus was occupied by a hard body which was at first taken to be a sequestrum; it was too large to be removed through the nostril: a portion of it was crushed and extracted with forceps. A week later the cavity of the right nasal fossa was again quite filled with caseous

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material; this was removed, and the supposed sequestrum again crushed, the fragments presented the characteristics of a rhinolith. A week later recurrence of the caseous matter had taken place, though not so abundantly; the remaining portion of the rhinolith was again crushed, and the whole of the fragments removed [two of the larger pieces were shown]. For the last fortnight, under an antiseptic douche, the caseous deposit had largely diminished and the fœtor become less marked.

The middle turbinal region is now seen to be the site of exuberant granulations, and crusts are present.

Cases of rhinitis caseosa are rare, and the ætiology of the condition is veiled in obscurity; in recorded cases granulations have usually been present in the nose, as in this case, and bone lesions are not uncommon. According to Massei ('Archiv. Ital. di Laringol.,' No. 2, 1896) three ætiological elements are generally present, viz. (1) an abundant purulent secretion; (2) an obstruction to its discharge; and (3) the presence of *Streptothrix album*.

Whether in this case the rhinolith was a cause or consequence of the caseous rhinitis is a matter of speculation, though the latter is more probable. The history afforded no clue to the sequence of events in reference to the destruction of bone; the one fact which could be positively stated, however, was that the caseous matter ceased to be deposited as the result of removal of the whole of the rhinolith together with antiseptic syringing of the nose.

Dr. Law asked if there was a history of a foreign body, because he had had a case where there was a calcareous collection round a smooth bead.

Dr. Grant mentioned a case where the nucleus of a similar case to Dr. Hill's was a piece of "blotting-paper" apparently.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *April 14th*, 1897.

CHARTERS SYMONDS, ESQ., F.R.C.S., in the Chair.

STCLAIR THOMSON, M.D., } Secretaries.
HERBERT TILLEY, M D., }

Present—27 members and 2 visitors.

The minutes of the previous meeting were read and confirmed.

Dr. Johann Sendziak, of Warsaw, and Mr. Herbert Davis, of St. Leonards-on-Sea, were elected ordinary members of the Society.

Mr. Wyatt Wingrave, 11, Devonshire Street, W., M.R.C.S.Eng. was proposed for election at the next Ordinary Meeting.

RECURRENT DENDRIFORM HYPERPLASIA OF THE LEFT INFERIOR TURBINAL, WITH MICROSCOPIC SECTIONS.

Shown by Dr. PEGLER. G. S—, æt. 13. There had been almost complete nasal obstruction owing to the presence of lobulated inferior turbinal hypertrophies in both nasal fossæ, and adenoids in the naso-pharynx. The case was exhibited on account of the persistent recurrence of the growths, after removal with the snare, and cauterisations, especially on the left side. He had not previously met with this tendency in similar cases. After having cleared away all visible traces of these hypertrophies, in three sittings, it was found that a considerable mass of tissue reappeared by the end of a week. This happened after five more con-

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secutive snarings, when the proliferating power of the mucous membrane became apparently exhausted, and at the present time (nothing having been done for several weeks) only a stumpy growth with much shorter digitations remained.

The case might easily have been mistaken for a papilloma, but the section under the microscope decided that point at once. It represented a portion of tissue of one week's growth, and all the elements of the normal turbinal mucosa, including mucous glands and vascular sinuses, were regenerated.

Case of Fibroma of the Right Vocal Cord in the Region of the Anterior Commissure.

Shown by Dr. Pegler. S. K—, æt. 40, had complained of hoarseness a few weeks. The little tumour was attached to the right vocal cord by a short pedicle, and was projected between the cords on phonation. The right cord was paretic and moved but little, the cause being apparently a mechanical one. The free movement of the left cord gave an appearance at first sight (during abduction) as though the growth were attached to it, but careful inspection under cocaine had shown that though temporarily resting on the surface of the left cord, it was not actually attached to it.

Dr. Herbert Tilley asked if Dr. Pegler could explain the extreme paresis of the right vocal cord. The small growth was so freely moveable that it seemed impossible for it alone to produce the immobility, which was so like that due to pressure on a recurrent laryngeal nerve.

Dr. Semon remarked that the immobility was an important point because, as a rule, it was a leading feature in malignant cases, and nearly always absent in benign growths, at any rate in their early phases.

Dr. Pegler could not give any explanation except the mechanical one of hampering the action of the cord.

Microscopic Section of Sarcoma of the Nose.

Shown by Dr. Lambert Lack at the last meeting.

It was proposed by Dr. Spicer and seconded by Dr. Hill that the specimen should be submitted to the Morbid Growths Committee, a course which was adopted by the Society.

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Tubercular Infiltration and Ulceration of the Soft and Hard Palate.

Shown by Mr. de Santi. Patient is a man æt. 44. The patient was quite well up to Christmas, 1896. He then noticed his palate was sore: this soreness increased, and swelling supervened; swallowing became difficult and was painful.

When seen the third week in January the appearances of the soft and hard palate were those of syphilitic ulceration—whitish patches and serpiginous ulcerations. No history of tubercle. He was put on iodides, but the swelling and ulceration increased. Later the ulcers were cauterised, but getting no better the parts were thoroughly sharp-spooned, and subsequently lactic acid well rubbed in. This was five weeks ago. He is now worse, with great swelling of the parts and infiltration of the uvula. No laryngeal view can be obtained; his breathing is occasionally difficult, and he has pain on swallowing. There is no lung mischief. Tubercle bacilli have been found in the pus from the ulcerations.

Case of Tubercle or Lupus of the Soft Palate and Uvula.

Shown by Mr. de Santi. Patient is a woman of 36. She had had soreness and swelling of soft palate and uvula for one year; the parts had been cauterised, but without benefit. Lately the swelling had increased; never very painful. Now there is swelling and infiltration with small tuberculous nodules of the soft palate and uvula. The nodules had been sharp-spooned and lactic acid rubbed in, but no great improvement has followed.

Paternal grandfather died of phthisis. No lung mischief in patient. Tubercle bacilli found in the secretion from the nodules. This case and the previous one were shown for an opinion as to further treatment.

Dr. Semon suggested arsenic in increasing doses, and if this failed to relieve, then injections of tuberculin.

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Bilateral Abductor Paralysis in a Man aged 36.

Shown by Dr. Furniss Potter. W. A— came to the hospital in June, 1895, with stridor, and complaining of trouble in breathing of two years' duration. The power of abduction of the left cord was seen to be markedly impaired, the right cord was similarly affected, but in slighter degree; this has increased, and at the present time the failure of abduction is very considerable.

The physical signs in the chest—viz. dilated subcutaneous veins below left clavicle, flat percussion note left apex, absence of vocal resonance and fremitus, and diminished respiratory murmur—indicate intra-thoracic pressure as a cause of the paresis.

History of syphilis twelve years ago.

In January, 1894, tracheotomy was performed for relief of urgent dyspnœa (in the Oxford Infirmary).

The patient states that every few weeks the attacks of dyspnœa are worse, and that he coughs up much yellow matter, after which the symptoms are relieved.

He has taken large doses of iodide of potassium, but with no improvement.

A point of interest in the case is whether the implication of the right vocal cord is due to extension of pressure to the right recurrent nerve, or whether it is affected by way of the nuclei (on the theory of Sir George Johnson).

Dr. Stoker has kindly allowed the case to be shown.

Drs. Hall and Semon pointed out that abduction was considerable, and was best seen if the patient was told to phonate for some time, and then inspired naturally.

Mr. Bowlby thought a spinal nerve lesion would explain the condition of things, and instanced a case which he had watched for some years, in which ultimately tabetic symptoms manifested themselves. He thought that if a growth in the chest produced double paralysis, there would be complete paralysis of one cord at least, and pressure on the trachea as well, which was not the case in this patient, where there was only some abductor paresis of both cords.

Dr. Potter agreed that the term "paresis" would be better than "paralysis," as he did not wish it understood that the paralysis was complete.

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A Case in which Bilateral Middle Turbinectomy has been performed to facilitate Removal and Treatment of obstinately Recurrent Nasal Polypi, and to relieve Obstruction to Nasal Respiration which had resisted other Measures.

Shown by Dr. Scanes Spicer. A medical man, æt. 31, sought advice in February, 1895, for nasal troubles. His discomfort commenced with a cold in 1893, when he lost his smell, and was never after that free from nasal stuffiness, sneezing, and rhinorrhœa.

On rhinoscopy, polypi of ordinary character were seen hiding the middle turbinates from view, and extending down over inferior turbinates. The polypi were thoroughly removed by snare and galvano-cautery, and chromic acid used at repeated sittings. It was observed that the middle turbinate areas always looked reddened and turgid. From time to time intra-nasal suppuration of indeterminate source was noticed. Similar procedures were repeated on and off several times until June, 1896, when the stuffiness which had persisted all along became more troublesome, and middle turbinectomy was suggested with the view indicated in the head-line; it was decided at first only to remove the anterior part of middle turbinate under cocaine. This was done. There was much pain and bleeding, as the parts were very vascular. Cocaine 20 per cent. solution did not appear to act very well. Considerable relief was experienced, but things were not quite satisfactory. Later on he had an attack of erysipelas, which lasted a week. During this the obstruction became as bad as ever, but the smell returned for a time.

Early in March, 1897, the symptoms got much worse again, and polypi were seen (and felt) to be obstructing posterior nares, and projecting into naso-pharynx, as well as surrounding the median part of middle turbinates. Dr. Spicer thought the posterior two thirds of the middle turbinates had undergone polypoid degeneration, causing the cells of bone to be distended, and that it was absolutely necessary to reduce it in order to clear the nose and treat exposed ethmoidal cells containing polypi. After a further consultation this was agreed on and performed under gas and ether, Dr. Hewitt giving anæsthetic in sitting position. On April 9th, under cocaine, a further snaring of polypi projecting from ethmoidal cells took place.

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On April 13th patient reports he has never been so clear in nasal respiration, or felt so well for whole of last four years as now; and there is no nasal obstruction, and stumps of polypi are insignificant.

In this case it is too soon to claim an absolute cure, but patient's symptoms are relieved, and it is now easy to treat polypi if they reappear. Moreover, other sinuses, as frontal and sphenoidal, may be affected. In fact, from time to time over both frontal sinuses there have been redness, bogginess, and tenderness with headache. There is none, however, at present. It is much easier now to attack sphenoidal sinuses or to drain the frontal, should such a procedure become necessary in the development of events.

A Case in which Bilateral Inferior and Middle Turbinectomy has been performed for Aggravated and Persistent Distress depending on Morbid Intra-nasal Conditions.

Shown by Dr. Scanes Spicer. M. D— was sent to St. Mary's Hospital in February, 1897, with a request that something radical should be attempted to cure her, as she had had to resign her situation. Polypi had been removed by a specialist, the galvano-cautery used several times, and numerous lotions, sprays, &c., locally, but she had got no relief from her symptoms, which were—constant frontal headache, pain and tension referred to the bridge of the nose, shortness of breath, mental depression, insomnia and restlessness associated with obstruction of nose, which was always present but varied in degree, and was always worse when she lay down. Her nasal respiration was very imperfect, and was (though but slightly) improved by cocaine. The inferior turbinate bodies were considerably enlarged, especially the posterior two thirds; the middle turbinates were tightly pressed against the septum, and enlarged; in concavities of middle meati were numerous small polypoid masses with muco-purulent secretion which was fœtid and profuse.

The operations mentioned in the head-line were carried out in two stages at intervals of a week after free use of 10 per cent. cocaine spray.

At the first sitting the inferior turbinates were removed with Jones's turbinotome; soft flaps were trimmed; very little hæmorrhage took place; iodoform was insufflated and a plug of creolin gauze inserted on each side. There was slight subsequent serous and

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hæmorrhagic oozing, and the plugs were removed on the fourth day, the nose being kept clean, as usual, with an alkaline wash, iodoform insufflations and a soothing ointment applied.

A week later the anterior portions of middle turbinates were removed with Grünwald's forceps and the cold wire snare, and the posterior portions with the turbinotome; stumps of polypi were snared and curetted cautiously with Grünwald's curettes. No plugs were used, but wounds cleaned and dressed as before. There was not much pain at operation, and none after. The removed middle turbinates showed polypi in the component cells, some of which latter were enlarged and their walls thinned, giving rise to a cystic appearance. The patient was kept in bed for a few days, but there was no rise in temperature nor after-trouble. The relief of her symptoms commenced at once, and is now, after about three weeks in the hospital and a month in the country, complete, though the wounds in the nose have not yet completely healed, and scabs are occasionally thrown off. It would be too much to say that all her nasal disease has been radically cured; but any recurrence of polypus here would be now easy of access and treatment, as well as any treatment of sphenoidal or frontal accessory sinuses, should these prove to be involved in the polypoid and purulent processes.

These cases are brought forward as an example of the expediency in selected cases of carrying out without delay measures which may seem to some severe but which are aimed at the relief of troubles which often completely incapacitate their victims from useful work, which usually cause great mental depression and general ill health, and which may otherwise require an indefinite continuance of milder and often quite inadequate means. When such operations are carried out under proper illumination of the nasal cavities, with a due knowledge of and respect for the important anatomical relations of the parts, not only can these operations be effected with safety, but often with no constitutional reaction, and with great probability of success.

Mr. Charters Symonds asked if Dr. Spicer experienced much purulent discharge after removal of the turbinates, as he had noticed it in some cases.

Dr. Spicer answered in the affirmative.

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A New Denture for Drainage in Diseased Antra.

Shown by Dr. Hill. The main characteristics were (*a*) a fixed tube, (*b*) a trap-door at the lower end of the tube which could be easily opened without removing the denture.

Report on Case of Nasal Obstruction.

By Dr. Bennett. The report referred to the case of Miss M—, shown at the January meeting. The first report was that the growth was a squamous epithelioma, but further examination proved that the correct diagnosis was tuberculosis of the inferior turbinal. This was in accordance with the opinion formed from the clinical appearance.

Case of Malignant Growth of the Larynx.

Shown by Dr. Bennett. Mr. H—, æt. 56. He was sent to the Leicester Infirmary on account of hoarseness, which first began about last Christmas. There was an almost complete absence of pain. The epiglottis was twisted to the right side. The right half of the larynx was immovable, and there was an ill-defined swelling in the pharynx of the right side. One gland on the right side of the neck is now enlarged.

Dr. Lack thought the case too advanced for operative treatment.

Case of Leontiasis.

Shown by Dr. Bennett. A middle-aged man applied at the Leicester Infirmary on account of left lachrymal obstruction. There is considerable enlargement of the nasal bones. The floor of the nose and the lateral wall are much hypertrophied with bony thickenings. The condition has lasted for fifteen years, and now causes much nasal obstruction and blockage of the left lachrymal duct.

Dr. Hill thought that removal of the turbinate bones might relieve the obstruction of the nasal duct.

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? Tubercular Ulceration of Nasal Septum.

Shown by Dr. Watson Williams. Miss G—, after suffering from a muco-purulent discharge, noticed about fifteen months ago some blocking of the right nostril. Seven months later (July, 1896) when seen she presented a smooth, bluish pink, sessile growth, the size of half a filbert, on the right side of the septum. There was some discharge in the left nasal passage which formed crusts, but no obvious disease. The growth was removed, and microscopically proved to be tubercular, though no bacilli were visible. The growth had begun to caseate and break down in the centre.

October 6th.—The tubercular deposit had spread through to the left side, appearing there as a pale pink outgrowth with a few slight crusts on the granulations. The base of the old growth was dry, with just a little secretion. Since then the septum on either side and the inferior turbinal have been repeatedly curetted, and lactic acid applied. There is a nodule in the posterior pharyngeal wall.

Dr. Williams desired to know whether members considered the case lupus or tubercle.

Dr. Grant thought it tubercle because it extended farther backwards than lupus, which generally attacked the cartilaginous parts.

A Case in which Sensations of Suffocation in a highly Neurotic Woman were temporarily relieved after Galvanic Cauterisation of Varicose Lingual Veins.

Shown by Dr. Dundas Grant. The patient had suffered for six years from the condition above mentioned, and was seen in 1894, when the only objective condition was a minor degree of varicosity of the veins at the base of the tongue. Astringents were applied and aperients freely administered, but no pronounced relief was obtained until the galvano-cautery was applied to the region mentioned. Relief from the suffocative attack ensued, and the patient disappeared until now, when she returned, complaining of a re-development of the suffocative sensations, and stated that during the three or four months following the previous cauterisation she had been free from the alarming sensations. At present the nervous condition of the patient is very obvious, there is great rapidity of the pulse (reaching occasionally 118 per minute), and a marked diminution of the pharyngeal

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reflex, but no hemianæsthesia or any of the more pronounced stigmata of hysteria.

Dr. SEMON appealed to Dr. Grant for a definite explanation of the relation (if any) between the appearances present at the base of the patient's tongue, and any symptoms from which she had suffered. He did not consider that any diseased condition was present, and that the slight fulness of the venous radicles at the base of the tongue was no more than might be seen in any person in good health. He was emphatic in his protest against associating pharyngeal and laryngeal symptoms with such a common condition as seen in this case; and for the benefit of those present, and for laryngology in general, he would like to ask Dr. Grant to enlighten him as to what possible relationship could exist between these small venous radicles and the suffocative attacks with rapid pulse and general neurotic symptoms from which the patient suffered, and he would also like to ask him whether, in his opinion, dilated veins *per se* constituted a diseased condition?

Dr. DUNDAS GRANT, in reply, stated that he considered the slight enlargement of the veins a minor element, and that the beneficial effect of the cauterisation was simply that of a counter-irritant which might have been applied in any other part. The influence was more psychical than physical. The region of the lingual tonsil was extremely well supplied with nerves, and among these there were branches from the superior laryngeal, irritation of which might readily produce sensations of discomfort in the larynx, and even excite muscular contractions. He thought that the venous congestion might act in this way. To illustrate the essential importance of the neurotic element, he reminded the Society of two cases which had been discussed before it, one of Dr. McBride's, in which a large tumour in this region had existed for many years, without causing the patient any discomfort whatever, and another of Dr. Grant's, in which a very small cyst in the pre-epiglottic region in a highly neurotic woman had caused the greatest possible discomfort, this disappearing entirely upon its removal. The veins described, dilated when pressure was exerted in the submaxillary region by means of the finger, or where enlarged glands or other tumours in the neck were present. He looked upon the appearance as occasionally symptomatic of such pressure, and thought it possible that occasionally these dilated veins might cause various symptoms which would be highly exaggerated in a neurotic patient.

Dr. HERBERT TILLEY thought it unfortunate that Dr. Grant should have brought forward this case as an example of the so-called "varicose veins at the base of the tongue." He agreed entirely with Dr. Semon that such a condition as the patient presented would in all likelihood be found in any healthy individual and in the majority of those present. In the routine examination of patients he had often seen much greater fulness of the dorsal lingual veins where perhaps they sought advice for some ear trouble and complained of no throat symptoms. He thought it regrettable and derogatory to the reputation of laryngology that when a patient had some

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"throat symptoms" and no marked objective lesions were visible, that these little veins should be selected for local treatment when there was no evidence that they were the cause of trouble.

Dr. StClair Thomson had often seen a fulness of these veins, and generally noticed that they were associated with congestion elsewhere, *e. g.* rectal hæmorrhoids, gouty manifestations, &c., and that a smart aperient often relieved them.

Dr. Hill had noted cases of varicosity where throat symptoms were present, but had not decided to regard them in the light of cause and effect.

Dr. Scanes Spicer had seen small black nodules on veins of base of tongue, which had ruptured and led to blood-stained expectoration. He frequently saw distended veins at base of tongue, but treated them by salines. Occasionally he had suspected that the coats of the veins participated in a general pharyngitis, but whether to such an extent as to entitle them to the term phlebitis he was doubtful. He should not call the veins abnormal in Dr. Grant's case.

Dr. Semon, replying to Dr. Grant's explanation, regretted that it was to him a disappointing one. He once more pointed out that a patient was brought to the Society suffering in the main from suffocative attacks and general neurotic symptoms, and they were asked to believe that the symptoms had their origin primarily in some little veins at the base of the tongue. Dr. Grant had failed to give any satisfactory explanation as to how visibility of veins at the base of the tongue could be supposed to produce any symptoms whatever. Was this condition to be held responsible for the rapidity of pulse observed in the case, as well as the suffocative attacks? He (Dr. Semon) was sorry this case had been brought forward, because he hoped that the controversy of last year ('Lancet,' February 15th to March 28th, 1896), in which the serious abuses which this assumed cause of disease had given rise to, were brought to light, would have sufficed to show its non-existence as a pathological identity. Undoubtedly any temporary relief obtained had been due to a powerful counter irritation, which might have been applied anywhere, and was not due to the removal of what he could not by any means admit to be a diseased condition.

Mr. Charsley showed a lad whom he had operated on for sub-hyoid fistula of congenital origin. He remained well for twelve months, when the mucoid discharge recommenced, and he asked for the opinion of the Society as to any method of treatment which could be recommended to ensure a more permanent result.

Mr. Symonds and Mr. Stewart recommended another dissecting operation, and quoted cases in their practice where a second or third attempt at removing the fistulous tract had been successful, and mentioned that sometimes the case cures suddenly after an apparently unsuccessful attempt at complete removal of the tract.

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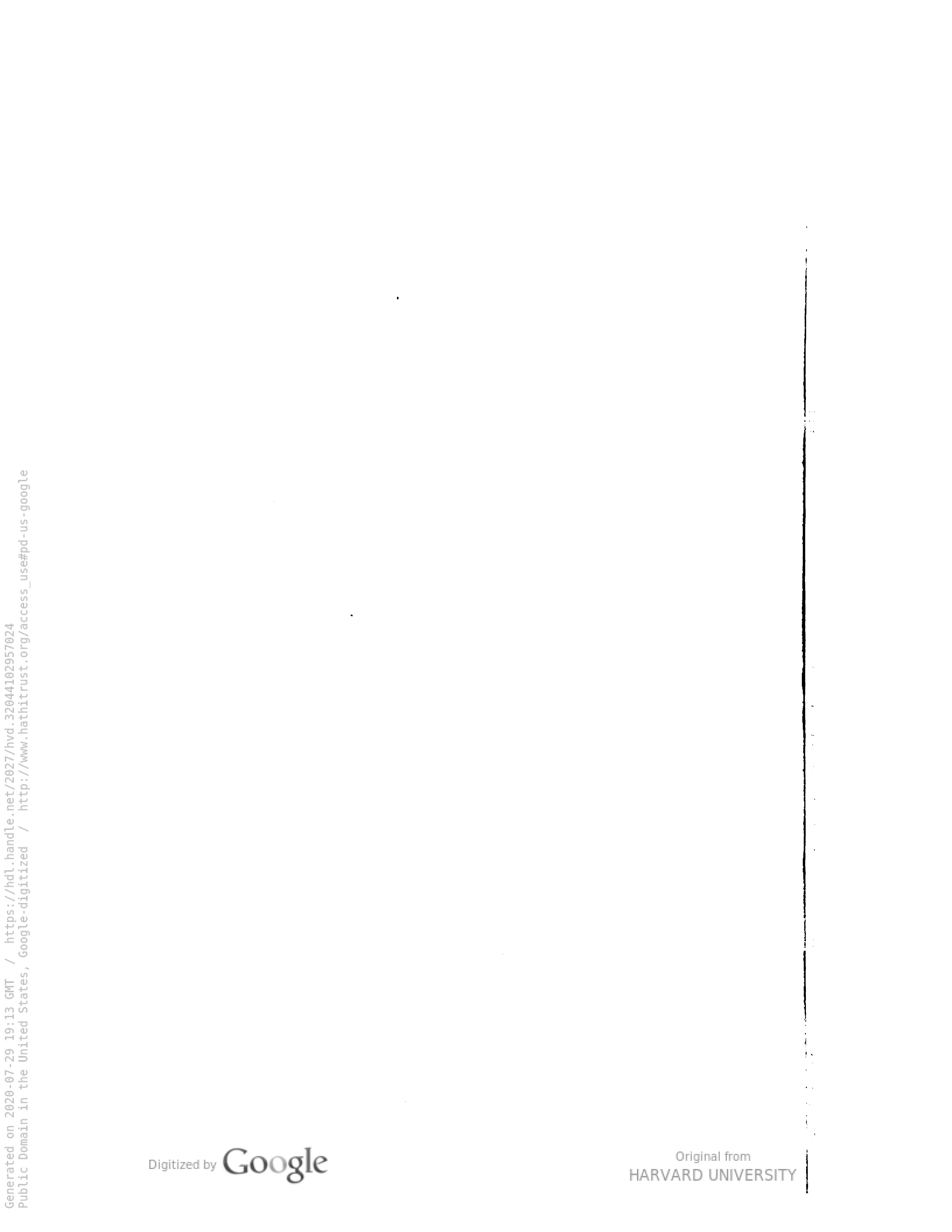

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *May* 12*th*, 1897.

HENRY T. BUTLIN, ESQ., F.R.C.S., in the Chair.

STCLAIR THOMSON, M.D.,
HERBERT TILLEY, M.D., } Secretaries.

Present—31 members and 3 visitors.

The minutes of the previous meeting were read and confirmed.

Mr. V. H. Wyatt Wingrave, M.R.C.S., 11, Devonshire Street, W., was elected an ordinary member of the Society.

Mr. McLeod Yearsley, F.R.C.S.Eng., 10, Bentinck Street, W., and Dr. William H. Kelson, M.D., B.S.Lond., F.R.C.S.Eng., 96, Queen Street, Cheapside, were proposed for election at the next Meeting.

At the Ordinary Meeting of the Society held on Wednesday, March 10th, 1897, the following gentlemen were elected ordinary members of the Society :

Mr. RONALD HERDMAN, M.B., C.M.Edin., of London.
Mr. ERNEST BROWN, of Montreal.

The Meeting was given up to a discussion, opened by Dr. DUNDAS GRANT, on "The Uses of Turbinotomy as applied to the Inferior Turbinated Body." Eighteen cases were exhibited by him illustrating the results of the operation.

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DISCUSSION ON THE USES OF TURBINOTOMY AS APPLIED TO THE INFERIOR TURBINATED BODY.

Opened by Dr. DUNDAS GRANT.

Turbinotomy or turbinectomy (perhaps better conchotomy or conchectomy), may be practised on the superior, middle, or inferior turbinated body, and it may be either total or partial. We might thus speak of total middle turbinectomy, total inferior turbinectomy, &c., or of anterior middle turbinectomy, posterior middle turbinectomy, and so forth. We are only concerned at present with the inferior turbinal and the operations of total inferior turbinectomy, anterior and posterior inferior turbinectomy.

Total inferior turbinectomy is chiefly practised by means of Mr. Carmalt Jones' ring-knife or "spokeshave," of which the cutting part is now made in a curved form, so as to be convex on the side next the turbinal, and concave on the one next the septum—an advantage when there is a septal outgrowth.

Partial turbinectomy may be performed by means of punch-forceps or other instruments, but Grünwald's "typical" operation for resection of the anterior extremity of the middle turbinal affords a method applicable to all. In this a notch is cut in the neck of the middle turbinal, and the piece thus marked off is readily removed by means of a hot or cold snare.

Anterior inferior turbinectomy is, therefore, to be effected by means of an incision along the anterior part of the line of attachment of the turbinated body, and the peninsula thus formed is removed by means of the snare. The part should be thoroughly cocainised, and nitrous oxide gas may be administered. This operation opens a free road into the middle part of the inferior meatus, which is much wider than the anterior, and the stump of the turbinal acts like an additional incomplete septum. The hæmorrhage is slight and easily controlled, as the portion removed is the furthest from the entrance of the large blood-vessels at the spheno-palatine foramen. The anterior obstruction being removed, no further enlargement of the passage may be required; but if later removal of the posterior half is called for, it is readily accessible for operation. At the same time the anterior operation removes a cause of negative pressure, and thus eliminates a

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source of engorgement of the posterior parts, which may then subside without further operation. The part removed, though doubtless of functional value, is not considerable, and is very frequently a source of discomfort.

Posterior inferior turbinectomy may be in the same way carried out by means of a scissors cut directed obliquely upwards and backwards from the lower border of the turbinal, the snare being then applied to the posterior portion. In some case the snare alone is sufficient. The "spokeshave" may also be used to cut partially through the turbinal from behind, and the snare may be introduced into the cut.

The *indications* for these operations are disturbances to health, comfort, or function resulting from nasal obstruction produced by enlargement of the inferior turbinated bodies, when this does not yield to simpler treatment, or when not likely to do so, especially if the time available for treatment is limited.

In general these are diseases of the nose, pharynx, and larynx, but incidentally diseases of the ear directly dependent on these.

The indications for *complete turbinectomy* or "spokeshaving" are those above mentioned under the conditions that the disturbances are sufficiently severe to justify exposure to the risk of a possibly considerable hæmorrhage and pyrexia; that the obstruction is due to enlargement of the posterior as well as the anterior part of the turbinal; that the patient is prepared to remain in bed and under observation for several days, and that there is some special call for prompt radical relief.

Posterior inferior turbinectomy is indicated when the obstruction is due to enlargement of the posterior part, the anterior portion being normal, or being readily reduced by cocaine, or having been previously removed without affording sufficient relief, more particularly if the snare alone has been inefficacious.

Anterior inferior turbinectomy is indicated when there is obstruction due to enlargement of the anterior part, not sufficiently diminished by cocaine to justify dependence on galvano-caustic methods. (When there is a deviation of the septum it has to be considered whether the removal of the septal outgrowth or anterior turbinectomy is more easy to accomplish.) When the enlargement is both anterior and posterior, the anterior operation may be performed first (unless there is urgent necessity for immediate clearance), and the posterior one subsequently if required.

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The *results* of *complete turbinectomy* are usually most excellent, and frequently brilliant, and Mr. Carmalt Jones deserves credit for drawing attention to its value, even though we limit the scope of its applicability much more than he has done.

Mr. Atwood Thorne has looked up the records of the cases in which I have operated, and finds about 35 of *complete turbinectomy* out of roughly some 11,000 cases of mixed throat, nose, and ear cases. Only 18 could be got to come up for re-inspection, and unfortunately the notes have been too meagre to allow of drawing deductions from any of the others. Out of the 18 (of whom 12 were males and 6 females, varying in age from 15 to 60) 9 were completely freed from their primary symptoms, and 9 relieved. Notable regeneration of the turbinal body took place in 6, and very little in the remainder. The formation of crusts disappeared within a short period in 17, but in 1 it has persisted since October, 1896. In all the general condition has improved. Hæmorrhage was very considerable in somewhat under a third of the cases (5), moderate in nearly one half (7), and practically absent in the remainder (5). In one case the hæmorrhage was such as to place the patient's life in considerable jeopardy, but her want of care was chiefly accountable for it.

We have to report 12 cases of *anterior turbinectomy* of which the results are as yet not available in more than 8, in 5 of whom the nasal symptoms are reported as cured, and in 2 as relieved. The restoration of nasal breathing seemed quite adequate. In none was there any ground for anxiety, and the bleeding after the operation was slight in 4, almost absent in 4, and profuse in 1. In the last case the patient took a long journey, and omitted to call in her local doctor, by whom the anterior hæmorrhage could easily have been controlled.

In view of the ease and safety attaching to the operation of anterior turbinectomy, as well as the comparatively good results as regards restoration of nasal patency, it is advisable to adopt it if only as preliminary to a subsequent posterior operation. The operation of complete turbinectomy involves a fairly considerable amount of risk from hæmorrhage, but there are circumstances in which, after due explanation to the patient, it may be justifiable to recommend its adoption.

These opinions are founded upon the consideration of a comparatively limited number of personal observations, and are offered as

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open to modification according to the results of the collective observations of the members of the Society.

Mr. CRESSWELL BABER said he had done inferior turbinotomy with the "spokeshave" thirteen times in nine patients. He considered it of value in cases of nasal obstruction due to enlargement of the inferior turbinated bodies which could not be relieved with the snare or the galvanic cautery. These milder measures should first be tried (the snare when the hypertrophy affects the posterior ends, the galvanic cautery when it affects the anterior ends), except in cases where the obstruction is manifestly due to enlargement of the bone itself. The results on the whole were very satisfactory. Several of the patients became distinctly stouter and more robust after the operation. He had not met with any troublesome hæmorrhage or complaint of dryness in the nose or throat. In one case he had seen a regrowth of soft tissue. He thought the operation was especially useful in cases of bad deflection of the bony septum, in which, after removing all the projecting portion of the septum possible, there was still insufficient breathing space. As regards the technique of the operation, like Dr. Dundas Grant he found it facilitated by inserting the forefinger in the naso-pharynx to get the spokeshave into position. He found the left inferior turbinated body more easy to remove than the right, perhaps because he held the instrument in the right hand in both cases. The spokeshave was also useful for removing projections on the septum, after first partially sawing them through if necessary.

Dr. LAMBERT LACK said that his experience of complete turbinectomy had been very limited, as he held the opinion that, except possibly in some extremely rare and altogether exceptional cases, complete relief could be obtained from the symptoms arising from enlargement of the inferior turbinated bodies by other and better means. He pointed out that enlargement of the posterior extremities of these bodies was always overgrowth of soft parts, and was never bony, and that we possessed in the cold wire snare an effectual and safe method of dealing with it. In particular the risk of severe or even very dangerous hæmorrhage, inseparable from the use of cutting instruments, could be entirely avoided by slowly tightening the wire loop. Enlargement of the anterior extremity of the inferior turbinate was sometimes of similar character and amenable to the same treatment. Undoubtedly, however, in a considerable number of cases there was in this region some bony overgrowth which required to be differently dealt with. The free edge of the inferior turbinal in these cases is usually curled downwards and fills the inferior meatus. In such cases under a good illumination this projecting free edge can be clipped away with a strong pair of nasal scissors, enough being removed to completely free the inferior meatus, but not so much as to reduce the inferior turbinal below what is considered to be its normal proportions. This procedure could also be applied when necessary to the middle part of the inferior turbinal, but the width of the nasal fossa in this region was so great that it was rarely required.

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This operation differed entirely in principle and in results from that which Dr. Grant had described as anterior turbinectomy. By these methods of dealing with the anterior and posterior extremities of the inferior turbinal which were commonly employed in his practice complete relief was given to nasal obstruction and the nose left with a practically normal-sized and practically active inferior turbinate. The dangers of hæmorrhage, primary and secondary, were greatly lessened,—he had not had cause for alarm in a single instance,—and the worse danger of having the nose in a condition similar to that of atrophic rhinitis was entirely avoided. In cases of deflected septum Dr. Lack urged that the septum should always be dealt with, and that it was bad surgery to make a passage round a deflection by removing a piece of a turbinate. The latter operation was certainly the easier; in fact, the ease with which it could be performed was the great attraction of turbinectomy, but no surgeon was justified in performing an inferior operation simply because it was an easier one for him to perform.

Dr. HERBERT TILLEY showed an enormous moriform hypertrophy of the right inferior turbinate bone which he had recently removed. The overgrowth extended from the anterior to the posterior naris, which latter it almost completely filled, and was only slightly reduced on cocainisation. He removed it with considerable difficulty by means of a Blake's snare, and left the turbinate bone in its entirety, and the patient with complete freedom of respiration. His experience in this and other cases quite coincided with Dr. Lack's, viz. that it is rarely necessary to remove the posterior end of the turbinate bones, because these are never bony enlargements, but mucous membrane hypertrophies which are accessible to the snare. The speaker's experience in complete turbinectomy had been limited to three or four cases. One of them was an inveterate case of hay fever, which completely incapacitated the sufferer during the summer months. The anterior nares were very small, and the inferior turbinates hypertrophied so that they almost touched the septum, the hypertrophy being bony and not due to the mucous membrane. The galvano-cautery was of no use in such cases because there is no redundant mucous membrane to destroy, and double turbinectomy was performed with great relief to the nasal obstruction and almost complete relief to the hay fever, so that for two summers the patient has been able to go into the country, and excepting for some slight suffusion of the conjunctiva he is cured of his old enemy. A second case of partial right inferior turbinotomy had recently been under his care, in which the patient, a medical man, was suffering from antral disease and ethmoidal cell suppuration. The septum deviated to the right, and the opposite inferior turbinate was much enlarged, so that it was impossible to get at the ethmoidal region without removing some of the obstruction. The ablation of the anterior half of the turbinate at once gave one the necessary room to curette the ethmoidal cells and produce a free nasal respiration. In about five weeks the patient was completely well and as pleased with the latter condition as he was troubled with the original antral and ethmoidal disease. As regards the complications, he thought the possibilities of

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"dry throat" should be borne in mind, for he knew of two singers, one making rapid progress at the Academy, who since the operation had had to completely give up their studies on this account only. A most careful selection of cases should be made, and he believed that in the vast majority partial anterior turbinectomy would be found to be amply sufficient to meet the needs of the case.

Dr. SEMON stated that, having no personal experience of the operation, he wished to have some fuller information on two points which seemed to him of considerable importance, viz. (1) the question of secondary hæmorrhage, and (2) the physiological question of the effect of so great a clearance of the nose proper as that effected by total turbinectomy with regard to the drying up of the mucous membrane of the pharynx and formation of crusts. With regard to the first point, he had been told by a leading general practitioner, that within a very short time he had been called to four of his patients in whom turbinectomy had been performed, and in whom serious secondary hæmorrhages had occurred several days after the operation. In one of these cases he had been compelled to sit up the whole night with his patient. With regard to the second question, Dr. Semon reported a case he had seen only two days before the meeting. A young student of theology had frequently suffered from laryngitis and loss of voice. He had consulted a London specialist, who had discovered an obstruction in the nose and had removed both lower turbinated bones. The immediate effect of the operation had been one of great relief to the breathing; two months afterwards, however, the patient began to suffer from great dryness in the throat, which gradually had become almost intolerable, and from the formation of crusts which he could only hawk up with much difficulty. It was quite certain that these symptoms had only made their appearance *after* the operation. At the same time his laryngitis had become much more pronounced and was now practically always present. On examination the nose presented exactly the same aspect as that seen in old atrophic rhinitis, *i. e.* the nasal passages in their lower part represented one large channel through which the pharyngeal mucous membrane and, on swallowing, the movements of the Eustachian muscles, were clearly visible. The whole posterior wall of the naso-pharynx and pharynx proper was dry and glazy, and was to a great extent covered with a yellow, firmly adherent, non-odorous crust. The pharynx itself looked congested, and the vocal cords were very red and much relaxed. This condition so entirely corresponded with what one would theoretically expect from removing a physiologically important structure, whose duty it was to moisten and warm the inspired air and to retain impurities penetrating into the air-passages during the act of inspiration, that he felt compelled to draw attention to that possibility, and to inquire whether this effect had not been more frequently observed. It had been very interesting to him to hear from Dr. Tilley's remarks that in the cases of two singers the same effect had been observed and had prevented the patients from following their vocation. In the case just detailed he was afraid the result would be the same, and this seemed to him so grave a contingency that he thought it right to draw attention to it.

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Dr. Scanes Spicer said that given a normal healthy subject free from all symptoms referred to the nose and adjacent organs, no one would suggest interference with the proportions which existed between the turbinated bodies and the passages in which they are placed. But, unfortunately, the subjects which presented themselves to the rhinologist exhibited departures from a state of nature and of health. These persons would not have sought advice had they not suffered from discomfort or distress referred or referable to the nose or adjacent parts, and examination discloses that these felt discomforts are constantly associated with more or less marked alterations in the natural proportions between the necessary respiratory air and the calibre of the passages through which, *naturally*, it should enter the air tract. In the majority of such cases there had arisen, from some pathological cause, a diminution in the nasal inspiratory channels. There might be imperfect evolution of the nostrils, alar collapse, deflected septum, ecchondrosis, exostosis, hypertrophic rhinitis in any of its forms, vaulted palate, imperfect evolution of antra, hyperostosis of inferior turbinates, or even the latter of normal size, but occurring in channels imperfectly evolved from other causes—any of these alone or in varying combinations might produce such narrowing of the channels that mouth-breathing had to be resorted to, as well as exhaustion of every cavity in pneumatic contiguity with the nose. To obviate these harmful conditions, surgical interference was needed to restore the natural airway, and to allow of the natural contact of the air with the nasal mucosa. As far as reduction of the soft parts goes, we have all been in the habit of using the snare cautery and scissors for years for mulberry growths and polypoid flaps; but it is well known that there are cases which do not yield even to prolonged use of such means. So that Mr. Carmalt Jones is in the position of having brought forward a new instrument, by means of which it is possible more efficiently, more safely, and more speedily than ever before to remove a common cause of nasal obstruction. It is true that in using this we remove at same time a small fraction of the mucous membrane, but we restore to full activity the immensely larger fraction with which the due amount of air was not beforehand able to gain contact. Besides, often after operation a flap of mucosa is seen presenting very much the appearance of a small regenerated inferior turbinate, not large enough to obstruct. Speaking from a large number of cases in his own practice and that of others, he thought that in suitably selected cases reduction of the inferior turbinate was of the greatest possible value, and that Mr. Carmalt Jones's instrument, used with judgment and discretion, was a very serviceable addition to our armamentarium. Only those cases were suitable for removal of bone in which previous reduction of soft parts was insufficient, or in which other complicated procedures could be avoided by a simple reduction of bone, such as septum straightening, difficult and complicated spurs, &c. Judgment was also needed in the amount of bone to be removed. Sometimes the anterior, sometimes the posterior part caused the obstruction; but usually a slice from behind forwards appeared to give the best result, and one's aim was to remove only so much as was

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necessary to get free nasal respiration. There was one point in Dr. Grant's excellent introduction from which he differed, and that was that the reduction should be done at two operations—the anterior and posterior halves on different occasions. He thought this was unnecessary, and gave the patient additional suffering. Dr. Spicer usually operated with the patient in a sitting posture under cocaine and gas or gas and ether. The index finger (left) was introduced into naso-pharynx, the turbinotome insinuated through corresponding nostril, engaged in posterior extremity of inferior turbinate, and rapidly withdrawn in the direction and with the pressure judged necessary to remove more or less of the bone. It was usually necessary to trim up the anterior part of the wound, as flaps of mucosa were detached but not removed. An objection had been raised that brisk hæmorrhage took place. It was unusual, and he did not usually plug at first, but kept patient at rest for some days in bed. Secondary hæmorrhage sometimes came on, on withdrawing the plugs or otherwise. It might be severe, and great caution was necessary that the patient could have effective aid if needed. He had never found any real difficulty in stopping the bleeding, and did not regard it as any real objection to the operation. The use of the turbinotome had been deemed unsurgical because it was impossible to regulate the amount removed. He could not agree to this, as by practice a sufficiently accurate proportion could be determined on. He had heard that the antrum had been once opened accidentally. With a sharp turbinotome and a swift cut he did not think this would occur. There was a free muco-purulent discharge from the wound after operation, with scab and crust formation. This might last for some varying time afterwards, and required appropriate treatment. It always disappeared eventually. He had never observed "pharyngitis sicca" after the operation; though patients sometimes noticed dryness at back of nose for a time, it was far less annoying than the dry mouth and throat before. On the whole, he would conclude that reduction of the inferior turbinated bone, usually partial, but varying in degree in different cases, has a legitimate place in the surgery of nasal obstruction; and if properly carried out is one of our safest and most effective ways of dealing with certain cases which are otherwise not at all curable, or only with a totally disproportionate amount of suffering and difficulty.

Dr. Watson Williams (Bristol) referring to the question of turbinectomy as distinguished from the less radical operation of partial turbinotomy, stated that he spoke under the disadvantage of never having had recourse to the procedure. His attention was particularly directed to this subject by a paper read at the meeting of the British Medical Association at Bristol in 1894 by Mr. Wyatt Wingrave, who brought forward a very complete summary of 200 cases of turbinotomy performed at the Central London Throat Hospital, within a comparatively short space of time. He had, in fact, obtained a Carmalt Jones first spokeshave, but although he had charge of a considerable clinique at the Royal Infirmary at Bristol, a city that afforded all the extrinsic conditions which tended to cause the development of hypertrophic rhinitis in marked degree, he had yet to see the case which, in his

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opinion, justified recourse to such a radical measure as complete turbinotomy, and which could not be adequately relieved by other methods to which allusion had been made by previous speakers (scissors, cautery, snare, &c.)—measures which were less dangerous, more under control, and less likely to be followed by unfortunate secondary complications. Having regard to what he had seen and heard of turbinectomy from various sources, he was convinced that the operation was performed by some operators with unjustifiable frequency, and he thought that they were to be congratulated on the subject having been brought forward by Dr. Dundas Grant, who had advised recourse to the operation in such guarded and temperate language as virtually to damn with faint praise the views of ardent enthusiasts of turbinectomy, and who had so definitely stated his conviction that turbinectomy ought to be restricted to a very narrowly limited class of cases, Dr. Grant having had recourse to the radical operation in only thirty cases out of more than 11,000 patients coming to his clinic. He felt that he was at one with Dr. Dundas Grant on most points in his address, but he could not help regarding the later instrument of Mr. Carmalt Jones as one to be discarded, inasmuch as its use appeared to involve the almost complete removal of the lower turbinals, which one had every reason to consider a very important physiological structure, and for his part he believed that it was generally far better and more scientific to employ other methods of removing portions of the hypertrophied turbinals which were more under the control of the operator.

Dr. William Hill considered it would be difficult to criticise in an adverse sense the practice which Dr. Grant had advocated in reference to partial turbinectomy; anterior and posterior turbinectomy with the snare had been practised for many years by most present, but the removal of a portion of the bone was a recent development, and he could testify to the excellent results obtained by the use of the scissors. In reference to the employment of Carmalt Jones's turbinotome, he, the speaker, did not aim at what was called complete turbinectomy with that instrument, and, as a matter of fact, the *complete* removal of an inferior turbinate was a very difficult matter. Jones's turbinotome was an instrument of precision by which a wide or narrow longitudinal slice, with or without bone, could be removed from the enlarged inferior turbinal. The larger operation was called for when an enlarged turbinal coexisted with a very narrow condition of the nasal cavities. Since the introduction of the spokeshave he had boasted that he could relieve any case of nasal stenosis where the snare and saw failed. He had recently been called upon to relieve practically complete obstruction in a child with snuffles three weeks of age; the smallest size turbinotome was too large for such cases, but he had succeeded in removing the cartilaginous turbinal by means of Mr. Butlin's scissors. During the last few years he had frequently practised anterior and posterior turbinectomy with scissors and snare, but it was only very exceptionally that he resorted to the use of the turbinotome. He was inclined to think that the reason why Jones's instrument was so popular with some practitioners was because so much greater manipulative skill was required to perform anterior and

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posterior turbinectomy with the scissors and snare, whereas the spokeshave operation was comparatively easy. He had seen very severe bleeding after its use, and recommended styptic colloid if hot water at the hæmostatic temperature failed to stop hæmorrhage.

Dr. StClair Thomson feared there must be something very seductive about this operation, since one instrument maker has sold more than a hundred spokeshaves. Considering how small was the number of cases in which turbinectomy was called for, it was really alarming to think that so many of these weapons were abroad in the world, for in injudicious hands they were capable of doing much mischief. The relief which it was to a patient to recover nasal respiration probably accounted for the demand for the instrument, but the appeal to the feelings of the patient was apt to be a fallacious criterion. When patients ceased to be satisfied with a result, they were very apt to consult someone else, and in this way we all became very conscious of one another's imperfections. He confessed that personally he was not aware of any cases in which the after effects had been harmful, but it took time for these to develop. Others, however, had demonstrated how the nose lost its function of warming and moistening the air when its mucous lining had been at all extensively destroyed. He referred to the experiments of Freudenthal, of New York ('The Journal of the American Medical Association,' November 9th, 1895), on patients who had been discharged as "cured" of nasal stenosis, but who later on fell into his hands with all the symptoms consequent on the loss of the warming and moistening function of the Schneiderian membrane. He thought the debate had served a useful purpose in emphasising the alternatives to turbinotomy, and, in addition to the suggestions of Drs. Lack and Tilley, he would like to point out that in many cases where the inferior turbinal appeared enlarged and blocked against the septum, it would be found that this was due to polypoid hypertrophy concealed from view in the concavity of the turbinal. This tissue could be turned out with a probe and snared, when the airway would be restored without loss of healthy mucous surface. It was well to remember that this turbinal hypertrophy was in many cases a consequence of a condition which could not always be remedied, such as a stenosis of the bony walls of the nose, either congenital or consequent on adenoids which had atrophied. One consequence was already apparent in every one of these cases which had been demonstrated at the meeting, and that was that there was a marked compensatory hypertrophy of the middle turbinals. If this went on these patients might return to be freed of this, and in that case there would be a last good-bye to the hygrometric functions of the nose, and they would be in a worse state than if they had been content with their more or less buccal respiration.

Dr. Dundas Grant, in reply, briefly referred to the various questions which had been raised by the different speakers.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *June 9th*, 1897.

HENRY T. BUTLIN, ESQ., F.R.C.S., in the Chair.

STCLAIR THOMSON, M.D., } Secretaries.
HERBERT TILLEY, M.D., }

Present—27 members and 3 visitors.

The minutes of the previous meeting were read and confirmed.

Mr. McLeod Yearsley, F.R.C.S.Eng., 10, Bentinck Street, W., and William H. Kelson, M.D., B.S.Lond., F.R.C.S.Eng., 96, Queen Street, Cheapside, were elected and admitted ordinary members of the Society.

Mr. Stephen Paget, F.R.C.S.Eng., Harley Street, W., proposed by Drs. Ball and Hall and Mr. Butlin, and Charles H. McIlwraith, M.D. (Glasgow), 17, Stradella Road, Herne Hill, proposed by Drs. Beale, Lack, Bond, and Thomson, were nominated for election at the next Ordinary Meeting of the Society.

A letter was read by the President from Professor Stepanoff, President of the Section of Laryngology of the International Medical Congress in Moscow, inviting members of the Laryngological Society of London to take part in the Congress.

The Report of the Morbid Growths Committee on Dr. Lack's cases of Sarcoma of Nose ('Proceedings,' March, p. 64) was read to the Society.

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Post-mortem Specimens from a Case of Laryngectomy for Malignant Disease of the Cricoid.

Shown by Mr. G. Spencer. I complete the account of this case, which has previously been before the Society, because of the exceptional site of the disease, and also because the opinion is widely held that laryngectomy is seldom indicated. A single woman, æt. 42, had worked for many years amongst steam and sometimes irritating vapours. Early in 1896 she suffered from her throat, and attended the out-patients; but growing worse, was admitted into the Westminster Hospital under Dr. Hall in August, 1896.

She was suffering from subglottic obstruction, due to thickening all round within the cricoid ring, which was covered by normal mucous membrane free from ulceration. She grew worse during the month, and finally I was called upon to do tracheotomy for an urgent attack of dyspnœa. A week later the cricoid ring below the cords was cleared of all growth through the tracheotomy wound, and a microscopic examination showed that every piece consisted of a malignant growth, which we called sarcoma.

The disease progressed rapidly, and we advised laryngectomy as the best palliative treatment. The whole larynx was removed, the trachea cut across at the third ring, and stitched to the lower end of the incision, and the wound sewn up in stages. The patient swallowed easily from the first, but after the removal of the sutures a little leakage occurred just below the hyoid bone, and a very small channel remained, through which saliva sometimes came. She improved much in health, and was able to converse freely in a hoarse whisper, and sometimes in a distinctly marked guttural but articulate voice. About three months after the operation there appeared induration in the neck. During the last month her pulse quickened, there was some cough and expectoration of mucus, and she became cyanosed. At night she had some attacks of difficult breathing, but after inhaling oxygen she used to go to sleep. She died quietly four months after the operation without any asphyxial struggles. Meanwhile there was no difficulty in swallowing, nor other of those distressing conditions seen towards the end of a case of malignant disease of the larynx where tracheotomy only has been done.

At the post-mortem the lungs were found to be thickly studded by

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the growth. There were also some nodules in the liver, together with infiltration of the deep structures in the neck, including the thyroid gland and the mediastinum.

The œsophagus forms a normal unconstricted channel continuous with the pharynx; just below the hyoid bone is a pouch lined by normal mucous membrane, but from which there was a small fistula opening on the skin. The upper end of the trachea was firmly united to the skin in the root of the neck, but was free from all compression.

I also show five microscopic specimens, one made for diagnosis, one from material removed at the operation, and three post-mortem specimens from the neck, lung, and liver. In my account of the case I gave my opinion that the case was a perichondral sarcoma of the cricoid, and in this my colleague Dr. Hebb, who made the specimens, concurs.

The Morbid Growths Committee, however, reported that it was a carcinoma. The growth is identically the same in all the microscopic sections which we have made. It is remarkable, if the growth originated from epithelial elements, that it should have extended outside the cricoid cartilage to the glands without causing any ulceration or alteration in the mucous membrane.

A Microscopical Specimen of Acute Ulcerative Lacunar Tonsillitis.

Shown by Mr. R. Lake. The patient, a young man of 22 years, was taken suddenly ill with sore throat on September 1st, 1896. On the 14th he went to a hospital, where he was treated until he came under my care, October 3rd. The ulcer was situated on the right tonsil, and was of about the size of a shilling, and covered with a tenacious grey slough. I removed the tonsil, and after five days the patient was well.

The specimen shows large masses of beaded bacilli situated in the advancing edge of the slough; in the older slough they are more rare. This goes to disprove Moure's idea that the cause of the ulceration was chiefly due to pressure of retained secretion, and not to micro-organisms.

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Two Cases of Cleft Palate with Enlarged Tonsils, Inferior Turbinates, and Excessive Quantity of Adenoid Growths.

Shown by Dr. Edward Law. The patients, a girl æt. 15 and a boy æt. 13, are sister and brother, and were both operated upon during infancy for harelip. They resemble in many respects the two cases brought before the Society by me on February 10th of this year. There is no complaint made of regurgitation, difficulty in swallowing, or deafness; and the only symptom causing discomfort is that the power of distinct articulate speech is most seriously impaired in both instances.

A broad cleft is seen in the middle line passing through the hard and soft palates. The tonsils are enlarged, long, and somewhat flattened with the uvula above them; the inferior turbinates are greatly hypertrophied, and the defective nasal septa are seen passing backwards to the posterior pharyngeal wall above, and, as it were, through the adenoid masses.

The cases are shown because such conditions have not been very carefully described in the chapters devoted to this subject in most surgical works, and in order to invite the opinion of members in reference to operative treatment.

Such congenital cases differ widely from acquired ones, as there is no normal function to be restored, the patient having never acquired the faculty of perfect articulation. The gap is an arrest in formation, not simply a hole or the want of union of a fissure, and there is not the same abundance of yielding tissue to draw upon as in harelip operations. These considerations account for the patient being so often terribly disappointed with the result of surgical interference. Is it possible that the gap will be closed in either of these cases by means of an operation?

If so, will the result be more than a surgical success, simply closing the cleft by means of a tense and rigid bridge, which in no way improves the imperfect speech (the only relief desired by the patient), and probably complicating the employment of suitable obturators and artificial vela. Much weight is attached by both Kingsley and Essig to the unsatisfactory conditions for prosthetic procedures, which may follow upon unsuccessful or only partially successful operations.

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If no operation be attempted to close the clefts, is it desirable to remove the tonsils and adenoids before handing the patients over to the dental surgeons?

Mr. SPENCER thought the case of the boy favorable for operation because good flaps could be made, and then the child could train himself, and not wear an obturator all his life. He should remove the adenoids after the cleft palate operation. The case of the girl was less favorable because good flaps could not be obtained, and she was anæmic, and probably the dentist would do most for her.

Dr. SPICER suggested the removal of adenoids and nasal obstruction first of all, so as to eliminate the pressure on the palate due to buccal respiration if the reverse order was followed.

Dr. GRANT had known marked improvement in these cases after removal of the excessive nasal mucous membrane.

Mr. BUTLIN advised removal of the adenoids first, and then operate for the cleft palates, but he considered the cases unfavorable ones.

CASE OF CYSTIC TUMOUR IN NASO-PHARYNX OF A MAN.

Shown by Dr. BOND. Patient, a man æt. 45, came to the hospital with throat trouble. On examination, a round, yellowish tumour, with small vessels ramifying on it, is seen springing from roof, posterior wall, and left side of naso-pharynx. Probably is a cyst of Luscha's tonsil.

Dr. WAGGETT asked for a microscopic specimen when it was removed.

CASE OF HYPERTROPHIC LARYNGITIS FOLLOWING A MEMBRANOUS LARYNX OF UNUSUAL CHARACTER.

Shown by Dr. BOND. The interest of the case consists in the fact that no Klebs-Löffler bacillus was found, but the *Bacillus pyocyaneus*.

The patient, a man æt. 28, was seen early in March for loss of voice and sore throat. His temperature was 100°, and later 101°. The base of epiglottis, the ventricular bands, cords, and outer arytænoid space were covered with a greyish-white membrane. On several occasions he brought up masses of this. They were examined on two occasions by the Clinical Research Association, who did not find either time any Klebs-Löffler bacillus. After many culture tests they isolated a bacillus which they considered to answer to the description given to the *Bacillus pyocyaneus*. They state that they

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investigated some eighteen months ago an epidemic of membranous pharyngo-laryngitis in pigs in which the same bacillus occurred, and that they were led to believe that the organism bore a distinct causal relationship to the disease.

Recurrent Laryngeal Growth.

Shown by Dr. Bond. The patient, a housewife æt. 27, has had a growth removed from the larynx at least four times in the last two years. The last operation was three weeks ago, and at present there is no sign of recurrence. The growth removed was dark, three-lobed, smooth, and sprang from the very bottom and posterior part of the left ventricular band, and it hung down between the cords, and was as large as a couple of small peas. It did not at all look like a papilloma, and on section it seems to be an epithelial growth of unusual character. Dr. Bond asked that it might be reported on by the Morbid Growths Committee, to which request the sanction of the Society was given.

Syringomyelia, with Paresis of the Left Half of the Soft Palate and Abductor Paralysis of the Left Vocal Cord.

Shown by Dr. Jobson Horne. The patient, a married woman æt. 31, was first seen in May, 1896, by Dr. Batten. For about six months previously she had experienced weakness of the hands associated with tingling sensation, and had had difficulty in doing her hair.

She had been married three years, but there had been no child and no miscarriages. Seven years ago she had had a "diphtheritic" sore throat.

Dr. Batten noted muscular atrophy about the small muscles of the hands, but more particularly of the thumb of the left hand, producing the main-en-griffe; the forearm was well developed, the biceps and triceps were normal, the left deltoid was weak but not obviously atrophied, the trapezii were normal; the gait was natural; the knee-jerks were exaggerated, but no "ankle-clonus" was present.

There was some ptosis of the left eyelid; this had been present from birth. Nystagmus, of a rotatory character, was noted in both eyes, more marked in the left than in the right, and increased on

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lateral diviation. The ophthalmoscopic examination was negative. The muscles of the face acted naturally.

The tactile sensation was perfect. The thermic sensation was impaired over both upper extremities and across the shoulder girdle; sensation to pain was impaired over the left shoulder, and probably over the whole of the area impaired to heat and cold, but to a less extent. The electrical examination showed no reaction of degeneration.

The features of special interest which led Dr. Horne to show the case were paresis of the left half of the soft palate and abductor paralysis of the left vocal cord; no sensory paralysis of these parts had been made out. The muscles of the tongue acted well, and the sense of taste was normal.

Dr. Horne drew attention to the rhythmical oscillations of the tissues covering the fixed arytænoid, occurring during respiration, and ceasing on phonation. To apply the term nystagmus to these clonic rhythmical spasms he thought might be introducing a possible element of confusion; and the movements were too regular to be described as choreic. He attributed the oscillations to a lack of muscular tone and of co-ordination in the motor apparatus. Dr. Horne commented upon the complete absence of interference with respiration and phonation, and regarded the case as a clinical instance of unilateral abductor paralysis, existing without giving rise to symptoms; and he thought that this clinical fact, or rather a lack of recognition of it, might perhaps account for the little mention made of laryngeal palsies in connection with these cases.

The general health of the patient had been well maintained. Massage had been used, and had done good. At first iodide of potassium was prescribed, but on account of depression had to be stopped: latterly strychnine had been given, and more recently iodide of potassium with strychnine. But whether the drugs had materially influenced the progress of the disease it was difficult to say; the stress of the disease had fallen upon the left side of the body, and the condition had not materially changed during the past twelve months.

Dr. DE HAVILLAND HALL said the case was a good illustration of the value of laryngoscopic examination, where no symptoms were present which would naturally lead one to investigate the larynx. He considered such cases very rare; in one which he had seen there was paralysis of the trapezius muscle.

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Sir FELIX SEMON mentioned that a case of similar nature had been previously shown before the Society, but not under the same heading. The great interest in the case was the absolute absence of symptoms, *e.g.* dyspnœa and monotonous voice. The oscillatory movement of the left arytænoid cartilage was of a choreic type.

Dr. SPICER thought the movements of the eye and palate were synchronous.

Dr. LACK pointed out that the similar case he had shown had crises with half paralysis of the palate, and double abductor paralysis of the larynx.

Dr. JOBSON HORNE said there was no paralysis of the trapezii in his case, and there were no crises.

CANCER OF ŒSOPHAGUS AND TRACHEA CAUSING OBSTRUCTION OF THE TRACHEA AND BILATERAL PARALYSIS OF THE VOCAL CORDS.

Dr. CLIFFORD BEALE showed the œsophagus, trachea, and larynx from a male patient æt. 55, who in May last was suffering from persistent cough, continued slight hæmoptysis, dysphagia, hoarseness, loss of flesh, and night sweating. These symptoms had been increasing for the four previous months. No evidence of tubercular disease could be found; the larynx was healthy as regards its mucous surface, but the vocal cords were absolutely fixed in the cadaveric position. The glottis was sufficiently wide for ordinary respiration, but some obstruction evidently existed in the lower part of the trachea. On attempting to swallow liquids the patient was unable to prevent leakage into the larynx and consequent cough; but he could swallow solids fairly well, although complaining of obstruction referred to the level of the sternal notch. A tube passed into the œsophagus with the double object of exploration and feeding was stopped at about eleven inches from the teeth, and a little food passed through it was regurgitated. No pressure was used to overcome the obstruction. The patient gradually sank from exhaustion and increasing congestion of the lungs, but was able to take a fair amount of food. The respiration was never accelerated, remaining at about 18, but each inspiration was attended with stridor. On examination an epitheliomatous growth was found involving the œsophagus and the lower end of the trachea and all the bronchial glands. The trunk of the vagus nerve on the right side was lost in the growth, and the recurrent laryngeal nerve on the left side was also involved. The growth

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projected into the trachea, and a tortuous channel through it was found to connect the œsophagus and trachea. On the œsophageal side the growth itself was hollowed out to form a pouch, but there was no dilatation of the gullet above the growth. This case illustrates very well the uselessness of tracheotomy where a double obstruction exists, and also the danger of the œsophageal bougie where the obstruction is attended with hæmorrhage. The least force applied in this case must have inevitably torn through the soft and vascular growth, and so have accelerated the death of the patient.

In connection with Dr. Clifford Beale's case, Dr. Bond referred to a case of double abductor paresis with a tumour of tongue, and the history of syphilis and a stab in right neck, which was recently shown for him to the Society by Dr. StClair Thomson. The patient has since died. The lingual growth was found to be epithelioma. The double paresis was due to the right recurrent having been cut, and the left pressed on by an enlarged gland.

Unilateral Paralysis with Displaced Arytænoid and Dyspnœa.

Shown by Mr. Waggett. A case of recurrent nerve paralysis on the left side, occurring in a young woman of 22, and dating from infancy.

She complains of attacks of dyspnœa, which lately have become more severe and persistent. No tracheal stenosis or serious lung disease is present, though the chest is deformed, owing probably to the prolonged presence of enlarged tonsils, which were removed three years ago. The left vocal cord remains motionless in the cadaveric position, and the right cord does not pass the mid-line on attempted phonation, which results in a forced whisper. The paralysed cord is extremely short, and the left arytænoid is considerably displaced inwards and forwards, and at first sight has much of the appearance of a growth overhanging the rima glottidis. The tissues over the arytænoid appear to swell occasionally and cause dyspnœa, but the latter is absent at the present time. The early onset of the loss of voice, together with the history (and evidences) of tubercular abscesses in the neck in infancy, suggest involvement of the recurrent nerve in diseased mediastinal glands as the probable cause of the paralysis.

Dr. Dundas Grant thought there was paresis of half the palate, and the tongue and the depression of the palate was most marked on

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the right side, and therefore the lesion seemed to be a central one. There was also no sight in the left eye, besides evidence of retinal changes.

Hypertrophic Laryngitis with Atrophic Rhinitis and Pharyngitis, consequent on an Attack of Typhoid Fever and Diphtheria.

Shown by Dr. StClair Thomson. Two years ago the patient, a man æt. 40, left a hospital after an attack of typhoid fever in the course of which he had the misfortune to contract diphtheria. During this he reports that fluids regurgitated through his nose, and the hospital notes—which are not very definite—report that there was "partial anæsthesia of palate; thickening of epiglottic and vocal cords, and the right cord moves with greater freedom than the left." Since that time he has had offensive scabs from the nose, and the voice, which at first was only a whisper, has become stronger, but has remained gruff. The voice becomes worse, and the throat gets dry after use.

The vocal cords move freely. There is hypertrophy of the arytænoid region, and of the ventricular bands, and slightly in front of each processus vocalis there is a red, hypertrophied spot. Part of the epiglottis and uvula has disappeared, and there is an atrophic and cicatricial condition of the pharynx and nose.

The case is presented to illustrate the damage which may be left in the naso-pharynx by diphtheria—or typhoid,—the consequent laryngeal mischief, and the benefit which may accrue to the latter by treating the nose and pharynx. This patient has only had the latter attended to, and his larynx has improved considerably, although he has continued at work as a shopman.

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OF THE

LARYNGOLOGICAL SOCIETY

OF

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LARYNGOLOGICAL SOCIETY OF LONDON.

RULES.

1. THE Object of the Society is the cultivation and promotion of Laryngology, Rhinology, and their allied sciences.

2. The Society shall consist of (*a*) Honorary Members, (*b*) Ordinary Members. All legally qualified practitioners shall be eligible for nomination as Ordinary Members.

3. The Officers of the Society shall consist of a President, two or more Vice-Presidents, a Treasurer, two Secretaries, and a Librarian, who, with five other Members, shall form a Council, and manage the Society's affairs. At least a quarter of the Council shall consist of provincial Members.

ELECTION OF MEMBERS.

4. Candidates shall be proposed on a form provided for the purpose, and signed by three or more Members from personal knowledge. The proposal paper shall be read at one Ordinary Meeting, and shall then be submitted to every Member of the Society with the notices of the following meeting, at which the Ballot shall be taken. No election shall take place unless ten Members vote, and no person shall be elected who does not obtain four fifths of the votes given.

FORM OF ADMISSION BY THE CHAIRMAN.

5. Members shall be admitted personally by the following form, after signing their names in the admission book and

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paying their first annual subscription: "By the authority and in the name of the Laryngological Society of London, I admit you a Member thereof."

Honorary Members.

6. The Council shall have the power of proposing men of distinguished eminence in Laryngology, or in the sciences bearing upon it, for election as Honorary Members. They shall be elected in the same manner as Ordinary Members.

Expulsion of Members.

7. A Member can be expelled only at a General Meeting specially called for that purpose, and of which a written notice shall have been sent to every Member at least fourteen days previously. At least ten votes must be recorded, and four fifths shall carry the expulsion.

Election of Officers.

8. The Officers of the Society shall be elected yearly by ballot at the Annual Meeting, to which all the Ordinary Members shall be summoned one week previously. No gentleman shall hold the same office for more than three consecutive years. Balloting lists of the names recommended by the Council for election shall be sent to each Ordinary Member, together with the notice of the Annual Meeting.

Bye-law 1.—If a Member wishes to propose for ballot any candidate for office other than those whose names stand upon the list recommended by the Council, the name of such candidate duly proposed by one Member and seconded by two other Members shall be sent to the Senior Secretary at least a week before the Annual General Meeting. It shall be the duty of the Senior Secretary to see that the name of such candidate, with the office for which he is nominated, together with the names of the proposer and two seconders, be sent to all Members at least two days before the Annual General Meeting.

Scrutineers.

9. Two Scrutineers, appointed by the Chairman at the commencement of the Annual Meeting, shall receive the lists during

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the first hour, and report the result to the Chairman. In the event of equality of suffrage the Chairman shall determine.

Subscriptions.

10. The Annual Subscription shall be One Guinea, payable in advance at the date of the Annual General Meeting. Each Member on election shall pay an Entrance Fee of One Guinea in addition to the Subscription, but in the case of a Member elected at a meeting of the session subsequent to October, he shall not be required to pay a Subscription during the next session. Any Member whose Subscription is six months in arrear shall be reminded of the same by one of the Secretaries, and if it be not paid within the current year he shall cease to be a Member.

Bye-law 2.—Country Members are allowed to "compound" for the sum of £10 10*s*. on entrance, which sum shall include the entrance fee.

Bye-law 3.—Country Members who have not paid five annual subscriptions shall be allowed to compound for the sum of £9 9*s*.

Bye-law 4.—These fees shall entitle the compounding Members to enjoy all the privileges at present accorded to Ordinary Members of the Society.

Bye-law 5.—The privilege of thus compounding is not, at present, extended to town Members.

The President and Vice-Presidents.

11. The President shall regulate all the proceedings of the Society and Council, state and put questions, interpret the application of the Laws, and decide any doubtful points. He shall check irregularities, and enforce the observance of the Laws. He shall sign the Minutes of General and Council Meetings. In the absence of the President one of the Vice-Presidents, the Treasurer, or some other Member chosen by the Meeting shall perform his duties.

The Secretaries.

12. The Secretaries shall manage all correspondence, shall attend every Meeting of the Society and Council, and take

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Minutes, which shall be read at the following Meeting. They shall notify to new Members their election. They shall arrange with the President the order of proceedings at all the Meetings. They shall have charge of, and keep a register of, all papers communicated, and shall be the Editors of the 'Proceedings.'

The Treasurer.

13. The Treasurer shall receive all moneys due to the Society, and make all payments ordered by the Council, keeping an account of all such receipts and payments. He shall keep a printed receipt book for the Subscriptions, and every receipt shall be signed by himself and countersigned by one of the Secretaries. He shall present to the Annual Meeting a written Report of the financial state of the Society, signed by himself and by two members of the Audit Committee.

Audit Committee.

14. The President, one of the Secretaries, and two Members of the Society nominated by the President at some Meeting of the Society previous to the Annual Meeting, shall form a Committee to audit the Treasurer's accounts.

The Librarian.

15. The Librarian shall have entire control of the Library, under the direction of the Council.

Bye-law 6.—That Members shall be permitted to borrow any of the works in the Society's library with the exception of single numbers of current periodicals at the monthly meetings of the Society through the Librarian only. Works so borrowed shall not be kept for longer than one month from the date of borrowing, nor for more than five days after they have been applied for by the Librarian. Books lost or damaged must be replaced or made good by the borrower.

Bye-law 7.—That an exact record be kept by the Librarian of all works so borrowed, showing the precise dates of their issue and return.

Bye-law 8.—That past copies of the 'Proceedings' should be kept and charged for at sixpence each, or two shillings a set.

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The Council.

16. The Council shall meet regularly four times a year, and at such other times as they may be specially convened. Five shall form a quorum. They shall determine questions by show of hands (or by ballot if demanded), the President having in both cases a casting vote in addition to his ordinary vote. They shall have the power of filling up any vacancies which may occur in any of the offices of the Society between one Annual Meeting and another. They shall decide upon all questions relating to the reception of communications and to their publication in the Society's 'Proceedings.' They shall also have the power to make Bye-laws, subject to confirmation at the next Annual General Meeting.

'Proceedings.'

17. A copy of the 'Proceedings' shall be sent to each Member of the Society.

Annual General Meeting.

18. The Annual General Meeting shall be held in the month of January, and shall be followed by a Dinner of the Members and their friends.

Hours of Meeting.

19. The Society's Ordinary Meetings shall be held between the hours of 5 and 6.30 p.m. on the second Wednesday in each month, from November to June inclusive.

Visitors.

20. Each Member shall be entitled to introduce two Visitors, but no Visitor shall be introduced more than twice in each Session. The names of all Visitors shall be entered in a book, and shall be submitted to the President, who shall announce to the Meeting the names of such Visitors, and of the Members introducing them.

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Business at Ordinary Meetings.

21. The business at Ordinary Meetings shall consist (*a*) of the exhibition of clinical cases, specimens, drawings, &c., and discussions upon them; but no discussion on the clinical cases exhibited shall be permitted in the presence of the patients; (*b*) of the reading and discussion of clinical memoranda, if approved by the Council; (*c*) of debates upon fixed subjects.

Order of Business.

22. At least one month's notice of any written communication shall be sent to the Secretaries, together with an abstract suitable for publication in the 'Proceedings;' and all communications shall be taken in the order in which they are received, subject to the discretion of the President. If any Member is absent when called upon for his communication, it shall be dealt with as the President may direct.

One week's notice shall, if possible, be given of any clinical cases, specimens, &c., intended for exhibition, and the order of the discussion upon them shall be at the discretion of the President.

Alteration of Rules.

23. Any proposed alteration of Rules shall be considered and decided upon at the Annual General Meeting only, notice of such proposed alterations having been given in the notice convening the Meeting. Ten shall form a quorum at this Meeting, and for the adoption of any alteration of the Laws four fifths of the votes given must be in its favour. Nothing relating to the Laws or management of the Society shall be considered at an Ordinary Meeting.

Special General Meetings.

24. A Special General Meeting may be called at any time, on one week's notice by the President, or by any three Members

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of the Council, or by any ten Members of the Society, the nature of the business being specified in the summons sent to each Member of the Society, and no other business being considered.

MORBID GROWTHS COMMITTEE.

Bye-law 9.—A Morbid Growths Committee shall be elected by the Society, consisting of Members of the Society.

Bye-law 10.—That a Cabinet be kept in the cupboard belonging to the Society, and that the Acting Secretary of the Morbid Growths Committee have charge of the key.

Bye-law 11.—That Members desiring to examine sections must do so at the Society's rooms, and that sections shall not be taken away.

Bye-law 12.—That those portions of the Report that are of interest to the general Members of the Society be printed and sent out in conjunction with the paragraphs of the Librarian's Report.

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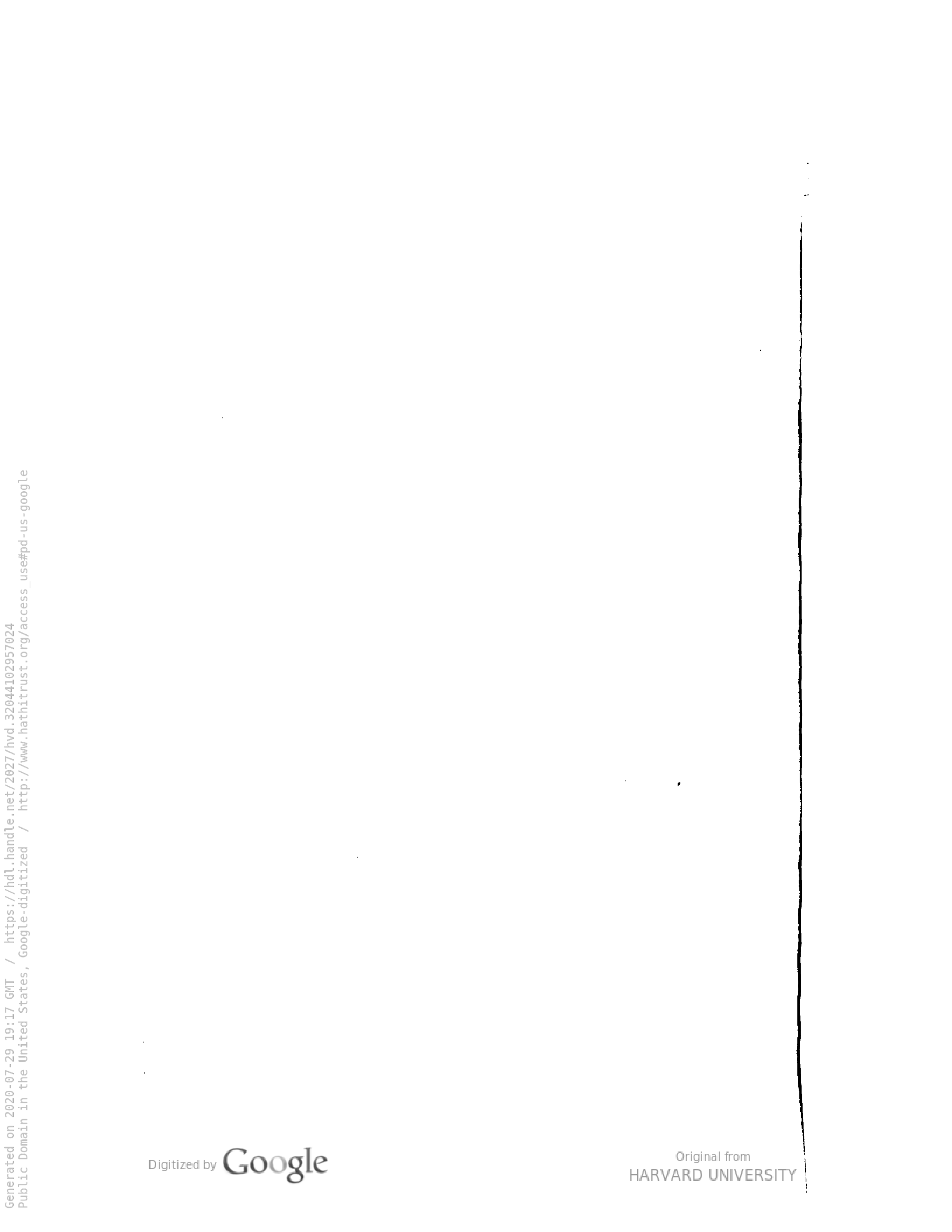

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LARYNGOLOGICAL SOCIETY

OF

LONDON.

LIST OF MEMBERS.

1897.

LONDON:
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1897.

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HONORARY MEMBERS.

FRAENKEL, Professor B., 12, Neustädtische Kirchstrasse N.W. Berlin.

GARCIA, MANUEL, Mon Abri, Shoot-up hill, Cricklewood.

LEFFERTS, G. M., 6, West Thirty-third street, New York, U.S.A.

MASSEI, Professor, 4, Piazza Municipio, Naples, Italy.

MOURE, E. J., 25 bis, Cours du Jardin Publique, Bordeaux.

SCHMIDT, Professor MORITZ, Frankfort-on-the-Main, Germany.

v. SCHRÖTTER, Professor, 3, Marianengasse I, Vienna.

SOLIS-COHEN, J., 1431, Walnut street, Philadelphia, U.S.A.

STÖRK, Professor, 9, Wallfischgasse I, Vienna.

DECEASED HONORARY MEMBER.

JOHNSON, SIR GEORGE . . Died 1896.

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Laryngological Society of London.

LIST OF MEMBERS,

JUNE, 1897.

INDEX TO ABBREVIATIONS,

Indicating Past or Present Officers of the Society.

(*P.*) President. (*L.*) Librarian.
(*V.-P.*) Vice-President. (*S.*) Secretary.
(*T.*) Treasurer. (*C.*) Councillor.
(O.M.) Original Member.

LONDON.

Members who pay their Annual Subscription through a Banker's Order (to be obtained from the Treasurer) have an asterisk prefixed to their names.

Elected.

1893 Aikin, William Arthur, M.D., 14, Summer place, Onslow Square, S.W.

1893 Ayres, Charles James, M.D., 47a, Welbeck street, Cavendish square, W.

O.M. Ball, James Barry, M.D., M.R.C.P., 12, Upper Wimpole street, W. *C.*

1896 Bateman, F. A. N., L.R.C.P., M.R.C.S., 4, Charles street, St. James's, S.W.

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Elected.

O.M. SEMON, SIR FELIX, M.D., F.R.C.P., 39, Wimpole street, W. *P. V.-P. C.*

1894 SHARMAN, HENRY, M.D., 16, Frognal, Hampstead.

1893 SPENCER, WALTER GEORGE, M.S., F.R.C.S., 35, Brook street, Grosvenor square, W.

O.M. SPICER, SCANES, M.D., 28, Welbeck street, Cavendish square, W. *S. C. V.-P.*

1895 STABB, EWEN C., F.R.C.S., St. Thomas's Hospital, S.E.

1895 STEPHEN, G. CALDWELL, M.D., L R.C.P., 54, Evelyn gardens, South Kensington.

O.M. STEWART, WILLIAM ROBERT HENRY, F.R.C.S.Ed., 42, Devonshire street, Portland place, W. *S. C.*

O.M. *SYMONDS, CHARTERS JAMES, M.S., F.R.C.S., 26, Weymouth street, Portland place, W. *C. V.-P.*

1894 *THOMSON, STCLAIR, M D., F.R.C.S., M.R.C.P., 28, Queen Anne street, Cavendish square, W. *S.*

1896 THORNE, ATWOOD, M.B., M.R.C.S., L.R.C.P., 10, Nottingham place, W.

1893 TILLEY, HERBERT, M.D., B.S., M.R.C.S., 64, Welbeck street, W. *S.*

1893 WAGGETT, ERNEST BLECHYNDEN, M.B., 45, Upper Brook street, Grosvenor square, W.

O.M. WALSHAM, WILLIAM JOHNSON, F.R.C.S., 77, Harley street, W. *T.*

1896 WHAIT, J. R., M.D., C.M., L.R.C.P., M.R.C.S., Charlton's Fair, Hazel gardens, South Hampstead.

O.M. WHISTLER, WILLIAM MACNEILL, M.D., M.R.C.P., 18, Wimpole street, W. *V.-P. C.*

1893 WHITE, WILLIAM HALE, M.D., F.R.C.P., 65, Harley street, W.

O.M. WILLCOCKS, FREDERICK, M.D., F.R.C.P., 14, Mandeville place, Manchester square, W.

O.M. WILLS, WILLIAM ALFRED, M.D., M.R.C.P., 29, Lower Seymour street, W.

1897 WINGRAVE, V. H. WYATT, M.R.C.S., 11, Devonshire street, W.

1897 YEARSLEY, P. MACLEOD, F.R.C.S., 10, Bentinck street, W.

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COUNTRY.

The names of Country Members who have paid a "Compounding" Fee are printed in heavier type.

Elected.

1896 Agar, Morley, M.R.C.S., L.R.C.P., Ponder's End, Middlesex, and 70, Wimpole street.

1895 Armstrong, W. G., M.B., Sydney, New South Wales.

O.M. Baber, Edward Cresswell, M.B., 46, Brunswick square, Brighton, and 114, Harley street, London, W. *C. V.-P.*

1895 Bark, John, F.R.C.S.Ed., M.R.C.P.I., 54, Rodney street, Liverpool.

1895 Baron, Barclay J., M.B., Clifton.

O.M. Bennett, Frederick William, M.D., 25, London road, Leicester. *C.*

1895 Brady, Andrew John, L.R.C.P.&S.I., Sydney, New South Wales.

O.M. Bronner, Adolph, M.D., 33, Manor row, and 8, Mount Royd, Bradford. *C. V.-P.*

1894 Brown, Alfred, M.D., Sandycroft, Higher Broughton, Manchester.

1897 Brown, Ernst R., M.D., C.M., Montreal, Canada.

1895 Browne, John Walton, M.D., M.R.C.S., 10, College street North, Belfast.

1893 Charsley, Robert Stephen, M.R.C.S., L.R.C.P., The Barn, Slough, Bucks.

1897 Davis, W. Herbert, M.A., M.B., M.R.C.S., L.R.C.P., 27, Grand Parade, St. Leonard's-on-Sea.

1893 ***Davison, James**, M.D., M.R.C.P., Streate place, Bath road, Bournemouth.

1895 Downie, J. Walker, M.B., 4, Woodside crescent, Glasgow.

1893 Duncanson, J. J. Kirk, M.D., F.R.C.P.Ed., 22, Drumsheugh gardens, Edinburgh.

1893 Embleton, Dennis Cawood, M.R.C.S., L R.C.P., St. Wilfrid's, St. Michael's road, Bournemouth.

1893 Foster, Michael, M.B., Villa Annita, San Remo.

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Elected.

O.M. BEALE, EDWIN CLIFFORD, M.B., F.R.C.P., 23, Upper Berkeley street, W. *S. L.*

O.M. *BOND, JAMES WILLIAM, M.D., 26, Harley street, W. *C. V.-P.*

O.M. BOWLBY, ANTHONY ALFRED, F.R.C.S., 24, Manchester square, W.

O.M. BUTLIN, HENRY TRENTHAM, F.R.C.S., 82, Harley street, W. *T. P.*

1895 CATHCART, GEORGE E., M.B., C.M., 35, Harley street, Cavendish square, W.

1895 CHEATLE, ARTHUR H., F.R.C.S., 117, Harley street, W.

1893 COLBECK, EDMUND HENRY, M.D., M.R.C.P., 14, Porchester terrace, W.

1894 CRIPPS, CHARLES COOPER, M.D., 187, Camberwell grove, S.E.

O.M. CRISP, ERNEST HENRY, 43, Fenchurch street, E.C.

1893 DAVIS, HENRY, 60, Queen Anne Street, Cavendish square, W.

1893 DONELAN, JAMES, M.B., 2, Upper Wimpole street, W.

1896 DORMAN, MARCUS R. P., M.B., B.C., L.R.C.P., M.R.C.S., 9, Norfolk crescent, Hyde park, W.

1894 DRYSDALE, JOHN HANNAH, M.B., M.R.C.P., 25, Welbeck street, W.

1897 DURHAM, HERBERT, E., M.B., B.C., F.R.C.S., 82, Brook street.

1896 GLOVER, LEWIS GLADSTONE, M.D., B.C., M.R.C.S., L.R.C.P., 1, College terrace, Fitzjohn's avenue, N.W.

1895 GORDON, A. KNYVETT, M.B., B.C., S.E. Fever Hospital, New Cross, S.E.

O.M. GRANT, J. DUNDAS, M.D., F.R.C.S., 8, Upper Wimpole street, W. *C. L.*

O.M. HALL, FRANCIS DE HAVILLAND, M.D., F.R.C.P., 47, Wimpole street, W. *L.*

1895 HAMILTON, BRUCE, M.R.C.S., L.R.C.P., 9, Frognal, West Hampstead.

1893 HARVEY, FREDERICK GEORGE, F.R.C.S.Ed., 4, Cavendish place, Cavendish square, W.

1897 HERDMAN, RONALD T., M.B., C.M., Throat Hospital, Golden square, W.

1894 HEY, CHARLES EDWARD MILNES, M.R.C.S., L.R.C.P., Westbury, Hornsey lane, N.

O.M. HILL, G. WILLIAM, M.D., 28, Weymouth street, W.

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Elected.

1894 HILL-WILSON, A. E., M.R.C.S., L.R.C.P., 217, Goldhawk road, W.

O.M. HOLMES, W. GORDON, M.D., 10, Finsbury square, E.C.

1894 HORNE, WALTER JOBSON, M.B., 17, Bartlett's buildings, Holborn, W.C.

O.M. HOVELL, T. MARK, F.R.C.S.Ed., 105, Harley street, W.

1895 JAKINS, PERCY, M.R.C.S., 120, Harley street, W.

1894 JESSOP, EDWARD, M.R.C.S., L.R.C.P., 81, Fitzjohn's avenue, Hampstead, N.W.

1897 KELSON, WILLIAM H., M.D., B.S., F.R.C.S., 96, Queen street, Cheapside, E.C.

O.M. KIDD, PERCY, M.D., F.R.C.P., 60, Brook street, Grosvenor square, W. *C.*

1895 LACK, LAMBERT HARRY, M.D., F.R.C.S., 55, Welbeck street, W.

1893 LAKE, RICHARD, F.R.C.S., 19, Harley street, W.

O.M. LAW, EDWARD, M.D., 35, Harley street, W.

O.M. LAWRENCE, LAURIE ASHER, F.R.C.S., 4, Queen Anne street, W.

O.M. MACDONALD, GREVILLE, M.D., 85, Harley street. *C.*

1895 MACGEAGH, T. E. FOSTER, M.D., M.R.C.S., L.S.A., 23, New Cavendish street, W.

1894 MACKENZIE, HECTOR WILLIAM GAVIN, M.D., F.R.C.P., 59, Welbeck street, W.

1893 PEGLER, LOUIS HEMMINGTON, M.D., 25, Old Burlington street, W.

1895 PERKINS, J. J., M.B., Hospital for Consumption, &c., Brompton.

O.M. POLLARD, BILTON, F.R.C.S., 24, Harley street, W.

1894 POTTER, EDWARD FURNISS, M.D., 64, Welbeck street, W.

1894 POULTER, REGINALD, 4, Gordon mansions, Francis street, Gordon square, W.C.

O.M. REES, JOHN MILSOM, F.R.C.S.Ed., 53, Devonshire street, Portland place, W.

1894 ROUGHTON, EDMUND, M.B., B.S., F.R.C.S., 38, Queen Anne street, W.

1893 SANTI, PHILIP ROBERT WILLIAM, F.R.C.S., 91, Harley street, Cavendish square, W.

1896 SCHORSTEIN, GUSTAVE, M.A., M.B., F.R.C.P., 11, Portland place, W.

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1895 FOURQUEMIN, GEORGE VINCENT, L.R.C.P., care of Messrs. Buchanan, Forsyth & Co., West street, Durban, South Africa.

O.M. HODGKINSON, ALEXANDER, M.B., 18, St. John street, Manchester. *V.-P.*

1894 HUNT, JOHN MIDDLEMASS, M.B., C.M., 55, Rodney street, Liverpool.

O.M. JOHNSTON, ROBERT MCKENZIE, M.D., F.R.C.S.Ed., 2, Drumsheugh gardens, Edinburgh. *C.*

O.M. KANTHACK, ALFREDO ANTUNES, M.D., F.R.C.S., Cambridge.

1895 LINDSAY, DAVID MOORE, L.R.C.P., L.R.C.S.I., 373, Main street, Salt Lake City, Utah Territory, U.S.A.

1895 MACINTYRE, JOHN, M.B., C.M., 179, Bath street, Glasgow.

1894 MACKERN, GEORGE, M.D., Buenos Ayres, Argentina.

O.M. MCBRIDE, PETER, M.D., F.R.C.S.Ed., 16, Chester street, Edinburgh. *V.-P.*

1893 MILLIGAN, WILLIAM, M.D., 337, Oxford road, Manchester.

O.M. **NEWMAN, DAVID**, M.D., 18, Woodside place, Glasgow. *C.*

O.M. PARKER, CHARLES ARTHUR, M.R.C.S., High street, Rickmansworth, Herts.

O.M. PATERSON, DONALD ROSE, M.D., M.R.C.P., 18, Windsor place, Cardiff.

1893 PERMEWAN, WILLIAM, M.D., F.R.C.S., 7, Rodney street, Liverpool.

1895 REYNOLDS, ARTHUR R., M.D. New York, 36, Washington street, Chicago, U.S.A.

1895 RIDLEY, W., F.R.C.S., Ellison place, Newcastle.

1895 *SANDFORD, ARTHUR W., M.D., M.Ch., 13, St. Patrick's place, Cork, Ireland.

1897 SENDZIAK, Dr. JOHANN, 139, Marszatkowska-Strasse, Warsaw, Russian Poland.

O.M. TEBB, WILLIAM SCOTT, M.D., Charlcombe, Boscombe Hill, Bournemouth.

1896 TOMSON, W. BOLTON, M.D., M.R.C.S., L.R.C.P., Park street West, Luton, Beds.

1896 TURNER, A. LOGAN, M.D., F.R.C.S.Ed., 20, Coates crescent, Edinburgh.

1893 WALKER, CHARLES ROTHERHAM, M.D., Glenfield, Silverdale road, Eastbourne.

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Elected.

1897 Walker, Henry Secker, F.R.C.S., 44a, Park square, Leeds.

O.M. Walker, Thomas James, M.D., 33, Westgate, Peterborough.

1895 Warner, Percy, M.R.C.S., L.R.C.P., Woodford.

1893 *Williams, Patrick Watson, M.D., 2, Lansdowne place, Victoria square, Clifton, Bristol. *C.*

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LIST OF EXCHANGES.

PERIODICALS:

The Journal of Laryngology, Rhinology, and Otology (London)
The Laryngoscope (St. Louis, U.S.A.).
The Annals of Laryngology, Rhinology, and Otology (America).
Annales des Maladies de l'Oreille, &c. (Paris).
Archives Internationales de Laryngologie (Paris).
Revue de Laryngologie, &c. (Bordeaux).
Revue Internationale de Laryngologie, &c. (Paris).
Centralblatt für Laryngologie.
Archiv für Laryngologie (Berlin).
Monatsschrift für Ohrenheilkunde, &c.
Archivio Italiano di Otologia (Turin).
Bollettino delle Malattie dell' Orecchio, &c. (Florence).
Archivii Italiani di Laringologia (Naples).

TRANSACTIONS OF THE FOLLOWING SOCIETIES:

British Laryngological, Rhinological, and Otological Association.
American Laryngological Association.
American Laryngological, Rhinological, and Otological Society.
Société Française de Laryngologie, &c.
Société Parisienne de Laryngologie, &c.
Gesellschaft der Ungarischen Ohren- und Kehlkopfärzte.

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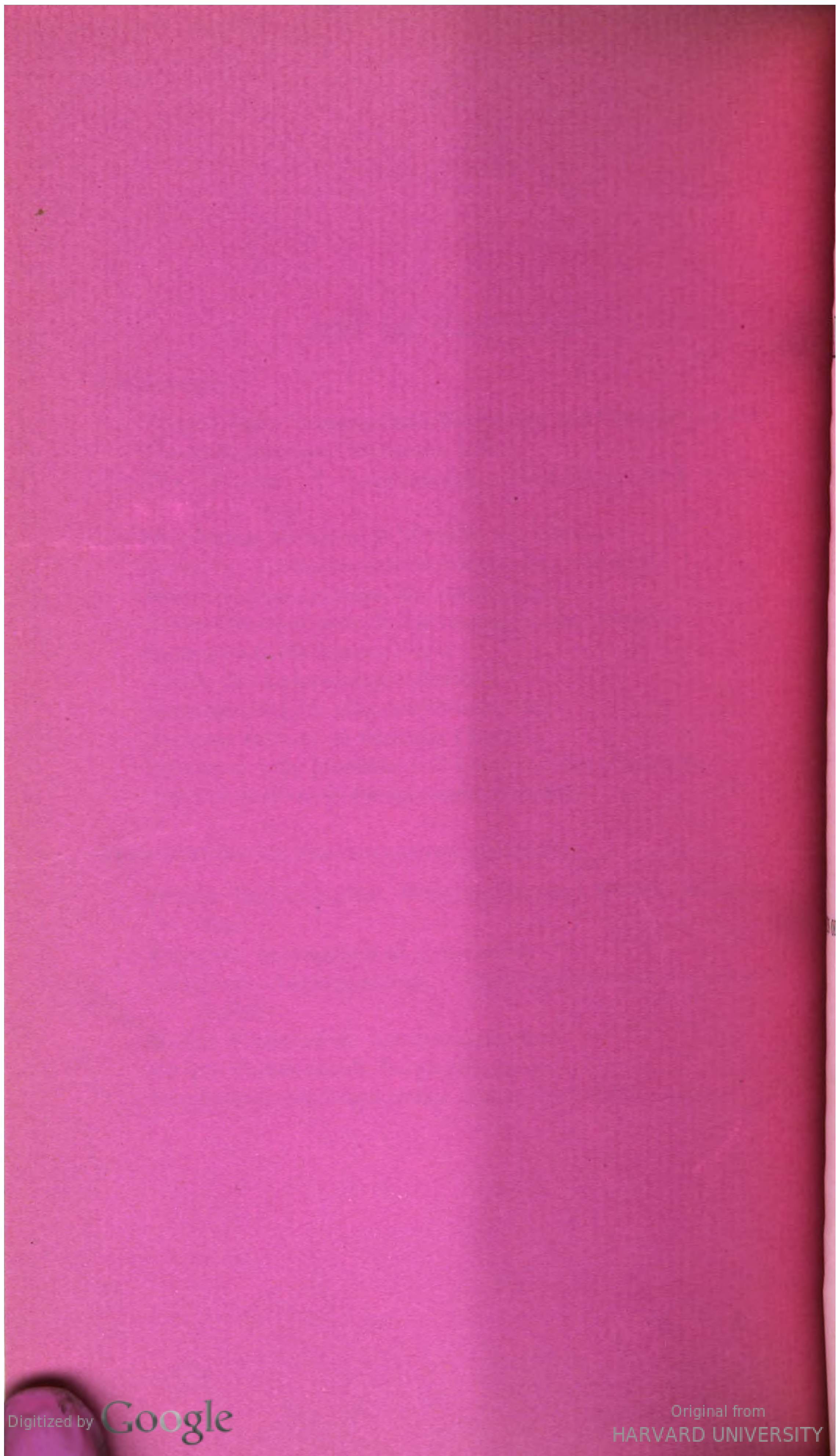

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY

OF

LONDON.

VOL. V.

1897–98.

WITH

LISTS OF OFFICERS, SUPPLEMENTARY LIST OF MEMBERS, ETC.

LONDON:
PRINTED BY ADLARD AND SON,
BARTHOLOMEW CLOSE, E.C.

1898.

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OFFICERS AND COUNCIL

OF THE

Laryngological Society of London

ELECTED AT

THE ANNUAL GENERAL MEETING,

JANUARY 12TH, 1898.

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H. TRENTHAM BUTLIN, F.R.C.S.

Vice-Presidents.

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F. DE HAVILLAND HALL, M.D.
SCANES SPICER, M.D.
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W. J. WALSHAM, F.R.C.S.

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Secretaries.

HERBERT TILLEY, M.D., F.R.C.S.
WILLIAM HILL, M.D., B.Sc.

Council.

A. A. KANTHACK, M.D.
W. R. H. STEWART, F.R.C.S. (Edin.).
SIR F. SEMON, M.D.
STCLAIR THOMSON, M.D.
P. WATSON WILLIAMS, M.D.

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PRESIDENTS OF THE SOCIETY.

(From its Formation.)

ELECTED	
1893	Sir George Johnson, M.D., F.R.S.
1894	Sir Felix Semon, M.D., F.R.C.P.
1895	Sir Felix Semon, M.D., F.R.C.P.
1896	Sir Felix Semon, M.D., F.R.C.P.
1897	H. Trentham Butlin, F.R.C.S.

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Laryngological Society of London.

SUPPLEMENTARY LIST OF MEMBERS

(*To July*, 1898).

LONDON.

Elected

1898 FALLOWS, JOHN, L.R.C.S.Edin., 2, Princes Mansions, 66, Victoria street, W.

1898 FERGUSSON, ARNOLD, F.R.C.S.Edin., 34, Canfield gardens, Hampstead.

1897 LAMPLOUGH, CHARLES, M.R.C.S.Eng., L.R.C.P.Lond., Chest Hospital, Victoria park.

1897 MCILRAITH, CHARLES HUGH, M.A., M.D.Glas., 17, Stradella road, Herne Hill, S.E.

1897 PAGET, STEPHEN, F.R.C.S.Eng., M.A.Oxon., 70, Harley street, W.

1897 RAMSAY, HERBERT, F.R.C.S.Edin., 35A, Hertford street, Mayfair.

1898 ROBINSON, HENRY B., M.S.Lond., F.R.C.S.Eng., 1, Upper Wimpole street, W.

1898 STEWARD, FRANCIS J., M.S.Lond., F.R.C.S.Eng., 24, St. Thomas's street, S.E.

COUNTRY.

1897 BEAN, CHARLES EDWARD, F.R.C.S.Edin., M.R.C.S. and L.R.C.P.Lond., 19, Lockyer street, Plymouth.

1898 BURT, ALBERT H., M.R.C.S., L.R.C P.Eng., Throat Hospital, Brighton.

1898 CLAREMONT, CLAUDE C., M.D., B.S.Lond., 57, Elm grove, Southsea.

1897 FOXCROFT, FREDERICK WALTER, M.B., C.M.Edin., 32, Paradise street, Birmingham.

1898 FRAZER, WILLIAM, M.R.C.S., L.R.C.P.Eng., Johannesburg.

1898 HUTCHINSON, ARTHUR, M.A., M.B., C.M.Glas., 225, Bath street, Glasgow.

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Elected

1898 **Kelly, Adam B**, M.B., C.M., 26, Blythswood square, Glasgow.

1898 **Marsh, Frank**, F.R.C.S.Eng., 34, Paradise street, Birmingham.

1898 **Scatliff, John E.**, M.D.Aberd., M.R.C.S.Eng., 11, Charlotte street, Brighton.

1897 **Snell, Sydney**, M.D., B.S.Lond., M.R.C.S.Eng., L.R.C.P. Lond., D.P.H., Shaftesbury House, Grays, Essex.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *November* 10*th*, 1897.

HENRY T. BUTLIN, Esq., F.R.C.S., in the Chair.

STCLAIR THOMSON, M.D., } Secretaries.
HERBERT TILLEY, M.D., }

Present—42 members and 6 visitors.

The minutes of the previous meeting were read and confirmed.

Mr. Stephen Paget, F.R.C.S.Eng., and Charles McIlwraith, M.D. (Glasgow), were elected ordinary members of the Society.

The following gentlemen were nominated for election at the next Ordinary Meeting of the Society:

Charles Lamplough, M.R.C.S., L.R.C.P., Chest Hospital, Victoria Park.
Sydney Snell, M.D., B.S. (Lond.), M.R.C.S., Grays, Essex.
Charles Edward Bean, F.R.C.S. (Edin.), M.R.C.S. (Eng.), L.R.C.P. (Lond.), of Plymouth.
Frederick Walter Foxcroft, M.B., C.M. (Edin.), of Birmingham.
Herbert Ramsay, F.R.C.S. (Edin.), of London.

NEW TRACHEOTOMY TUBE FOR PERMANENT USE.

The designer, Mr. W. Heywood, a working jeweller, of 81, Davies Street, W., was introduced by Sir Felix Semon, and exhibited the instrument.

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The main tube is similar to that of an ordinary tracheotomy tube, but has a small, easily removable metal box, fitting into the proximal end of the tube. The anterior wall of the box is replaced by a narrow metal bar, and hanging from the upper surface of the box, a little way from its anterior extremity, is a light metal flap, so inclined that a current of inspired air easily passes through the box, but on expiration the metal flap is driven forward, and effectually acts as a "stop" to expiration through the tube. Hence the patient can (in this case suffering from abductor paralysis) phonate quite easily without placing his finger on the proximal end of the tube, as is necessary in the ordinary patterns. Moreover the little box is very easily detached and cleaned, and having a larger and freer lumen is much less liable to become obstructed by mucus than the common tracheotomy tubes.

The inventor acknowledged that he derived the idea of the instrument from Mr. de Santi's tube, but considered the new design presented advantages over any previously invented tracheotomy tubes.

Mr. de Santi remarked that the new tracheotomy tube for permanent use shown by Sir F. Semon's patient was practically a modification of his own shown some time ago at the Society's meeting. He, however, considered that the present modification was a distinct gain, because it gave more breathing space and was far easier to clean than his own tube. He had two patients, however, who were wearing and were well satisfied with his tube, and his friend Mr. Bowlby also had a couple of patients wearing his tube with great satisfaction. He congratulated Sir F. Semon's patient on the improvements he had made, and hoped he would get the patent he had applied for.

Syringe for making Submucous Injections in Laryngeal Tuberculosis.

Dr. Donelan showed a syringe for this purpose. His attention was recalled to this treatment by Dr. Chappell's paper, read before the New York Laryngological Society in 1895, reporting a number of successes with this method. The exhibitor since that time tried the injections in seven cases of advanced laryngeal tuberculosis which had proved refractory to curetting and lactic acid, and was able to speak most favorably of the effect of the injections on the local condition. The syringe consists of a steel barrel and tube mounted on a modified "pistol handle." The tube has a rect-

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angular laryngeal curve, and at the distal end a rather coarse thread, capable of carrying safely nozzles varying in length according to the depth at which it is desired to make the injections. Each nozzle terminates in a rounded shoulder from which a hollow needle projects ¼ inch, that being the depth of puncture found necessary to insure retention of the fluid. As it was found that the creasote speedily rendered the piston leathers useless, these were replaced in this syringe by a "plunger" fitting closely to the interior of the barrel and graduated in minims. The whole instrument and its case are therefore sterilisable.

The syringe is filled by pouring guaiacol into the barrel until it is full, and the oil begins to drip from the needle. The plunger is replaced and compressed until only the desired dose is left in the barrel. The needle is then guided by the laryngoscope into the previously cocainised larynx, and inserted in the site selected. Then the thumb is placed in the button of the plunger, which is driven quickly home. The needle should not be withdrawn if possible for a moment or two longer.

In the cases referred to the injections were followed by remarkably little local reaction, which was always controlled by sucking ice. The most remarkable immediate effect of this treatment was the relief of dysphagia, especially after two to three injections.

In another case an obstinate tubercular ulcer in the interarytænoid fold was quite cured. The injections were made at intervals of from four days to a week. The dose was generally one minim of pure guaiacol, and never more than two minims in obstinate cases. Besides the injections the most important part of the treatment was the frequent cleansing of the larynx by antiseptic and other sprays, most frequently an oily solution of guaiacol.

Case of Fibro-sarcoma of the Nasal Septum.

Shown by Dr. J. B. Ball. Emily P—, æt. 25, seen August 14th, 1897, complaining of a stoppage of the nose. About three or four months previously she began to suffer from repeated attacks of epistaxis. The bleeding was from the left nostril at first, but subsequently from both nostrils. During the last two or three months the nose gradually became more and more obstructed, first the left side,

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then the right, but the bleeding was less frequent and severe than before. She had experienced no pain.

Examination showed each passage to be almost completely obstructed by a smooth pinkish mass presenting in the upper part of each vestibule. Its attachment was made out to be to the cartilaginous septum. The posterior choanæ were found to be free, and the growth could not be felt with the finger passed into the posterior nares.

A small portion of the tumour was removed with a snare from the left side for microscopical examination. Its removal was followed by brisk hæmorrhage. The Clinical Research Association's report was that the growth consisted of young connective tissue, and might be termed a fibro-sarcoma.

On August 24th the growth was removed by Mr. Swinford Edwards. For this purpose the left ala nasi was detached and turned up, and the growth was easily removed together with a certain amount of the cartilaginous septum. The greater part of the cartilage had, however, been absorbed. The tumour was about the size of a walnut, and presented a constriction towards the right side marking the point where it had grown through the septum.

The patient was shown together with the tumour and microscopical specimen.

Tumour of Tongue—Patient and Specimen.

Shown by Mr. Morley Agar. The tumour was removed from the right posterior dorsum of tongue in a lad æt. 15. It was readily enucleated, and followed by very little hæmorrhage. The growth had apparently only taken one week to attain its size.

Mr. Butlin suggested that it was a fibroma or fibro-sarcoma, and noticed a thickening around the area of removal which was suspicious of its sarcomatous nature. At his suggestion the specimen was submitted to the Morbid Growths Committee for examination.

Separation of Old-standing Adhesion of the Soft Palate to the Pharynx.

Shown by Mr. W. G. Spencer. The patient, a middle-aged woman, had suffered severely from tertiary syphilis, and the soft

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palate had become completely united to the back wall of the pharynx. As a result of this she had great pain in the ears and over the mastoid processes, as well as collections of muco-pus which she could not expel from the nose. Antisyphilitic remedies had ceased to give any relief, and so severe and continuous was the pain that her general health and spirits had become impaired.

When she was anæsthetised, the mouth gagged open, and the tongue depressed, the respiration became bad or stopped. Therefore the operation had to be carried out with only a partially opened mouth. The head was hanging low. The line of union between the palate and pharyngeal wall was first incised by an angular cleft palate knife, when it was found that the whole of the naso-pharynx above the palate was filled by dense fibrous tissue. This was penetrated from the mouth by using cleft palate raspatories, and from the nose by thrusting in a strong pair of nasal dilators. The soft palate was after this drawn forwards and fixed by two silk sutures to the muco-periosteum of the hard palate. There was free venous hæmorrhage during and after the operation, but the nose and naso-pharynx could not be plugged because the soft palate largely obstructed respiration through the mouth. The hæmorrhage stopped the next day. The sutures holding the soft palate forwards cut out in about a week. The separation has since then been kept up by the patient passing full-sized nasal bougies, and by stretching at intervals of a fortnight the soft palate by using an aneurism needle under cocaine. The patient has lost the pain in the ears, and can breathe easily through and blow the nose. She is now in very good health, and is cheerful. The opening will admit two fingers when the palate is stretched; the latter is mobile. There is still a small muco-purulent discharge.

It is generally held that the occurrence of these adhesions cannot be prevented by any of the contrivances which have been proposed, and that it is useless to separate them when formed, owing to the tendency to recurrence. This opinion is no doubt correct as a rule, and Mr. Spencer had not heard of a successful case. But this patient is brought forward to show that, granted sufficient indications, the operation may be undertaken with some hope of affording relief. It will doubtless be necessary to keep up the dilatation in the present case for some time.

No better way of operating seems to have been proposed. Measures which entail the cutting or partial excision of the soft palate

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would be likely to set up fresh trouble, owing to the passage of food into the nostrils.

Mr. de Santi congratulated Mr. Spencer on his excellent result. He had a similar case under observation where the patient had severe pain in the ear and mastoid; he intended to try Mr. Spencer's method of operation.

Papilloma of the Tonsil.

Dr. William Hill showed two tonsils, on the surface of each of which a papillary growth, about one third of an inch in diameter, was seen. They had been removed from a female and male, æt. 21 and 22 respectively, who were sufferers from chronic pharyngitis. Although these neoplasms were common enough on the palate and pillars of the fauces, little information appeared to be obtainable of papillary growths springing from the surface of the faucial tonsils. It was suggested that these cases might, up to now, have been considered too trivial to be worth recording. A papilloma on the tonsil in a middle-aged person, however, might in certain circumstances be of much clinical significance.

Messrs. Wingrave and Waggett reported having met with cases similar to those described by Dr. Hill. In Mr. Wingrave's case the papilloma seemed to be attached to the base of a follicle.

Sir Felix Semon thought it would be of great interest if members would bring full reports of such cases, and expressed surprise that so many cases had been seen by members of the Society. Hitherto he had shared in the general belief that benign tumours of the tonsil were practically non-existent.

Mr. Butlin recalled two cases of papilloma of the tonsil, and agreed that it would be well to obtain full reports of any such cases occurring in future.

Dr. Jobson Horne remarked that he had met with these growths on the tonsils, and referred to notes of two cases. Case 1.—January 25th, 1894. Edward C—, æt. 17, with a history of a sore throat extending over six months. A papilloma of the size of a boot button, surface finely papillated, springing from the lower part of the left tonsil close to the junction of the anterior pillar with the base of the tongue. Both tonsils were hypertrophied and indurated. Case 2.—May 22nd, 1896. Sarah E—, æt. 48, subject to sore throats for fifteen months. Follicular tonsillitis, follicles of right tonsil plugged; projecting from behind anterior pillar on right side, and lying across the upper surface of the tonsil, was a smooth white polypoid growth attached to a stalk running behind tonsil. After removal of growth

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the abnormal sensations and discomfort referred to the fauces disappeared.

Mr. Macleod Yearsley said that in 1894 he saw a patient, aged 45, who presented a small polypoid growth about the size of a grape-stone at the upper part of the left tonsil, which was itself enlarged. It had only been noticed by her for about four weeks, and caused no symptom beyond a frequent desire to swallow. It was removed under cocaine and did not recur. On section it was found to consist of adenoid tissue with a covering of stratified epithelium. At one spot in the growth was a small hæmorrhage.

Lupus of the Larynx.

Dr. William Hill showed a young girl, æt. 13, who had been brought before the Society last winter, when she had lupus of the tip of the nose and palate. By persistent scraping and cauterisation (she had been under an anæsthetic nearly twenty times) the nose and palate had healed by August last, and the epiglottis showed no infiltration at that period, when she was sent to a convalescent home. Six weeks ago the patient presented herself again, complaining of cough; on examination the epiglottis was seen to be thickened and infiltrated and rather pale,—in fact, very suggestive of the ordinary form of tuberculosis; now, however, it was red, irregular and granular on the surface, and conforming with the appearances of chronic tubercular lupus. The patient also had a patch of lupus on the face and on the left foot.

Dr. Dundas Grant thought it a case of lupus of the larynx.

Dr. Beale had seen many such cases, and found the surface of the epiglottis remained free from ulceration, and therefore he advised leaving the local condition alone.

Dr. Hill, in reply, said he purposed trying a new form of tuberculin.

Cyst of Epiglottis.

Shown by Dr. Jobson Horne. The patient, a man æt. 36, complained of cough and wasting. Pnlmonary tuberculosis was diagnosed, and it was whilst looking for evidence of tubercle in the larynx that he met with this cyst on the epiglottis.

The cyst had the appearance of a small grape; it was tense, slightly translucent, and coursed by vessels. It was situated on the lingual

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surface of the epiglottis, occupying the left half, and was attached by a broad base close to the free edge.

The man had been suffering from dysphagia for six months; for some time he had been taking only food fairly chopped, but latterly had had to reject even fluid food. The dysphagia had been so gradual in developing that he regarded it as occasioned by his general ill-health.

The cyst was removed with a hot snare, a faint linear scar indicating its situation. It contained a watery thin fluid. Since the removal of the cyst dysphagia had completely disappeared, the cough had been less, and the man's health had considerably improved.

Dr. Horne considered that in the interarytænoid folds there was evidence of a deposition of tubercle.

In both nostrils the mucous membrane of the turbinal borders was in a condition of true hypertrophy, and was causing partial obstruction.

Mr. Cresswell Baber instanced a case of a child æt. five months in whom there was a cyst, about the size of a marble (apparently congenital), to the right side of the epiglottis. It produced noisy respiration and occasional dyspnœa. The cyst was ruptured by means of forceps, and collapsed completely. The breathing was relieved.

Dr. Bronner, Sir Felix Semon, and Dr. Dundas Grant reported similar cases in which large cysts had been present and given rise to well-marked symptoms.

Case of Paralysis of Right Vocal Cord, Right Side of Soft Palate, and Right Side of Pharynx, probably due to Nerve Lesion high up in Neck.

Shown by Dr. Scanes Spicer. J. W—, æt. 72. Has been a smith. In good health until Christmas, 1896, when after a cold he became hoarse and had difficulty of swallowing; no difficulty of breathing even on exertion, though occasionally his breathing is noisy; when first ill could not lie on his left side. On examination the right vocal cord is seen to be immobile and in the middle line; the right arytænoid cartilage jerks a little on commencing phonation; there is no marked alteration in contour of the right crico-arytænoid joint, and the left side of the larynx is normal. The right side of soft palate is paretic, the faucial arch being lower than the other and flatter, and the patient states he does not feel as well on right side of pharynx as on left when probed. The tongue, sterno-mastoid, and

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trapezius are not paretic or wasted. These points were confirmed by Dr. Wilfrid Harris, who also examined the chest with a negative result. No evidence of pressure in neck. By process of exclusion it appears probable that some lesion has involved some of the roots of the spinal accessory and vagus, perhaps a peribulbar pachymeningitis, or possibly focal degeneration of bulbar or spinal nerve cells.

The patient denies specific history, and there are no evidences of it. He has, however, been taking iodide of potassium, ten-grain doses thrice daily, for three months, without any marked change in condition three weeks ago.

Dr. HALL was inclined to view the local appearances as due to inflammatory mischief.

Sir FELIX SEMON thought the appearances were almost within physiological limits, in which Mr. BUTLIN agreed; but Dr. GRANT thought the palate paralysis was quite marked.

Dr. STCLAIR THOMSON also confirmed Dr. Grant's opinion, and observed that Dr. Hughlings Jackson laid stress on observing the soft palate in all cases of motor impairment, and to accept as distinctly typical of hemiparesis that condition in which on phonation one side of the palate remained lax, while the opposite showed a contraction dimple, and the median raphe was drawn towards the unaffected side.

In reply, Dr. SCANES SPICER thought that the palate condition had altered since his last examination, and the faucial arches were now of equal height.

CASE OF CHRONIC LATERAL HYPERTROPHIC LARYNGITIS SIMULATING MALIGNANT DISEASE.

Shown by Dr. HERBERT TILLEY. Patient is a male æt. 38. He had suffered from hoarseness for six months, but no pain or difficulty of swallowing, and has not lost weight to any appreciable degree.

He is a confirmed asthmatic, and has to rise every night to smoke his "powder."

On examination the right vocal cord is seen to be quite immobile on phonation. It is in parts of a pale milky colour. The thickening extends nearly the whole length of the cord, and some is seen in the anterior commissure.

There is an enlarged gland in the right submaxillary triangle.

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Sir Felix Semon said that it was only fair to say that the title of the case was really due to his suggestion made some week or two ago, when he saw the case in consultation with Dr. Herbert Tilley, who had brought the patient to him for confirmation as a case of malignant disease, and to discuss the advisability of operating. Appearances in the patient's larynx had since altered, and now he felt inclined also to look upon it as malignant, but would not like to be positive in the matter.

Dr. Bronner suggested removing a piece for microscopic examination, and Dr. Dundas Grant asked that the sputa might be examined for tubercle bacilli.

Dr. Herbert Tilley, in reply, stated that he thought there was no suggestion of tubercle in the case; the patient was a great sufferer from asthma, and asthma and phthisis were rarely found together. It would be difficult to examine his sputum, as it was impossible to obtain anything except small pellets of clear mucus, which he expectorated after burning his "asthma powder." He thought the case would turn out to be malignant.

Thyro-hyoid Cyst.

Shown by Mr. Wyatt Wingrave. A little girl, æt. 5, when first seen complained of a "running sore" in her neck. Her history was that ever since a few months old a swelling had existed below her chin, which gradually grew to the size of a cobnut. Twelve months ago, becoming red and tender, it was "cut" by her doctor, and had discharged ever since.

On examination the aperture of a fistula was seen in the middle line of the neck, superficial and apparently attached to the isthmus of the thyroid body, moving with deglutition and discharging pus-like matter, which was found to consist of epithelial cells undergoing fatty degeneration, suggestive of colostrum corpuscles.

From its situation, anatomical relations, and history it was diagnosed as the vestige of a cystic thyro-hyoid duct.

It was dissected out, and on microscopical examination presented an irregularly corrugated canal with diverticula, lined by spheroidal and ciliated "palisade" epithelium, resting on an ill-defined hyaline basement membrane, outside which were occasional clusters of small-cell tissue. The wall or capsules was composed of densely packed bundles of white fibrous tissue.

These histological details exactly correspond with those occurring in a perforation made two years ago from a case under the care of

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Dr. Dundas Grant, and although such examples may not be of unfrequent occurrence clinically, in the absence of other microscopic records relating to this particular portion of the thyreo-glossal duct they may be of interest to the Society.

Mr. BUTLIN had removed two or three of such cysts with their ducts, and had been obliged to follow the latter up to the base of the tongue by going in front of the hyoid bone.

Mr. WALSHAM and Mr. STEWART reported similar cases.

CASE OF NECROSIS OF THE LEFT INFERIOR TURBINAL WITH A HISTORY OF TRAUMATISM.

Shown by Dr. PEGLER. Mrs. A—, seen July, 1897, complained of discharge from and obstruction in the left nostril. When a young woman she had struck her nose violently against a post. The organ was said to have been broken, and there was much epistaxis at the time. Since that time there had been some trouble connected with it, *i.e.* obstruction, offensive discharge, and more recently bleeding. Two pieces of dead bone are said to have been taken away some time ago.

Externally there is now some deflection of nose to the right. There is a mucocele in the inner canthus of the left eye. A mass of granulation tissue blocks up the left meatus and is bathed in pus. With the probe a rough grating may be felt beneath the granulations like that of dead bone. Little has been done in treatment, owing to patient's objection to an anæsthetic.

Such cases are probably not rare, but have not received the attention they deserve, and the exhibitor would like the opinions and experiences of members of the Society in similar cases.

Mr. CRESSWELL BABER thought the rough body in the left nasal cavity was either a piece of necrosed bone, a rhinolith, or a foreign body. He advised its removal with forceps after it had been, if necessary, broken up.

Mr. WALSHAM said he thought the mass would easily come away.

Dr. STCLAIR THOMSON thought that the history of injury dated rather far back, but that if trauma was actually the cause it was important to put such a case on record along with Mr. Walsham's, for Tissier said that necrosis of a turbinal was so pathognomonic of syphilis, that whenever found it was superfluous to inquire for a specific history.[1]

[1] 'Wiener klin. Wochenschrift,' No. 37, 1897.

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Dr. PEGLER, in reply, stated that he had not regarded the case as syphilitic, because the appearances were entirely different from what he had seen of that disease.

In reply to Dr. StClair Thomson, the history might be rather ancient, but the woman was very intelligent in the matter. There seemed to be a definite continuation of nose trouble, traceable directly back to the date of the accident.

In reply to Dr. William Hill, there was no reason why the case should not be regarded as one of rhinolith with dead turbinate bone for a nucleus.

DISEASE OF THE RIGHT VOCAL BAND FOR DIAGNOSIS.

Shown by Dr. PEGLER. E. C—, æt. 56, complains of loss of voice.

History.—The trouble commenced five or six years ago by a feeling as of always wanting to swallow; this was followed by a bad cough. Her voice gradually left her, and has never returned. The woman has had seven children born alive; the eighth pregnancy terminated in a miscarriage. There is no pain in the throat.

Laryngoscopically the most conspicuous object is a deep red somewhat conical growth occupying the upper surface of the anterior third of the right vocal band. The right vocal cord is entirely concealed, the left is intensely red. The arytænoid cartilages move freely and equally on attempts at phonation, and there was no infiltration of the laryngeal structures.

Mr. BUTLIN thought a piece of growth might be removed, in which Sir FELIX SEMON concurred.

In reply to the President, Dr. PEGLER said he had not been able to decide between malignant disease and syphilis. Dr. Whistler had examined the patient with him, and was inclined to regard it as syphilitic; he should try the effects of an antisyphilitic treatment in the first instance.

PROLAPSE OF VENTRICLE OF MORGAGNI.

Dr. WORTHINGTON, who showed the case for Dr. Percy Kidd, said that there was dyspnœa and stridor for three weeks before her admission to hospital, and great dyspnœa on admission; also great œdema of epiglottis, which subsided in a day or two, leaving the small tumour which is now seen.

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Dr. StClair Thomson reminded the Society that Koschier—Stoerk's first assistant—had published a paper founded on the histological examination of nineteen cases, and demonstrating that there was no actual eversion of the sinus in the condition known as "prolapse of the ventricle of Morgagni." Such cases turned out to be solid tumours, cystic or fibromatous, taking their origin from the wall of the sinus; but the actual wall of the sinus remained *in situ*.

Dr. Bond also made remarks on the case.

Case of Early Tubercular Laryngitis.

Shown by Dr. Lawrence. C. N—, æt. 22, general servant. One sister of nine suffers from "weak chest." Patient lost her voice two years ago, and at that time had atrophic rhinitis, pharyngitis, and laryngitis. She quite recovered from this under appropriate constitutional and local treatment. There is almost complete aphonia now, and pharynx is as before. Vocal cords do not move freely, and there is a small pinkish swelling in the interarytænoid space.

Examination of chest shows a flattening and impairment of the note at right apex, fine crepitations and cogwheel breathing under right clavicle. The exhibitor considered these latter symptoms with the swelling of the interarytænoid space indicated early tubercular laryngitis.

Dr. Beale thought there was no evidence of tubercle, but only chronic laryngitis, which was probably secondary to nasal disease,—an opinion in which Mr. de Santi agreed.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *December 8th*, 1897.

CRESSWELL BABER, Esq., M.B., in the Chair.

STCLAIR THOMSON, M.D., } Secretaries.
HERBERT TILLEY, M.D., }

Present—33 members and 5 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were elected as ordinary members of the Society:

Charles Lamplough, M.R.C.S., L.R.C.P.
Sydney Snell, M.D., B.S. (Lond.), M.R.C.S.
Charles Edward Bean, F.R.C.S. (Edin.), M.R.C.S. (Eng.), L.R.C.P.
Frederick Walter Foxcroft, M.B., C.M. (Edin.).
Herbert Ramsay, F.R.C.S. (Edin.).

THE POSITION AND CONDITION OF THE VOCAL LIPS IN THE CHEST AND HEAD REGISTERS.

Dr. JOBSON HORNE, on behalf of Dr. Musehold, of Berlin, showed a series of photographs of the larynx demonstrating the above conditions. Dr. Horne referred to the researches of Dr. Musehold, and drew attention to what he understood from Dr. Musehold to be the more important conclusions which had been arrived at with the help of the stroboscope, and which the photographs demonstrated.

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In the chest register it was seen that the glottis is "opened and shut, whereas in the head register it is "widened and narrowed," a difference still more demonstrated with the stroboscope.

The cords themselves in the chest register, and more particularly in the production of loud chest-notes, showed a rounded or tumid form. This was accounted for by the expiratory current of air meeting with an increased resistance, and forcing the cords upwards; and it was the analogy of this condition of the cords with the condition of the lips when applied to the mouth-piece of a trumpet in producing loud notes that suggested the term "vocal lips" in the present instance.

The photographs further showed that the deposition of the mucus secreted on to the cords was along different lines in the two registers; this was attributed to a difference in the manner and intensity of the vibrations.

For a more detailed description of the photographs and of the photographic apparatus and stroboscope used, Dr. Horne referred to Dr. Musehold's paper which had recently appeared in the "Archiv für Laryngologie und Rhinologie.'

Defect of Speech resulting from Paresis of Soft Palate, occasioned by Lymphomatous Tumours projecting posteriorly from either side of the Septum.

Shown by Dr. Pegler. The patient is a youth æt. 23. The defect of speech precisely resembled that of cleft palate.

There was complete nasal obstruction, depending upon hypertrophies and moriform bodies attached to both middle and inferior turbinates, &c., in addition to the septal growths. A diffuse lymphoid mass presenting a well-marked Tornwaldt's bursa lined the roof of the nasopharynx, but there were no post-nasal adenoids.

The appearances of the septal lymphomata and microscopical sections (here shown), displaying pure lymphoid tissue throughout, were described in two recent numbers of the 'Journal of Laryngology' (9 and 12). The growths were exceedingly tough, and had been taken away by means of the turbinotome. The other sources of obstruction having also been removed, nasal respiration was quite free. A much thickened septum is exposed.

The drawings handed round showed the post-rhinal image before

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and after operation. Papilliform lymphoid hyperplasiæ had been suspected to occur by Jonathan Wright and others, but these were the first that had been microscoped and recorded so far as Dr. Pegler was aware. The paresis of the palate was bilateral and reflex, and the defect of speech remained, but was improving.

The Case of Apparent Necrosis of Left Inferior Turbinate following Injury shown at the Last Meeting by Dr. Pegler.

The patient was brought up again to show the condition of the nasal fossa after the loose body had been removed, and also the fragments themselves. The granulating surface was entirely healed over. The two pieces handed round had all the appearance of necrosed inferior turbinate bone encrusted with lime. The precise date at which pieces of dead bone had been extracted after the original accident had been ascertained. Dr. Pegler said he should be happy to have sections made if that were possible and report again.

Papillomata of Faucial Tonsil.

Shown by Mr. Wyatt Wingrave. The interest exhibited in Dr. Hill's cases shown at the last meeting, and the suggestion made by the President and Sir F. Semon, induced the exhibitor to present two examples occurring in his own practice.

1. Papilloma removed from the left tonsil of a man æt. 44. Consisted for the most part of a fibro-vascular core covered with fimbriæ of stratified squamous epithelium, with a few concentric bodies. Slight symptoms of irritation. Tonsils enlarged; with history of several quinsies.

2. Fibro-vascular papilloma removed from the right tonsil. It looked like a red polypus hanging from the surface of the tonsil, but under cocaine became anæmic. It apparently grew from a dilated lamina, and was removed by snare, coming out like a tooth. It was about 2 cm. in length, and consisted of fibro-vascular and small-cell tissue covered with smooth stratified epithelium. Sore throat and history of quinsies. Reported in 'Journal of Laryngology' as "Polypus of Tonsil," vol. viii, p. 358.

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The papillomata generally grow from the surface, whilst the so-called polypi spring from the interior of lacunæ. Their origin is suggested by examining sections of chronic lacunar tonsillitis, in which papillary excrescences will be found growing from the fundus and sides of dilated lacunæ. An exaggeration of such a condition would readily form a papilloma or a polypus.

Female on whom Tracheotomy had been performed, with Immobility of Left Cord and Partial Immobility of Right.

Shown by Dr. J. W. Bond. (No notes received.)

Female with Tumour of the Epiglottis.

Shown by Dr. Bond. (No notes received.)

Mr. de Santi thought that the tumour was too soft and vascular-looking for an epithelioma, and took the view that it was sarcomatous and considered the enlarged glands to be a contra-indication to any operation.

Case of Paralysis of Left Vocal Cord and Dilator of Pupil, with Ptosis of the Same Side.

Shown by Dr. Spicer. T. R—, æt. 59, a gardener, complains of hoarseness and swelling in the neck.

Laryngoscopic examination shows the left vocal cord in the middle line, and immobile. There is no deformity in the larynx nor pathological changes. Left pupil contracted. Left upper eyelid in condition of ptosis. There is a mass of three or four enlarged glands under the left sterno-mastoid opposite the cricoid cartilage. Patient has taken iodide of potash for more than six weeks. No history of syphilis.

? Mucous Patches on Fauces; Case for Diagnosis.

Shown by Dr. Scanes Spicer. Charles D—, æt. 3. About four months ago the mother noticed a white, ulcerated-looking surface on

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the tonsils, uvula, and soft palate, which has never disappeared but varies in its extent of surface. There are enlarged cervical glands, and swallowing is easy. Patient had "thrush," which lasted three weeks, when he was a month old, followed by an ulcer on eye and in the groin. He has also had an hydrocele. There has been no contact with diphtheria. When the white patches are removed the surface bleeds.

The diagnosis seemed to be between chronic diphtheria, mucous patches, lupus, tuberculosis, papillomata, and simple ulceration.

Dr. Plimmer reports that there are diphtheritic organisms present.

A cultivation of the ulcerated surface shows streptococci and sarcinæ.

The treatment had consisted of internal administration of chlorate of potash, but it had not altered during the past six weeks.

Dr. Barclay Baron had seen a similar case, which was not syphilitic.

Dr. Lambert Lack had a patient in whom a similar ulceration was combined with lupus, and he advised arsenic as an internal remedy.

Rapidly Recurrent Tumour of Nasal Septum.

Shown by Dr. Spicer. Albert H—, æt. 35, sent to St. Mary's for epistaxis. On examination a spongy, very red and vascular growth is seen attached by a broadish base to right side of cartilage of nasal septum. A portion was at once removed with scissors, and felt hard on cutting through. It has grown again nearly to original size in a fortnight, and base is larger.

Report by Dr. Plimmer.—Large amount of fibrous tissue; few sarcomatous cells; lymphoid tissue; very few vessels; prognosis as to benignancy favorable.

Dr. StClair Thomson was of opinion that the growth was simple in character, and was a fibro-angioma or bleeding polypus of the septum. He recalled a very similar case he had shown to the Society two years ago ('Proceedings,' vol. iii, January, 1896). In that case the growth rapidly recurred soon after removal, and the sections of the growth were found by some members to be so suggestive of sarcoma, that they warmly recommended speedy and radical excision. However, the recurrence was simply removed with the snare, the base curetted and then well seared with the galvano-cautery (without

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perforating the septum). He had kept the patient under observation, and now, at the end of two years, there had been no recurrence. The growth was declared by the Morbid Growths Committee to be a fibro-angioma, and he suggested that the sections in the present case might be submitted to the same Committee.

Mr. WINGRAVE suggested that the tendency to alveolation of the cells was in favour of its sarcomatous nature.

CASES SHOWN BY DR. LAMBERT LACK.

A girl æt. 6 and a boy æt. 3, who have had congenital obstruction, to show the persistent malformation.

The two cases are in most respects similar. Both came under the care of my colleague Dr. Sutherland and myself, when a few weeks old, presenting all the characteristic signs of the affection known variously as *congenital laryngeal stridor, infantile respiratory spasm*, &c. The signs of laryngeal obstruction increased for some months, and then gradually passed off until, at two years of age, they had practically disappeared. The true pathology of this affection, hitherto generally considered a form of laryngeal spasm, was demonstrated in a recent paper by Dr. Sutherland and myself ('Lancet,' September, 1897). We found that the epiglottis is folded laterally so sharply that its lateral halves come very close together, or even into actual contact. The arytæno-epiglottic folds, thus approximated, flap inwards at each inspiration, reducing the upper aperture of the larynx to a narrow slit or even completely closing it. In these two cases the stridor and other signs of laryngeal obstruction have completely passed off, apparently because the upper aperture of the larynx is larger, and the tissues forming it less flaccid than in infancy. The malformation of the epiglottis, however, remains unaltered—in the girl the folds being very close, in the boy in actual contact. This persistence of the curved epiglottis seems to me very important as showing (1) that although, as above stated, constantly present in this affection, and playing an essential part in its pathogenesis, it is not the actual curve of the laryngeal obstruction, and (2) that this form of epiglottis is not the normal type in infancy, as Escat and others have stated. The latter point is further shown by the fact that I have never yet found the malformation in a large series of examinations of the larynx in babies during the past two years.

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Dr. HILL and Dr. GRANT had seen similar cases, and the former asked Dr. Lack if there was ever any subluxation of the crico-arytænoid joints in such cases.

CASE OF TORNWALDT'S DISEASE.

Shown by Mr. RICHARD LAKE. The patient, a young woman, had been troubled for ten years by the crust formation, which she used to expel every second or third day. A point of interest in this case lies in the fact that the patient went to a throat hospital three years ago, and was treated for this trouble by having her inferior turbinates removed, and she seems to believe she has since become somewhat worse.

Mr. CRESSWELL BABER had found the galvanic cautery applied with the aid of the rhinoscopic mirror of considerable benefit in these cases in arresting both the discharge and hæmorrhage.

LARGE TUMOUR IN THE NECK.

Dr. DONELAN showed a man æt. 56 with a large tumour occupying the left side of his neck from the temporo-maxillary joint to the clavicle. In last April the patient first noticed a small swelling behind the jaw, which was painless but continued to grow until in September it was about the size of an ostrich egg. He then went to University College Hospital, where its removal was advised, but patient declined. Since then the growth had rapidly increased to its present size. There had been, however, no pain until within the last few weeks, when there was some neuralgia in the left side of head.

The points of interest to the Society were the paresis of the tongue, the immense displacement of the larynx to the right with paresis of left vocal cord and swelling of left arytænoid body. The latter is difficult to see from overlapping of ary-epiglottic tissues and ventricular band. There was entire absence of dyspnœa and dysphagia, and but little change in the voice. On seeing the patient for the first time Dr. Donelan thought the case one of lymphadenoma, but now believed it to be a malignant tumour, probably sarcomatous. It was doubtful if anything could now be done.

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Mr. de Santi considered this case to be one of malignant disease; probably primary epithelioma of the cervical glands. The mass was fixed, extensive, and of stony hardness. He could not get a view of the larynx. An examination of the œsophagus should be made. The case was quite inoperable.

Sketches and Specimen of Benign Tumour of the Tonsil.

Shown by Mr. Waggett.

Sketches and Specimen of Papillary Hypertrophy of the Tonsil.

Shown by Mr. Waggett. This patient has complained for about six months of "stoppage in the nose." About two months ago he came to the London Hospital, and some polypi were removed from both nostrils. The posterior ends of both inferior turbinates were also removed, and he ceased attending for the time. The polypi were not examined microscopically, but gave rise to no suspicion of being anything beyond simple polypi.

Patient returned again on December 8th, appearing very ill. No polypi were seen anteriorly. On digital examination a hard mass about the circumference of a shilling was felt on the posterior naso-pharyngeal wall, apparently growing from the first or second cervical vertebræ in the middle line. It was very tender to the touch, and bled slightly after examination. There was no impairment of movement of the cervical vertebræ.

Dr. Herbert Tilley instanced a case recently seen by him in which it was almost impossible to get the finger into the naso-pharynx because of the prominence of the upper cervical vertebræ. The patient was well built, with no obvious deformity in the neck.

Dr. Dundas Grant said he had referred in another Society to such a prominence simulating the presence of adenoids.

Mr. Cresswell Baber said he had not had an opportunity of making a thorough examination in this case, but he had noticed considerable thickening of the soft palate and prominence of the tubercle of the atlas.

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Soft Swelling in the Neck.

Shown by Dr. Pegler. Patient was a young female with a large swelling in the neck, apparently extending outwards and backwards from beneath the left sterno-mastoid.

Dr. Herbert Tilley said that by getting a strong light behind it and examining it like a hydrocele, a small amount of light penetrated it, and from its feel he thought it was cystic.

Mr. de Santi looked upon this case as one of cystic nature, probably cystic hygroma. Probably the fluid was thickish and the aspirating needle small, thus accounting for the negative result on puncturing. It might be a very soft fatty tumour; but its shape, situation, history, and non-adhesion of the skin and absence of lobulation were against this diagnosis. He advised an exploratory incision.

Case of Persistent Branchial Cleft in Neck.

Shown by Dr. Dundas Grant. (No notes received.)

Symmetrical Ulceration of Tonsils, Perforation of Nasal Septum, in a Young Boy.

Shown by Mr. Atwood Thorne. A boy æt. 13, under the care of Dr. William Hill (by whose permission the case was shown).

On admission the boy had been ill for three weeks, complaining of a "cold, sore throat, and running from the nose."

Examination showed symmetrical inflammation of both tonsils, spreading on to the soft palate, and with a well-defined margin. The right tonsil contained a cheesy mass, which was removed, and the cavity painted with chromic acid. The glands behind the sterno-mastoid were enlarged and hardened on both sides.

There was a blood-stained discharge from both nostrils, and a perforation of the bony septum, covered with scabs. Over the chest there was a well-marked macular rash.

Mr. Thorne suggested as a provisional diagnosis "secondary, or early tertiary syphilis."

Mr. Cresswell Baber suggested that the case was one of congeni-

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tal syphilis, and considered that one of the teeth was somewhat suggestive of that disease.

Dr. Hill concurred in this opinion.

Dr. Atwood Thorne, in reply, said that the family history seemed to negative "hereditary syphilis." Both history and examination contra-indicated tubercle.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ANNUAL GENERAL MEETING, *January* 12*th*, 1898.

HENRY T. BUTLIN, Esq., F.R.C.S., President, in the Chair.

STCLAIR THOMSON, M.D., } Secretaries.
HERBERT TILLEY, M.D., }

Present—43 members and 3 visitors.

The minutes of the Fifth Annual Meeting were read and confirmed.

Dr. Jobson Horne and Mr. Atwood Thorne were appointed Scrutineers of the ballot for the election of Officers and Council for the ensuing year; they reported the result of the ballot as follows:

President.—H. Trentham Butlin, F.R.C.S.
Vice-Presidents.—J. W. Bond, M.D.; A. Bronner, M.D.; F. de Havilland Hall, M.D.; Scanes Spicer, M.D.; T. J. Walker, M.D.
Treasurer.—W. J. Walsham, F.R.C.S.
Librarian.—J. Dundas Grant, M.D.
Secretaries.—Herbert Tilley, M.D.; William Hill, M.D.
Council.—A. A. Kanthack, M.D.; Sir F. Semon, M.D.; W. R. H. Stewart, F.R.C.S.; StClair Thomson, M.D.; P. Watson Williams, M.D.

The following Report of the Council was then read and adopted:

The Council has much pleasure in reporting the continued prosperity of the Society, both as regards the increase in the number of its

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members and the sustained interest in the work of the Ordinary Meetings.

The Society now numbers 119 ordinary members and 9 honorary members, 16 ordinary members having been elected during the past year.

We have not lost any members through death, but Dr. Walton Browne of Belfast has resigned owing to distance from London, and Messrs. Ewen Stabb and Davis have severed their connection with the Society owing to other claims upon their time.

The meetings of the Society have been well attended, the average attendance of ordinary members being 31, of visitors 5. This is a higher average than any formerly attained by the Society.

The ordinary meeting held May 12th was given up to a discussion, introduced by Dr. Dundas Grant, on "The Uses of Turbinotomy as applied to the Inferior Turbinate Bone." The subject being one of much importance elicited some interesting experiences from many members who joined in the discussion which followed the reading of the paper.

The Council have discussed, without coming to any definite conclusion, the advisability of limiting in some way the admission to the membership of the Society, in order to minimise the excessive examination to which many patients are subjected at the Ordinary Meetings.

The Council consider that the Society is to be heartily congratulated on the honour of knighthood which has been conferred during the past year upon its past President, Sir Felix Semon, M.D.

The Treasurer's Annual Statement was then presented as follows:

The actual receipts for the year ending December 31st, 1897, have amounted to £141 15*s*. 6*d*. This amount includes four subscriptions for 1898.

There are still a few subscriptions for 1897 outstanding (£7 7*s*.), all of which are good, and will appear in the balance-sheet for 1898.

The actual expenditure was £83 17*s*. 8*d*., leaving a balance for the year of £57 17*s*. 10*d*. This, with the balance of £112 2*s*. 7*d*. brought forward from the 1896 balance-sheet, leaves in the Treasurer's hands on December 31st, 1897, the total balance of £170 0*s*. 5*d*.

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BALANCE-SHEET, 1897.

Income.

	£	s.	d.
Balance from 1896	112	2	7
Subscriptions—			
100 members at £1 1s.	105	0	0
13 members at £2 2s.	27	6	0
1 member at £9 9s.	9	9	0
Excess on Edinburgh cheque	0	0	6
Returned by Rogers (excess paid on cheque)	0	0	3
Total . .	£253	18	4

The income for the year is . . . £141 15 6

Expenditure.

			£	s.	d.
Rent and Electric Light (20, Hanover Square) . . .			31	10	0
Adlard for Printing and Postage, October 8th, 1896, to June 3rd, 1897 . . .			44	14	6
Mayer and Meltzer (specula, &c.)			2	15	0
Petty Cash—					
Rogers (Carbolic Acid and Spirit). . .		£0 14 6			
Secretarial Expenses:					
Dr. StClair Thomson	£1 5 0				
Dr. Tilley	0 2 5				
		1 7 5			
Stamps		0 12 0			
Doughton, attendance		1 0 0			
Bank Charges: Scotch and Irish cheques		0 1 6			
Indexing volume, 1897 (Clarke) . .		1 1 0			
			4	16	5
Deficit on foreign cheque . .			0	2	0
Balance in Treasurer's hands			170	0	5
Total . .			£253	18	4

The expenditure for the year is . . £83 17 8

Audited and found correct,
January 6, 1898.

E. B. WAGGETT.
STCLAIR THOMSON.
E. CLIFFORD BEALE.

The following embodies the Librarian's Report, which was then read.

The following works have been added to the Library during the past year:

Laryngologische Gesellschaft zu Berlin Verhandlungen, Band vi, 1895. Ausgegeben 1897.

Gesellschaft der Ungarischen Ohren- und Kehlkopfärzte, Jahrbucher, Band ii, 1896.

Brighton and Sussex Medico-Chirurgical Society. Proceedings and Annual Report, 1896–7.

Niederlandische Gesellschaft für Hals, &c., Bürger's Berichte, 1896.

Moritz Schmidt, Krankheiten der oberen Luftwegen, 2nd edition. (Presented by the author.)

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Photographic Album of Views of the Vanderbilt Clinic for Diseases of the Throat. (Presented by Dr. Lefferts.)

Monographs and Reprints on Laryngological and Rhinological Subjects, by Dr. Hugo Bergeat. (Presented by the author.)

Gouguenbeim, Dr. Monographs and Reprints. (Presented by the author.)

Moure, Dr. E. J. (Bordeaux). Monographs and Reprints. (Presented by the author.)

Ardenne, Dr. Tumeurs benignes de l'Amygdale. (Travail de la Clinique de Moure, 1897.)

Stirling, Dr. On Bony Growths invading the Tonsil; Chicago, 1896. (Presented by the author.)

Monographs presented by Dr. de Havilland Hall:

Cagney, J. On the Laryngeal Motor Anomalus, Abductor Tonus, and Abductor Proclivity, 1894.

Donaldson, F. Gr. Paralysis of the Lateral Adductor Muscle of the Larynx, with Unique Case, New York Med. Journ., February 12th, 1887.

Donaldson, F. Gr. Further Researches upon the Physiology of Recurrent Laryngeal Nerve (Johns Hopkins University), New York Med. Journ., August 13th, 1887.

Sewill, H., and England, W. Empyema of the Antrum.

American Laryngological, Rhinological, and Otological Society, Transactions of the Second Annual Meeting, 1896.

The numbers of the newly added exchanges have duly arrived, and several will start in January, 1898.

The following volumes have been bound:

Archiv für Laryngologie (Fränkel), vols. iv, v, vi.
Revue de Laryngologie, &c. (Moure), vols. 1894, 1895, and 1896.
Revue Internationale (Natier), vol. 1896.
Bolletino delle Malathe, &c. (Grazzi), vol. 1896.
Archivii Italiani (Massei), vol. 1896.

The Librarian expects to present the volumes for 1897 at the next Annual Meeting.

The Morbid Growths Committee for the ensuing year will be composed of the following gentlemen:

Mr. Bowlby, Dr. Kanthack, Dr. Pegler, Mr. Spencer, Mr. Waggett, Dr. Tilley.

The Thirty-seventh Ordinary Meeting of the Society was subsequently held, the President being in the Chair.

The minutes of the previous meeting were read and confirmed.

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The following gentlemen were nominated for election at the next Ordinary Meeting:

John Fallows, L.R.C.S.E. and L.S.A.(Lond.), 66, Victoria Street, S.W.
William Frazer, L.R.C.P., M.R.C.S., Johannesburg.

Two Pressure Pouches of the Œsophagus.

Shown by Mr. Butlin (President). Removed from living subjects. The references are to be found in the 'Medico-Chirurgical Transactions,' vol. lxxvi, p. 269, 1893, and in the 'British Medical Journal,' 1898, vol. i, p. 8. The attention of the members of the Society is particularly directed to the return of particles of undigested food many hours or even days after they have been swallowed, as the one constant symptom in the diagnosis.

Nasal Hydrorrhœa—Analysis of Liquid.

Mr. Cresswell Baber read notes of this case, and brought forward the analysis of the liquid. Patient, a married lady æt. 42. The right side of the nose only affected. Five years before, after eight months' excessive watery discharge following influenza, she had had a polypus removed; the secretion then stopped, but returned again at Christmas, 1896, after another attack of influenza. A polypus was removed in May, 1897, and the galvanic cautery applied, but as the secretion still continued the case was referred to me. When I first saw her, on June 16th last, there was no obstruction, very little sneezing, no pain, only profuse non-fœtid watery discharge from the right side, which continued day and night. No headaches of consequence. Examination showed that the right nasal cavity was much narrowed by deflection of the septum, and the mucous membrane was sodden and catarrhal in appearance. No polypus, but a little irregularity on the middle turbinated body. Transillumination showed both infra-orbital regions light, and nothing came out of the right antrum on hanging down the head. The fundus was normal in both eyes. No loss of sensation could be detected in the right nasal cavity. Spirit and cocaine spray was tried, but without any effect; the dripping of watery liquid continued constant, and on one occasion

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(July 17th) I collected 70 mm. in five minutes. On this date I began the constant current, applying eight cells externally to the nose. This stopped the secretion for a few minutes. Patient was ordered to use it for five minutes twice a day. In a week's time (July 24th) she reported that the running was rather less in the mornings, but when I saw her it still continued. A small piece of projecting mucous membrane was snared from the middle turbinated body, but only proved to be hyperplasia of normal tissue. Ordered, in addition to the constant current, a 20 per cent. solution of menthol in paroleine for a nasal spray twice a day. I did not see the patient again till September 15th, when she reported that about a month previously the running began to diminish, and had got so much less that she only used two handkerchiefs daily instead of twelve. Character of the secretion as before. Treatment continued. October 5th.—No watery discharge at all for the last four days. Examination shows that there is much less swelling of the mucous membrane in the nasal cavity. To use spray and galvanism once a day only for three weeks. November 3rd.—No discharge at all from the right side since the last visit. Omit all treatment. Letter received from patient dated January 3rd, 1898, reports that there has been no return of the nose trouble. About an ounce of the liquid was sent to the Clinical Research Association, and they report that its chemical composition is as follows:

		Per 100 c.c.	
Organic solids		0·160	gramme.
Containing—	Mucin	0·060	,,
	Proteids	0·025	,,
	Undetermined constituents	0·075	,,
		0·160	,,
Inorganic solids		0·880	gramme.
Containing—	Sodium chloride	0·770	,,
	Calcium phosphate, &c.	0·110	,,
		0·880	,,

Microscopical examination showed the presence merely of a few squamous epithelium cells and a few leucocytes. They note that the greater proportion of the solid matter consists of sodium chloride, and that the proportion of this closely approximates to the "normal saline" fluid.

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From the absence of head symptoms, and especially from the beneficial effect of the continuous current, I think we are justified in concluding that the liquid in this case is simply an excessive secretion from the nasal mucous membrane, and not an escape of cerebro-spinal fluid. It seems probable that many of the cases reported may be explained in a similar manner.

Dr. StClair Thomson said that the analysis which had been made for Mr. Baber was unfortunately, so far as the question of cerebro-spinal fluid was concerned, most incomplete. Since he had shown his case to the Society, he had assisted at repeated analyses of cerebro-spinal fluid, and also of other fluids from the nose which were supposed to come from the subarachnoid space. In hopes that other members might come across similar cases, he would just recapitulate the chief points which were characteristic of cerebro-spinal fluid. It was perfectly colourless and limpid, feebly alkaline, varying in specific gravity from 1005 to 1010, contained no albumen, but traces of a proteid which was found to be globulin; it reduced Fehling's solution, but it did not contain sugar, for it failed to give the fermentation test with yeast. This reducing body was pyro-catechin, which had a pungent taste, and formed particular crystals. The analysis of the present case gave no information on these points.

Dr. de Havilland Hall asked Mr. Baber if he thought that the menthol spray had any real effect on the issue; his experience was that it rather increased the discharge from the nasal mucous membrane.

Mr. Baber thought it was the constant current rather than the menthol spray that had had the beneficial effect in this case.

Radical Operation for Frontal Sinus Disease.

Mr. Ernest Waggett showed a patient on whom he had performed Luc's operation five weeks previously for right frontal sinus suppuration of many years' standing. The skin incision followed the line of the eyebrow, and the trephine hole was made immediately above the superciliary ridge. The sinus was completely cleared of all the mucous membrane, which was throughout polypoid and bathed with pus. Attention was drawn to the advantages of carefully suturing the periosteum over the trephine hole, and of removal of the anterior end of the middle turbinate. From the first the cavity was irrigated by passing a fine flexible tube up through the drain-tube. The latter was removed on the thirteenth day. No pus had been seen since the operation, symptoms were absent, no depression of the bone could be detected, and the skin scar was unnoticeable.

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Dr. HERBERT TILLEY thought that the case was a good illustration of the value of the incision through the line of the eyebrow, for the resulting scar was scarcely noticeable. He mentioned this because one authority on frontal sinus disease had maintained that a median vertical incision should be made in every case, whether the symptoms were uni- or bi-lateral. Mr. Waggett's case was at least the second or third which had been before the Society, and in which the value of the supra-orbital incision was very evident.

NEW INSTRUMENT—TURBINOTOMY CAUTERY.

Mr. ERNEST WAGGETT showed a galvano-cautery point, practically of the same shape as Jones' turbinotome, a hot platinum wire taking the place of the cutting edge. He has used it to remove hypertrophies of the mucous membrane of the turbinates, particularly moriform bodies. All hæmorrhage is avoided, and the shrinkage caused by cocaine rather facilitates matters than otherwise. The copper wires should be thick, so as to avoid over-heating by the current.

TRIGEMINAL NEURALGIA RELIEVED BY TURBINECTOMY.

Shown by WALTER G. SPENCER. The patient was a carpenter, æt. 46, who had had good health, and had not suffered in any similar way before. In April, 1897, he was in bed for two days with influenza. Some few days afterwards, at 9 a.m., he was suddenly seized with severe pains in his face. The pains first occurred in the lower lip and skin over the left side of the jaw, then on the cheek over the infra-orbital foramen, over the supra-orbital nerve at the back of the eye, and at the back of the nose. He became dazed, and cannot remember his journey home from work; he is said to have staggered up the street like a drunken man. His memory is also a blank for the next fortnight. He suffered from neuralgia involving all the branches of the fifth nerve, attended by most severe paroxysms of pain, for which his doctor had to give opium and morphine in increasing doses. My colleague, Dr. Allchin, was after three weeks called to a consultation, and he concurred in the treatment by opium and morphine in large doses.

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The patient got somewhat better, but on account of the pain could not sleep well at night, nor concentrate his attention on any work. He was much depressed, and opium or morphine was required when the pain became severe. This was his condition in September, after he had been ill five months, and Dr. Allchin then consulted me with a view to some surgical measure. I could not insert a speculum into the left nostril, on account of hyperæsthesia, until he had been given an injection of morphine. The interior of the left nostril showed no definite disease. On touching the interior with the end of a blunt probe, nothing occurred until I touched the anterior part of the left middle turbinal, when a severe paroxysm of pain and itching was set up of the kind from which the patient had been suffering. After the nostril had been treated with cocaine 20 per cent. the middle turbinal could be touched without exciting the above symptoms.

No other lesion was found, in particular there were no signs of antral disease. Some teeth had been removed without affording any relief. I and Dr. Allchin agreed that, assuming the neuralgia to have originated from an attack of influenza, it was not unlikely that the neuralgia would in course of time pass off. Therefore we considered that there were then scarcely sufficient indications for surgical treatment of the three roots of the fifth nerve, or of the Gasserian ganglion. I proposed to try removal of the middle turbinal for much the same reason as a specially tender tooth is extracted in the hope that it may afford relief to trigeminal neuralgia. I therefore excised the middle turbinal, taking away also the anterior end of the inferior turbinal to obtain room. I found nothing abnormal in the tissue removed, and it was not in contact with the septum. From the time of the removal the patient has never had any pain, and has not required any narcotic. He has slept well, recovered his spirits, and has been at his work for three months. He still has, however, at times, itching in the distribution of the terminal ends of the fifth nerve on the face, also at the back of the eye and nose. This annoys him and tempts him to scratch, but does not prevent his work. It is worse in the day, and is quite relieved by lying down, whereas the old pain was worse when lying down. The interior of the left nostril is now hyperæsthetic, so that the patient is easily made to sneeze, but no pain or itching is excited by touching the interior. I have told the patient that this itching will pass off in time, but I shall be glad to learn of any means of hastening its disappearance.

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Mr. Cresswell Baber mentioned the use of common salt as a snuff in cases of facial neuralgia, and also suggested the use of the galvanic cautery where very sensitive spots on the nasal mucous membrane were detected.

Dr. Spicer said that the patient's nasal passages were still deficient, and were producing an "exhaustion rhinitis;" he advised the use of dilators to alleviate the chronic rhinitis, and removal of a small spur which was present.

Dr. StClair Thomson said that the present case confirmed what he had ventured to insist upon elsewhere,* viz. that every case of trigeminal neuralgia should be submitted to a thorough exploration of the nose and accessory cavities before operative procedures were undertaken. He happened to know of cases where extensive, dangerous, and in some instances unsatisfactory operations on the Gasserian ganglion had been carried out, and where the idea of examining the nose had never been even entertained. Amongst other instances of trigeminal neuralgia relieved by intra-nasal medication, he instanced one where a medical man had placed himself under the care of a distinguished neurologist who had referred the case to Dr. Thomson, although the patient himself was perfectly convinced that he was suffering from "brow ague," having passed some years in the tropics, where he contracted malaria, he scouted the idea of the "brow-ague" being due to an empyema, and was only convinced when an exploratory puncture expelled a quantity of foul-smelling pus, and drainage at once cured his neuralgia. As to labelling the present a case of "cure," he thought we should be a little careful of using that term when the objective symptoms in the nose had been so slight. We all knew the beneficial effects of operation *per se*, and these were especially marked in the case of idiopathic trigeminal neuralgia. In Sir William Gowers' well-known text-book on nervous diseases there was the record of a case which an American author had traced for some dozen or so years. During this period the one individual's case had been published by something like fifteen different physicians, and each one claimed to have cured him.

Subpharyngeal Cartilage of the Tonsil.

Mr. Wyatt Wingrave exhibited microscopic sections of tonsils showing small islands of hyaline cartilage representing the *subpharyngeal cartilage*, a rudiment of the third visceral arch.

The cartilage was enclosed in the connective tissue of the bed of the tonsil, but according to MacAlister it is generally situated beneath the mucous membrane below the tonsil, and often attached to it.

He had found three examples in about 200 cases examined.

* 'The Year-book of Treatment' for 1897.

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Larynx of Patient shown at Meeting held November 10th, 1897.

Dr. Herbert Tilley stated that shortly after the November meeting the patient died after suffering for three or four days from fever, intense headache, and delirium. Only the larynx and the brain were available for examination. The base of the latter was thickly covered with lymph and other evidences of meningitis.

The larynx exhibited extensive superficial ulceration of the right vocal cord and process, but the left side was healthy. A small track led through the mucous membrane of the right arytænoid cartilage, the latter being felt bare at the end of the sinus.

When seen during life the right cord was rigidly fixed during phonation; there was an enlarged gland in the right submaxillary region, and what appeared to be a greyish mass was seen situated in the position of and hiding the right vocal cord. The almost unanimous opinion then was that it was a case of malignant disease, but the exhibitor thought that the recent history indicated tubercular laryngitis, and at his suggestion the growth was referred to the Morbid Growths Committee for more detailed examination.

Case of Malignant Disease of Larynx.

Shown by Dr. Furniss Potter. A man æt. 64, who came under observation complaining of hoarseness for nine weeks previously, but who in other respects was in good health. On examining the larynx the left side was seen to be occupied by an extensive infiltration, involving the arytænoid region, the ventricular band, and the aryepiglottic fold; the left vocal cord was invisible, and the crico-arytænoid joint appeared to be fixed and immoveable.

There was no history of syphilis, and no complaint of pain except a little occasionally shooting into the left ear; there was no dysphagia, but slight stridor occasionally. The patient had been put on potassium iodide in doses increasing to grs. xx three times a day, but as yet with no appreciable result.

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Papillomata of Larynx.

Dr. Bronner (Bradford) showed a large number of papillomata removed from the larynx of a man æt. 48, on December 13th. On several previous occasions growths had been removed, the last time in March. Various local and internal remedies had been used.

On December 13th patient had a violent attack of dyspnœa whilst in a railway carriage, and was unconscious for some time (?).

Dr. Bronner wished to have the advice of the Society as to whether laryngotomy or tracheotomy should be performed, or if the growths should be periodically removed *per os*.

Mr. Butlin and Sir Felix Semon concurred in the view that thyro-chondrotomy would afford no guarantee against recurrence of the growth, and might induce other undesirable complications.

Mr. Spencer suggested that a crico-tracheotomy might be useful in enabling the operator to more efficiently remove the growths.

Complete Recurrent Paralysis.

Mr. Symonds exhibited a man of 61 showing the left cord lying in the cadaveric position. The patient had a stricture of the œsophagus 12½ inches from the teeth, and gave a history of nine months' dysphagia, with loss of voice for four months. When first seen two months ago the condition was identical with that now existing. The case was brought forward to illustrate paralysis of the lateralis muscle following upon that of the posticus, which was presumed to have preceded the present stage. The patient also exhibited well the inability to speak a sentence of more than a few words, and gave a good view of his larynx.

Sir Felix Semon said that he could not agree to this being a case of adductor paralysis, and expressed a hope that his friend Mr. Symonds would see his way to change the title of his communication. Adductor paralysis clearly meant that a vocal cord could not be properly adduced on intended phonation, whilst on deep inspiration it freely went outwards. In the present case, however, the vocal cord stood motionless between the phonatory and ordinary cadaveric position, and there was no question of adductor paralysis. He made it a point to protest against the title because otherwise it would be almost certain to be made capital of. Of greater importance, however, than this individual case was another question he wished to submit to the

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Society. Was it not time to altogether abolish the expressions "adductor" and "abductor" paralysis? No doubt they were convenient enough, but somehow or other there seemed to be a sort of fatality about misprints with regard to these two expressions, which but too often absolutely spoilt the author's meaning. He instanced several recent experiences of his own to that effect. In Germany, following an analogous proposition of Professor Moritz Schmidt, the two expressions had almost completely vanished. If the words "glottis openers" and "glottis closers" were considered to be too clumsy, why not simply speak of "posticus," "lateralis," "externus," &c.?

In his reply to remarks by Sir Felix Semon, Mr. Symonds recast the original title of the case from that of adductor paralysis.

Removal of Half the Larynx.

Shown by Mr. Symonds. Mr. S— was brought before the Society in February, 1897, with fixation of the right cord, and a diagnosis of early carcinoma. The general opinion at that time was in favour of tubercle. A gland made its appearance in the end of April, and was removed March 17th. It had grown with great rapidity, and was already softening. The right half of the larynx was removed April 20th. The man was brought forward again, not to show the result of the operation, but because it was thought members would be interested to recall the early appearances. At present the man does full work, and has a moderate voice.

Subglottic Carcinoma?

Shown by Mr. Symonds. A man of 55 had been hoarse six months. He came under treatment at Guy's Hospital in December with grave stenosis of the larynx. Both cords were fixed, and were visible; the chink was in the centre, and was elliptical in shape; the left cord appeared then slightly pushed up. The arytænoids were fixed. Tracheotomy was necessary on January 1st. The diagnosis lay between malignant disease and syphilitic perichondritis. There was no breach of surface, but there was an abundant foul expectoration. The man was then in low health. Mr. Symonds regarded the case as one of subglottic carcinoma, and asked for an expression of opinion.

Note.—At the meeting Mr. Symonds reported that since his last examination of the patient three days ago, when the above report

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was written, a marked change had taken place. The left side had become more prominent, and a whitish edge was visible along the left cord—appearances pointing to malignant disease.

January 17th.—Mr. Symonds sends a note to say the whole interior of the larynx has become swollen, that a papillated whitish mass can be seen in the position of the left cord, leaving no doubt of the malignant nature of the case. The general health has greatly improved.

Formative Osteitis (Leontiasis Ossium).

Shown by Dr. Watson Williams (Bristol). A specimen of the septum nasi and a portion of the frontal bone and left malar bone from a male æt. 46. There was no history of syphilis, and no known cause for the disease.

Post-mortem examination.—The patient presented large, smooth, bony thickenings on either side of his nose, and a smaller boss on the left side of the forehead.

On removing the cranium pus was found situated between the dura mater and the bone over the frontal lobe. This pus seemed to have originally started from the frontal sinus on the left side, which was full of pus. The frontal sinus on the right side was found to be obliterated by soft cancellous bone. The pituitary body was normal in size.

Examination of the nose showed that the sphenoidal sinus and ethmoidal cells were entirely obliterated by cancellous bony growths. The cavity of the nose on the left side was almost entirely filled up by growth from the septum. Apparently also the antra of Highmore were completely filled up with cancellous bone formation. The bones in the face were found to be growing from the malar and upper part of the superior maxillary bones. There was nothing noteworthy about the other organs, and no deformity of bones elsewhere.

Case of Clonic Spasm of Pharynx.

Shown by Dr. Lambert Lack. The patient, a girl æt. 19, came under observation at the Throat Hospital about two months ago, complaining of "phlegm in the throat." On examining the pharynx, one

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at once notices a twitching movement of the posterior pharyngeal wall, which seems to be sharply drawn to the left and then relaxed. The movement curiously resembles nystagmus. The palate sometimes seems to move slightly in association. The larynx is healthy, and there is no twitching of the laryngeal muscles. The patient has some chronic rhinitis, but otherwise is in robust health, and is not of a specially nervous disposition. This pharyngeal spasm has been constantly present every time the patient has been seen in the last two months, but its duration beyond that is doubtful, as it apparently gives rise to no symptoms.

The case seems identical with that of a man shown by Dr. Bond during the last session of this Society, and is brought forward in the hope that other members of the Society will state their experience of this apparently rare affection, or give some information as to its ætiology or pathological associations.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *February 9th*, 1898.

HENRY T. BUTLIN, Esq., F.R.C.S., President, in the Chair.

HERBERT TILLEY, M.D.,
WILLIAM HILL, M.D., } Secretaries.

Present—32 members and 2 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were elected ordinary members of the Society:

John Fallows, L.R.C.S.Ed., L.S.A., 2, Princes Mansions, Victoria Street, S.W.
William Frazer, L.R.C.P., M.R.C.S.(Eng.), Johannesburg.

The following gentlemen were nominated for election at the next meeting:

Frank Marsh, F.R.C.S.(Eng.), 34, Paradise Street, Birmingham.
John E. Scatliff, M.D.(Aberdeen), M.R.C.S.(Eng.), 11, Charlotte Street, Brighton.
Henry B. Robinson, M.S., F.R.C.S.(Eng.), 1, Upper Wimpole Street, W.
Adam B. Kelly, M.B., C.M.(Glasgow), Blythwood Square, Clifton.
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Report of Morbid Growths Committee.

The following reports were drawn up:

Slide L.S.L. (Laryngological Society of London), No. 11.—From case shown by Dr. Spicer as "Rapidly Recurrent Tumour of the Nasal Septum" ('Proceedings,' vol. v, p. 19, December, 1897). The committee finds that the growth is a fibro-angioma, and quite benign in character.

Slide L.S.L. No. 12.—From case shown by Mr. Morley Agar as "Tumour of Tongue" ('Proceedings,' vol. v, p. 4, November, 1897). The specimen is composed in part of dense fibrous tissue, and in other parts of a looser connective-tissue with some connective tissue cells. There is no evidence of malignancy. The committee would call attention to the fact that such growths in the tongue without any admixture of lymphangiomatous tissue are rare.

Slide L.S.L. No. 13.—From case shown by Dr. Bond as "Recurrent Laryngeal Growth" ('Proceedings,' vol. iv, p. 104, June, 1897). The patient was a female æt. 27, and had had a growth removed from the larynx at least five times in two years. Growth was as large as a couple of small peas, and sprung from the very bottom and posterior part of the left ventricular band, and hung down between the cords. It did not look like a papilloma, and on section it seemed to be an epithelial growth of unusual character. The committee confirms Dr. Bond's observations, but as the members had only one section to examine, they desire to postpone a definite report until they have examined other sections.

January 6th, 1898.

The Supra-tonsillar Fossa.

Dr. Paterson showed specimens and photographs of this space. His attention was drawn to its importance by a case which came under his care two years ago, and since that time he had accumulated a large number of observations on its variations and the affections to which it is subject. A search into the literature showed that it had been practically ignored by writers on diseases of the throat, and the index of the 'Centralblatt für Laryngologie' contained no reference

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to it. The space which is met with in the majority of individuals is situated behind the anterior palatal fold in its upper part, and has been erroneously looked upon as an enlarged tonsillar crypt. It has been described by His as an anatomical space, to which he gave the above name, and he regarded it as the remains of the second visceral cleft. The exhibitor, from the examination of a large number of specimens, both in the living and the dead subject, concluded that two main factors influenced the situation and relations of the space. (1) The disposition of the plica triangularis may affect the size and the outlet of the cavity. This structure is a triangular fold of mucous membrane found projecting from the anterior palatal arch between the fourth and fifth months of fœtal life, and frequently persistent into adult life. (2) The development of the tonsillar adenoid tissue in the sinus tonsillaris varies considerably, and will modify the extent and even the position of the fossa; in some, indeed, its situation is not above the tonsil, and the designation "palatal recess" would perhaps be a more appropriate term. It extends in various directions, and comes into relation with the deeper parts. It is liable to certain affections; in two cases the exhibitor observed it as the starting-point of malignant disease, and its importance is increased by the fact of it being frequently the seat of infection in certain forms of disease.

Dr. Scanes Spicer was much interested in the definite anatomical and developmental facts concerning the supra-tonsillar fossa brought forward. He had long regarded the fossa as a morphological entity. Clinically the morbid conditions (retention cysts, grit, calculus, and suppuration) as common causes of chronic and recurrent discomforts referred to the tonsils were well known to most specialists, and personally he considered they usually demanded surgical interference. Formerly he had confounded these fossal conditions with lacunar disease; later he had regarded them as occurring in a cavity formed by abnormal adhesions; but for some years he had been convinced that we had in this supra-tonsillar recess a definite and regular anatomical structure. He had frequently known the adenoid mass of the faucial tonsil to hypertrophy into the fossa, from which it could be easily withdrawn.

Dr. Hill expressed some surprise that Dr. Paterson had found no literature on the subject, as in the 'Proceedings' of the Society a little while ago a case was brought forward in which a calculus was lodged in the fossa.

Dr. StClair Thomson was also surprised to hear that there were so few references to the subject in leading text-books. He was under the impression that the supra-tonsillar fossa was recognised and frequently referred to in current German literature. Quite recently he had read an article by Grünwald in the 'Münchener medizinische Wochenschrift' recommending that peritonsillar abscesses should be opened

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through the supra-tonsillar fossa; and Killian (in the 'Monat. für Ohrenheilk.') had pointed out that abscesses of the tonsil could be easily opened with a probe in the peritonsillar fossa. This region, which had been so fully investigated and well described by Dr. Paterson, was of clinical importance with regard to peritonsillar collections of pus. For Dr. Thomson thought that most laryngologists opened the abscess cavity in this region, although they did not enter it, as Grünwald recommended, between the pillars of the fauces, but by puncturing the anterior pillar with a pair of sharp sinus forceps, which were then opened as they were withdrawn.

In reply, Dr. PATERSON wished to emphasise the important difference between this space and what it has usually been regarded as, viz. an enlarged tonsillar crypt.

PAPILLOMA OF TONSIL.

Shown by Dr. PATERSON. The specimen was obtained from a boy æt. 10, who came under notice for enlarged tonsils. These were excised, care being taken to bring away intact the little tumour. It was about the size of a hemp-seed, was provided with a well-marked stalk, and consisted microscopically of squamous epithelium. It gave rise to no symptoms. The object in showing the specimen was to point out that, although situated on the anterior and inner aspect of the tonsil, it did not grow from that gland, but sprung from the plica triangularis, which was well marked. The latter fold could be readily made out lying loosely over the tonsil and giving origin to the papilloma. From his observations the exhibitor concluded (1) that most of the so-called papillomata of the tonsil—which may either be little masses of lymphoid tissue covered to a varying extent with epithelium or true papillomata, as in the present specimen—spring from the plica, and do not grow from the tonsil; and (2) that they are frequently in relation to the outlet of the supra-tonsillar fossa, and may be induced by discharge from that cavity. Care is often necessary to distinguish the plica, which may be intimately adherent to the subjacent tonsil.

A NEW SNARE FOR THROAT AND NOSE WORK.

Shown by Dr. LAMBERT LACK. The chief advantage claimed for this snare is that the wire loop having been adjusted round a growth can be rapidly drawn tight so as to seize the growth firmly, and that

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then, if required, the loop can be further tightened by a screw. By this latter movement sufficient force is obtained to cut through the firmest growths; at the same time the division is slowly effected and all bleeding arrested. The instrument is strong in all its parts, the mechanism simple, and it has nothing to get out of order. The instrument is entirely of metal, and easily takes to pieces for cleaning, &c. The wire can be easily and quickly attached, and is very firmly fixed. It may be of any size, and the loop may be over six inches long. The snare works noiselessly; the clicking of some instruments is very distressing to sensitive patients. The instrument has three ends—a thick barrel for very tough growths, a fine end for aural and nasal polypi, and a curved end for use in the larynx or post-nasal space.

The instrument requires the use of two hands to work the screw; but the growth having been already firmly seized, I do not think this can be considered a disadvantage.

I am greatly indebted to my friend Mr. Bingham (an engineer) for much help, and for suggesting the method by which the screw is brought into action; and to Messrs. Mayer and Meltzer, who have made the instrument for me.

Radical Cure of Long-standing Antral Empyema.

Mr. Waggett showed a middle-aged woman with an eight years' history of left antral empyema, during which time she had practised daily irrigation through a tube in the alveolus. He performed Luc's operation, making a large opening through the canine fossa, removing entirely the polypi and the thick purple papillated lining of the cavity, which was cleared until the white bone was laid bare throughout. The bony structure was exceedingly soft and yielding, and in inserting a drain-tube held in a pair of fine sinus forceps through the hole drilled into the inferior meatus, the hard palate was wounded. The latter fortunately healed in the course of a few days; nevertheless to avoid such accidents it would seem advisable to puncture and insert the tube from the nasal side rather than the antral. The muco-periosteum was sutured over the canine fossa wound, which healed firmly. The drain-tube into the bone was removed on the third day, and in the speaker's opinion might well be dispensed with altogether.

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No reaction followed the operation. From the day of operation, five weeks ago, no pus has been secreted in the cavity; injections made through the inferior meatus opening at intervals of eight days returning perfectly clear, while the nose has been entirely free from discharge.

Dr. William Hill and Mr. Lake demurred to the credit of this operation being given to Luc, as Dr. Spicer had reported and shown a case of this particular operative procedure before Luc had written his paper on the subject. Senn has also independently described an osteoplastic resection of the anterior wall with a nasal opening.

Dr. StClair Thomson asked if a piece of the bony wall was detached and replaced in making the opening through the canine fossa, and how long the drainage-tube from the antrum into the inferior meatus was left *in situ*.

Dr. Scanes Spicer was surprised at Dr. Waggett's referring to the method as a new one. Dr. Luc ('Bull. et Mém. de la Soc. Franç. d'Otologie, Laryng., et de Rhinol.,' 1897) had, indeed, claimed it as a "new operative method for the radical and rapid cure of chronic empyema of maxillary sinus. He specially claims (ibid., p. 81) as the original feature of his operation the "creation of an artificial opening which serves to drain the sinus cavity by the corresponding nasal fossa." He also gives as the date of his first operation case February 16th, 1897 (ibid., p. 84). Both Dr. Waggett and Dr. Luc have overlooked the numerous references which have appeared in the English medical press during the last four or five years detailing a method differing in no essential detail from that now put forward (*vide* 'Brit. Med. Journ.,' December 15th, 1897, 'Journ. of Laryng.,' 'Proc. Laryng. Soc. Lond.,' &c.). Moreover, a formal discussion on chronic antral empyema was held by the Laryngological Society of London, one of the leading features of which was the general condemnation of the method advocated by the speaker on that occasion as unnecessarily severe, leading to facial deformity and falling in of cheek, rendering patient unable to smoke his pipe, and leaving a permanent bucco-antral fissure. Further experience has confirmed the speaker that these objections were visionary and theoretical; and, in fact, not one of these sequelæ ever followed. Many others besides Dr. Luc were now using the method with success. What he wished to emphasise was that this large canine fossa opening, curettement, no buccal drainage-tube, free counter-opening into inferior meatus of nose for drainage, had been practised largely by British rhinologists for about five years, and numerous references to the results are to be found. He congratulated Dr. Waggett on his result in this case, and, speaking from a large experience, could assure the Society that in *uncomplicated chronic* antral empyema they would find the method radical and certain, and not followed by any one of the dreadful results predicted for it.

Mr. Waggett, replying to Dr. Thomson, said that with the exception of some white fibrous tissue underlying the infra-orbital nerve, all the soft structures were removed. He did not for a moment dispute

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Dr. Spicer's claim to originality in the method, and would give him all credit for it; and with reference to the latter's opinion that where the floor of the antrum was on a lower level than that of the nose, it was advisable to leave the canine fossa opening patent for purposes of drainage, Mr. Waggett thought it better to avoid the necessity of prolonged drainage altogether by removing the glandular lining of the cavity.

Immobility of Right Cord.

Shown by Dr. Willcocks. Henry O'B—, æt. 70. He first came under observation about five months ago, when he had loss of voice and considerable swelling, affecting chiefly the right side of the glottis and the interarytænoid space. The swelling gradually subsided under the influence of soothing inhalations and iodide of potassium, and was for a time confined only to the posterior end of the right cord.

Present condition.—The right vocal cord is immobile and somewhat congested. There is no evidence of intra-thoracic pressure of any kind.

Sir Felix Semon thought the case one of mechanical immobility, both from the history and the improvement under potassium iodide. There was a particularly "clean" appearance about the larynx, which he thought was indicative of its non-malignant nature.

Mr. Butlin inclined somewhat to the malignant nature of the case on account of the presence of enlarged glands and the bad health of the patient.

Early Epithelioma of Cord.

Shown by Dr. Herbert Tilley. Fred. W—, æt. 49. Patient complained of loss of voice for two months, but there was no pain or difficulty of swallowing. At the anterior end of the left vocal cord is a whitish patch; the posterior part of the cord congested, and more so than the corresponding part of the right one. There is slight loss of movement on phonation.

The President and Sir Felix Semon both agreed it was an excellent case for operation, but suggested the advisability of removing a small portion of the growth for examination previous to the radical operation.

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Case of Primary Epithelioma of the Uvula. Two Coloured Drawings of the Parts and Microscopic Sections of the New Growth.

Shown by Dr. Walker Downie. The patient, a man æt. 56, came under observation in July, 1897. He complained of having had sore throat for fully two months, and that within the past few days he had had some difficulty in swallowing, along with considerable discomfort in breathing while asleep.

On examination the uvula was represented by a large fleshy body; the greater portion of its surface anteriorly and to the right was ulcerated, the mucous membrane in the middle line and to the left side being alone intact. The tip, which rested on the dorsum of the tongue, was also raw. The whole structure was found to be hard and firm on palpation, and manipulation caused the surface to bleed. The faucial pillars were unaffected.

It was diagnosed epithelioma, and without delay the whole of the uvula was removed under cocaine, the incisions going well into the soft palate. The surface was practically healed in four days; and now, at the end of six months, the man is in perfect health, and there are no evidences of recurrence.

Interarytænoid Growths.

Shown by Mr. Lake. Patient was a female. The growth occupied the upper portion of the interarytænoid region, and was a pale pink colour, but no breach of surface. No subjective symptoms except loss of voice.

The pieces shown were removed on February 3rd, 1898. Since then the patient has improved very much in her general condition.

Dr. Clifford Beale asked Mr. Lake to keep the patient under observation if possible, and to report the result of the operation after an interval of three months. He thought it very desirable that the limits of operation on this class of case should be defined. The interarytænoid tumours were well recognised since Professor Stoerk first drew attention to them; and, as a rule, they did not give rise to sufficient trouble to warrant any operation. The resulting wound was apt to remain unhealed, and to become the starting-point of a further tubercular infiltration. In Mr. Lake's case the voice had been improved, but there remained a large ragged sore in the interarytænoid space, and it would be desirable to watch its progress.

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Carcinomatous Tumour of the Epiglottis and Base of the Tongue.

Mr. Spencer showed a tumour which had occupied the upper epiglottis and superficially the base of the tongue. It was about the size and shape of a Tangerine orange, with a nodular surface, and appeared firm and white on section. Under the microscope the growth was found to be a carcinoma. Columns of epithelial cells projected downwards from the surface epithelium to mingle with the main structure of the tumour, which consists of polyhedral oval and spindle cells, and soft connective-tissue stroma. In the lymphatic gland, which was enlarged in the neck, the structure at first sight appeared like an oval and spindle-celled sarcoma with a stroma between the individual cells. There are a few nest-cells in the primary growth, about one in each section, but none have been met within the glands. A distinct alveolar arrangement is absent both from the primary and secondary growth; but there can be little doubt that the growth originated in the epithelium, in the fold between the epiglottis and tongue.

The tumour was taken from a man over 70, who complained of increasing difficulty in swallowing. He had suffered for three or four months, and had become reduced to soft substances like well-masticated bread and butter. He was further troubled by the constant rising up into the mouth of ropy mucus, and a tense swelling in the neck had formed, which gave him pain. He had lost flesh and felt weaker since the swallowing had become difficult. His breathing had not troubled him, but his voice had become somewhat muffled. On examination the lower part of the pharynx appeared to be completely filled by the tumour, which could be touched by the finger; but neither the opening of the larynx nor that of the œsophagus were visible. There was an enlarged superficial gland in the neck, which was breaking down, and was tense. When the administration of the anæsthetic was commenced the patient became dyspnœic, and preliminary tracheotomy was at once done. The pharynx was then more thoroughly explored by the finger. The larynx was found to be drawn up behind the tumour, and the arytæno-epiglottic folds were stretched over its posterior surface. Transverse subhyoid pharyngotomy was therefore done, the base of the epiglottis cut across, and the

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arytæno-epiglottidean folds divided. A pedicle was thus made, and the tumour was quickly removed by the galvano ecraseur. The wound in the pharynx was completely sewn up, the tracheotomy tube removed, and the broken-down gland in the neck incised, wiped out with a strong antiseptic, and the skin united. The previously weak patient stood this palliative operation well, could swallow easily, and felt relief from the tension in the neck. Unfortunately on the fifth day there was a bad fog, some bronchitis then started, and the patient died a week after the operation. There were no signs of pneumonia, neither during life nor post mortem. The pharyngeal wound and the cut made into the broken-down gland were firmly stuck together, and the tracheotomy wound was filling up by granulations. The primary tumour had been completely removed, but there were some small nodules, apparently in the lymphatics of the pharyngeal wall, also the secondary gland in the neck, but nothing else abnormal.

It does not appear that the tumour could have been satisfactorily removed by an ecraseur through the mouth, even at an early stage, for there was no pedicle until the base of the epiglottis and the arytæno-epiglottidean folds had been cut through; and if these latter had been included in the snare, œdema glottidis or other complications might have ensued.

Mr. Waggett suggested that the Morbid Growths Committee should investigate the nature of the growth.

Sir Felix Semon commented on the curious fatality which attended subhyoid pharyngotomy, and yet the post-mortem evidences gave no explanation of the matter. He could recall no case which had recovered.

Mr. Butlin's experience was much the same, and he instanced a case in which jaundice and acute mania preceded death.

Epithelioma of Left Vocal Cord.

Shown by Mr. Stephen Paget. D. R—, male æt. 43, had suffered from hoarseness for six months, and now experienced some pain on swallowing.

The left vocal cord was ulcerated and thickened, the ulceration extending to the interarytænoid space. It was quite immobile on phonation. An enlarged gland was present in the left submaxillary region.

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Sir Felix Semon advised operation without delay, and said that he feared the disease would be found more advanced than the laryngoscopic appearances suggested.

Mr. Butlin agreed, and also stated that there was an enlarged submaxillary gland, and that a partial laryngectomy might be necessary as well as removal of the gland.

Erratum.

'Proceedings,' December 8th, 1897, p. 22, line 9, *read* "shown by Mr. Morley Agar (by kind permission of Mr. Mark Hovell)."

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *March 9th*, 1898.

HENRY T. BUTLIN, Esq., F.R.C.S., President, in the Chair.

HERBERT TILLEY, M.D., } Secretaries.
WILLIAM HILL, M.D., }

Present—38 members and 2 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were elected ordinary members of the Society:

Henry Betham Robinson, M.S.(Lond.), F.R.C.S.(Eng.), 1, Upper Wimpole Street, W.
Arthur J. Hutchinson, M.A., M.B., C.M.(Glasgow), 225, Bath Street, Glasgow.
Adam Brown Kelly, M.B., C.M., B.Sc.(Glasgow), Blythwood Square, Glasgow.
Frank Marsh, F.R.C.S.(Eng.), 34, Paradise Street, Birmingham.
John Scatliff, M.D.(Aberdeen), M.R.C.S.(Eng.), 11, Charlotte Street, Brighton.

REPORT OF MORBID GROWTHS COMMITTEE.

Slide L.S.L. No. 14.—From larynx of case shown by Dr. Herbert Tilley at the November meeting, 1897. The Committee report, "Along the border of the section in the subepithelial lymphoid layer are several typical giant-cells, in some of which nuclei can be distinguished,

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and mostly surrounded by an abundance of small-cell infiltration. Tubercle bacilli were also found in the section. Lower down is to be seen a large tubercle in a state of caseous degeneration. We consider that the case was, therefore, one of tubercle of the larynx."

Slide L.S.L. No. 15.—From specimen shown by Mr. W. G. Spencer on February 9th, 1898, as "carcinomatous tumour at the base of tongue and epiglottis." The Committee report that "the tumour is of malignant type, and is composed of epithelial cells. The cells are arranged in masses without intercellular substance, and are partly spheroidal and partly squamous, and cell-nests were not found in the depth of the tissue, but only in the superficial layer of epithelium. The growth is a carcinoma, but whether it originated from the squamous epithelium is not certainly shown by the specimen; it is, however, probable that such is the case. Considering the situation, it is probable that it originated from the surface epithelium."

Slide L.S.L. No. 16.—The gland shows collections of exactly similar cells, and here also without cell-nests. In neither growth is there any evidence of keratinous change.

Lepra Tuberosa of the Larynx, Mouth, and Nose, with Remarks upon the Origin and Nature of "Globi" and "Giant-cells."

For Dr. Paul Bergengrün (Riga), communicated by Prof. A. A. Kanthack. Prof. Kanthack demonstrated for Dr. Bergengrün a complete series of photographs and coloured drawings illustrating the macroscopic and microscopic appearances of leprous lesions of the larynx, tongue, fauces, and nose; and a number of coloured sketches of the laryngoscopic images obtained in lepra tuberosa laryngis.

Larynx.—Indurative and ulcerative processes are well marked; ulceration along or below the vocal cords or in false cords is common; ulceration may be extensive, and the whole epiglottis may be destroyed. Thickening and infiltration of epiglottis, in some cases amounting to lepromata, is remarkable. Favourite seats of infection are the epiglottis, and especially its petiolus, the region just above and below the anterior commissure of the vocal cords. The ary-epiglottic folds are thickly infiltrated and often nodular. The epiglottis is often curved upon itself, and may be so thickened that the interior of the larynx

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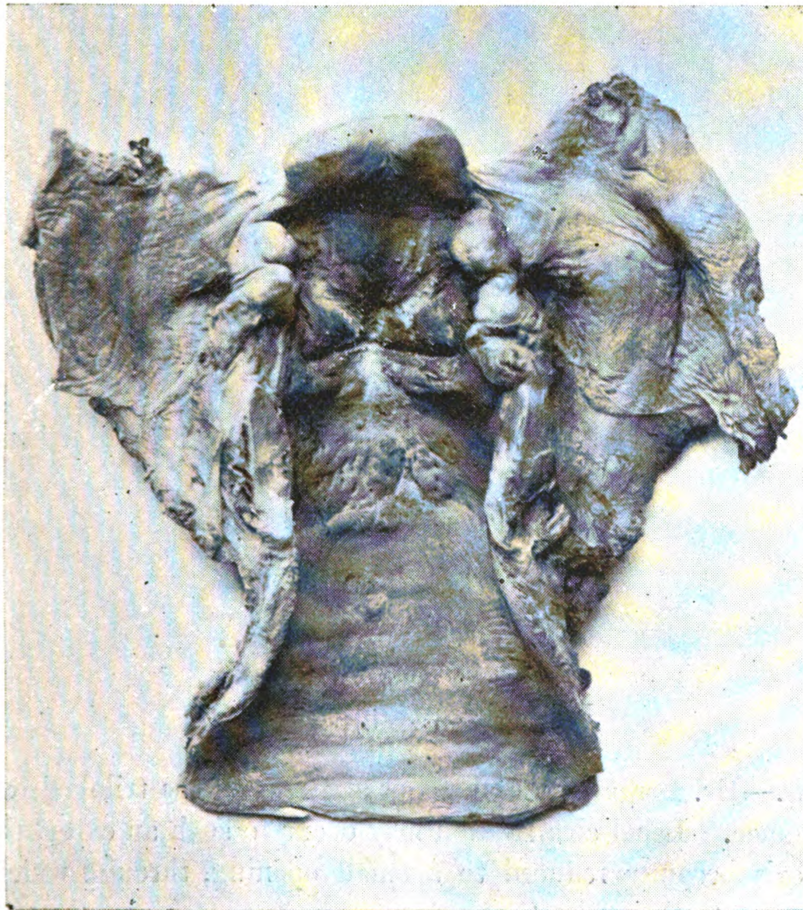
cannot be seen. The cords may be normal, although there is extensive disease. The mucosa over the arytænoid cartilages often becomes swollen, in the shape of thick globular masses. The ventricular bands are almost always diseased, either infiltrated, nodular, or ulcerated.

Tongue.—The tongue frequently becomes irregular and nodular; the nodules may be large and numerous; they may be arranged symmetrically on either side of middle line, separated by a deep groove. Occasionally the "silver tongue" of Léloir may be observed, when there are flat, low, silvery, disc-like swellings on the tongue, with a finely granular surface, and also broader silvery streaks.

Uvula.—Frequently diseased; may be converted into a coarse nodular mass or into a pyriform swelling with granular, nodular, or ulcerated surface; may become fibrous and cicatrised or completely slough away.



Leprous larynx seen from behind.

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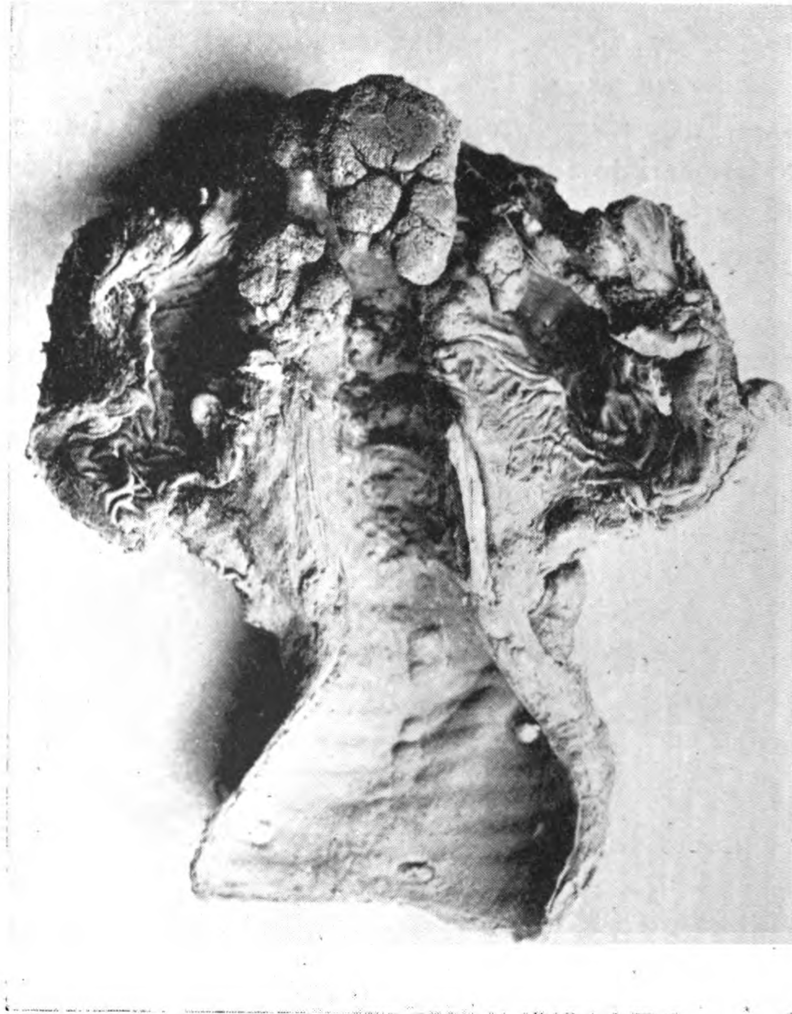
Fauces.—While the anterior fauces remain intact, the posterior become nodular or ulcerated.

Palate and Gums.—Hard and soft palate may be infiltrated with small lepromatous nodules, extending backwards in the middle line as far as the uvula, and forwards through the incisors as far as the gums. Ulcers on the gums and palate are also observed.



Leprous larynx seen from behind.

Nose.—Dr. Bergengrün lays special stress on the trilobed external appearance. Local cicatrisation may occur to such an extent that the rima oris becomes reduced to a small opening, through which only one or two teeth can be seen.

Histological observations.—Prof. Kanthack also demonstrated beau-

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tiful microscopical specimens and coloured drawings prepared by Dr. Bergengrün, which clearly proved two points: (*a*) that the so-called "globi" are bacillary thrombi lying in the dilated lymphatics; and (*b*) that the lepra giant-cell develops from the lymphatic endothelium. As to the globi, in longitudinal section, they appear as sausage- or chain-like narrow strands or bands, which run through the connective tissue as parallel streaks. These are curved and tortuous, short and long, broad and narrow, and often lie in spaces lined by a typical endothelium. The formation of the lepra giant-cells is explained as follows:—The bacillary thrombi in the lymphatic vessels act like foreign bodies, and irritate the endothelium lining the lymphatics, so that here and there endothelial cells divide and proliferate. The diseased cell protoplasm cannot keep pace with the nuclear division, and the protoplasm of different cells fuses into a plasmodial mass. Thus a giant-cell forms around the bacillary thrombus, gradually wrapping itself around the latter. The microscopic specimens left no doubt as to the correctness of this interpretation.

Dr. Bergengrün has once and for all settled the old controversy regarding the distribution of the leprosy bacilli, by thus showing that the intra-cellular distribution is almost insignificant when compared with their endolymphatic distribution. This has recently also been confirmed by Dohi, Herman, and others.

Case of Ozæna following Removal of Inferior Turbinate.

Shown by Mr. Stewart. P. S—, a female. For some years she had suffered from the usual discharge and symptoms consequent on hypertrophy of the nasal mucous membrane. Turbinotomy was performed in 1893 for deafness and discharge from right ear. Since operation crusts have formed in the throat and back of nose, with a considerable amount of fœtor.

Dr. Spicer thought that the history of the case scarcely proved the *post et propter* aspect of the operation. The patient had a distinct history of nasal suppuration since a child, and it was possible that the operation only accentuated the intra-nasal drying of the discharge. The shape of the nose is also that seen in atrophic rhinitis, a condition which could scarcely have developed since the operation.

Mr. Waggett said the patient had distinctly told him that there were no crusts before the operation.

Mr. Stewart in reply stated that he brought forward the case for

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what it was worth. They could not, however, get over the facts that the patient stated that, previous to the operation, the discharge from the nose was what one usually finds in hypertrophic conditions of the mucous membrane, and that since the operation there had been crust formation, and both objective and subjective fœtor, and that when first seen at the hospital the nose and throat were thickly coated with very offensive crusts.

Case for Diagnosis—Laryngeal Swelling.

Shown by Mr. Edward Roughton. J. P—, an iron moulder æt. 52, has suffered from hoarseness for one year and eight months, and from pain on speaking and swallowing and dyspnœa for six months. Attributes his condition to inhaling fumes of sulphur. Both false cords are swollen; they overlap on phonation; some swelling of ary-tænoids and ary-epiglottic folds; true cords remain almost immobile during respiration, and adduct with difficulty on phonation, the left moves more than the right. There is also some subglottic thickening. Œsophageal bougie passed without encountering obstruction.

Lungs.—Chronic bronchitis and emphysema. No evidence of phthisis.

No history of syphilis; gonorrhœa many years ago. Has been taking Pot. Iodid. for a month; no improvement.

Dr. Clifford Beale regarded the case as tubercular, and called attention to the excessive amount of sputum, which might, if examined, show the presence of bacilli.

Dr. StClair Thomson entirely agreed with Dr. Beale's suggestion.

Mr. Symonds thought that it was possibly a case of malignant disease, and pointed out the enlarged submaxillary glands in support of this view.

Lupus of Face, Nose, and Mouth.

Mr. Roughton also showed a young woman suffering from lupus of face, nose, palate, tongue, and epiglottis.

Mechanical Fixation of Vocal Cords.

Shown by Dr. Herbert Tilley. Patient is a man æt. 43, who two years ago applied to hospital for hoarseness and pain on swallow-

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ing of three weeks' duration. There was also slight stridor, which much increased in the course of the next few days. Examination of the larynx showed marked œdema over the arytænoids and sluggish action of the cords. There were no physical signs in the chest, nor evidence of nerve lesions of any kind. The stridor increased so rapidly that tracheotomy was performed, and the man has worn the tube ever since. He is in perfect health, and can produce a fairly good voice with expiration. Inspiration is impossible without the tube. The history of sudden onset with a cold, pain on swallowing, and œdema over the arytænoid region suggest implication of the crico-arytænoid joints, with subsequent fixation of the cords in their present adducted position.

Double Abductor Paralysis without Apparent Cause.

Shown by Dr. Herbert Tilley. Patient is a man æt. 49, who seven years ago applied to hospital for difficulty of breathing, especially marked on exertion. He was otherwise a very healthy man, with no abnormal physical signs in his chest and no evidence of commencing tabes. The vocal cords were seen to be adducted, but were otherwise healthy in appearance, as also the rest of the larynx. Tracheotomy was performed at once and without anæsthesia. After the skin incision the patient complained of very little pain.

Patient is now a particularly healthy-looking man; he still has to wear his tube, and, as in the last patient, his voice is very good.

The knee-jerks and pupils have normal reactions. The question arises whether such a condition might not be a form of peripheral neuritis, and whether many of the laryngeal paralyses which are seen where there is no evidence of pressure on the recurrent laryngeal may not be due to a similar cause.

Fluctuating Swelling over the Left Ala of Thyroid Cartilage.

Shown by Dr. Herbert Tilley. Patient is a lad æt. 10, with a swelling as described. It has been noticed only three weeks, and no reason can be assigned for its presence. It extends slightly across the middle line, fluctuates, and is rather painful on pressure. The left

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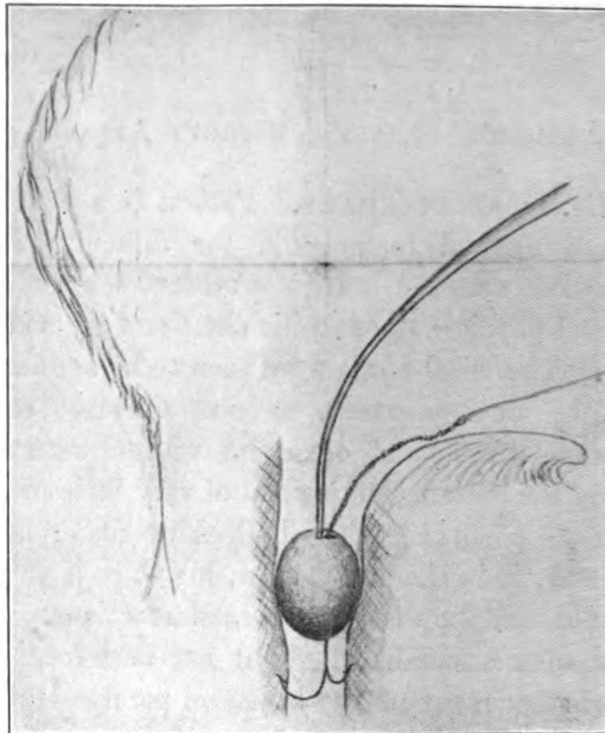
side of the larynx (internally) is distinctly more swollen than the right, especially the left vocal process.

Mr. BUTLIN thought it was a thyro-lingual duct tumour, which are occasionally situated to one side of the median line.

ORIGINAL DRAWING AND DESCRIPTION BY SIR ROBERT CHRISTISON OF A METHOD FOR REMOVAL OF A DOUBLE FISH-HOOK FROM THE GULLET (DATE 1819).

Shown by Dr. STCLAIR THOMSON for Dr. WALKER (Peterborough).



[COPY.]

EDINR.;
Septr. 24*th*, 1819.

DEAR SIR,

The rude sketch given above will communicate a pretty good idea of the mode in which the hook was extracted from the boy's throat at our hospital here about a fortnight ago. The hook was double (one division being less than the other), and had *fixed* itself across the gullet from before backwards, though not so far down as I have represented it. The wire attached to it hung out of the

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mouth. A hole was drilled through the *Ivory* ball of a Probang, *but not in its centre,* the reason of which is evident when it is considered that the two divisions of the hook were unequal. The boy was able to give a tolerably accurate description of its size and form, so that it fortunately happened that the ball suited it exactly; both barbs were covered by the ball, and the whole was easily removed after being first slightly pushed down in order to loosen the attachments of the barbs. The extraction was considerably facilitated, in the opinion of the surgeon, by previous suppuration. Though it had remained about twelve days the boy recovered without a bad symptom.

I remain, yours most sincerely,

R. CHRISTISON.

EPITHELIOMA OF THE LARYNX FROM A CASE EXHIBITED ON JANUARY 12TH.

Mr. SYMONDS reported that the patient, æt. 55, he exhibited at the January meeting improved so much in general health, owing to local treatment, that he was able to remove the larynx on January 24th. The œsophagus and pharynx were closed anteriorly, and the muscle and skin united. The severed trachea was attached to the skin just above the sternum. Primary union took place in the greater part of the wound, and the man was able to swallow after twenty-four hours, and made an excellent recovery.

Mr. Symonds exhibited the patient, who showed great improvement in general health.

The disease proved extensive, as the specimen showed. The right ala was penetrated by growth and the left partly destroyed. There was also considerable extension to the pharynx, a further inch having to be removed after separation of the larynx. The specimen showed extensive disease of the whole interior of the larynx, the cords being destroyed. The starting-point was probably in front below the left cord, but as both sides were almost equally involved, it must have really spread to the right.

Though rapid extension took place after the man was exhibited on January 12th, the pharyngeal growth must have existed at that time. No enlarged glands were found at the operation.

§

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The microscopic characters were those of a squamous-celled epithelioma.

Microscopic Specimen of Early Epithelioma of Vocal Cord from Dr. Tilley's Case shown at February Meeting.

Shown by Mr. Ernest Waggett. The correctness of the diagnosis was abundantly proved by the nature of the specimen.

Post-mortem Specimen of Epitheliomatous Larynx which had been twice operated upon.

Dr. David Newman showed the larynx removed post mortem from a man who had thyrotomy performed twice for epithelioma.

The patient was first operated on for epithelioma on the anterior third of the left vocal cord in 1890 by thyrotomy,* and no recurrence took place till 1893, when a small growth the size of a barleycorn was discovered close to the anterior commissure, and on removal proved to be an epithelioma. From 1893 till 1897 no appearance of recurrence, although patient was examined regularly every two months. In March, 1897, symptoms of slight laryngeal obstruction and evidence of œdematous swelling in larynx, which prevented a complete view of larynx being obtained. Laryngeal symptoms were accompanied by symptoms and physical signs of chronic parenchymatous nephritis. Patient died suddenly from laryngeal œdema, and post mortem the larynx was found to be occupied by an epitheliomatous ulcer.

Naso-pharyngeal Papilloma.

Dr. David Newman also showed a very large papilloma removed from the naso-pharynx of a young man. The growth was the size of a hen's egg.

* See Newman, 'Malignant Diseases of the Throat and Nose,' p. 93.

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Adhesion of Soft Palate to Posterior Pharyngeal Wall.

Shown by Dr. Willcocks. Mrs. R—, æt. 43. This patient had always enjoyed good health until eleven years ago, when at about a month after her confinement (the fourth) she had an ulcerated throat. She is the mother of five children, all living and healthy, and has had no miscarriage.

Present condition.—The soft palate is adherent to the posterior pharyngeal wall, and the only communication with the naso-pharynx is a small slit in the median line of the soft palate.

The vocal cords are normal, but the edge of the epiglottis is somewhat nodular.

For the last two months she has been taking a mixture containing Liquor Hydrargyri Perchloridi and iodide of potassium.

Mr. Symonds thought as there was an opening into the nose, the patient had better be left alone. A small aperture permitted respiration and descent of mucus, and prevented the cleft-palate voice.

Mr. Spencer said that with regard to the operation for the separation of the soft palate from the pharynx, he had never done nor recommended it except for the relief of distinct complication, Eustachian obstruction with pain in the ear, persistent laryngitis from breathing through the mouth, and so forth.

Case of Syphilitic Pharyngeal Stenosis.

Shown by Mr. Walsham. Patient is a middle-aged man in whom the soft palate is drawn into contact with the posterior wall of the pharynx as the result of cicatrisation following tertiary syphilitic ulceration. There is also destruction of the septum and falling in of the bridge of the nose.

A Case of Rhinitis, Pharyngitis, and Laryngitis Sicca.

Shown by Sir Felix Semon, M.D. The patient is a gentleman æt. 48, sent by Dr. Rattray of Upper Holloway, who began to suffer from a discharge from the right nostril without any definite cause being known. Crusts were formed in the right nostril, and also often

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evacuated through the mouth, whilst the throat became dry and the voice gradually hoarse. There has never been any dyspnœa. The patient has not lost the sense of smell, and is not aware that the discharge has ever been very fœtid. On examination the right nostril is found to be abnormally wide, with considerable atrophy of the lower and middle right turbinated bones, but without any evidence of actual disease of the bony framework of the nose or of any of the accessory sinuses. Further, there is considerable dry naso-pharyngeal and pharyngeal catarrh, with formation of crusts, after removal of which the mucous membrane looks wrinkled and shining. In the larynx on the first examination both vocal cords were completely covered with green dry crusts, after removal of which the cords appeared red and dry, whilst the ventricular bands were considerably swollen and equally dry. The patient having been treated for a week with benzoin inhalations aud the use of salt water injections into the nose by means of a Higginson's syringe, all the conditions described appeared to be considerably improved on the occasion of his second visit, but as soon as these simple cleansing measures are neglected the previous conditions return.

The case is shown, first, on account of the one-sidedness of the atrophic rhinitis, which in the observer's experience is comparatively rare unless due to a distinctly local process, such as impaction of a foreign body, or disease of the accessory cavities, or again to a syphilitic process, of all of which contingencies there is not the least evidence in the present case.

The second remarkable feature consists in the persistence of the process. In the observer's experience ordinary ozæna usually exhausts itself about the age of forty or thereabouts, but it is remarkable that in a man of forty-eight like the patient it should still be so active.

The third remarkable fact is the extension of the process into the larynx, which in this country at least is very rare. It is seen with slightly greater frequency on the Continent.

Case of very Uncommon Laryngeal Tumour.

Shown by Sir Felix Semon, M.D. The patient, æt. 40, is a married lady who formerly lived in North-west Canada, and up to about ten years ago enjoyed good health, apart from the fact that she sometimes suffered from slight "spasms in the throat."

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Ten years ago she first observed a swelling in the left submaxillary region, which gradually grew until it attained its present size, that of an average walnut. At first it gave no discomfort, and particularly caused no difficulty in breathing, or, so far as she knows, in the voice. In spring and autumn it used to swell, but always returned to its previous size. Gradually it became tender on pressure, and her breath became permanently short, whilst the previous attacks of spasms in the throat increased in severity. She went to Montreal and consulted Dr. Major, who found not only the external growth as described, but also a growth in the larynx. He is stated to have attempted to puncture the latter, but without striking fluid. He also tried, according to the patient's statements, to snare the laryngeal growth, but the snare broke. Dr. Major then recommended the patient to go to England and to take further advice; he had never seen a similar growth. The patient went to London and was treated in a special hospital. This was seven years ago. Her medical attendant is stated to have attempted to snare the intra-laryngeal growth off with the galvano-caustic snare, but to have brought up a very small piece of growth only, whilst during the attempt the throat and the tongue were severely burnt. Three weeks afterwards her difficulty in breathing had increased to such a degree that tracheotomy had to be performed. This was followed by immediate relief of the breathing and very great improvement in general health, the patient previously, according to her description, having wasted away to a skeleton. The little piece of growth removed was stated by her attendant to have been of a malignant nature,—indeed, of a cancerous character. No further attempts were made to interfere with the intra-laryngeal growth. The external swelling has never been explored. Two years ago the external swelling in the spring again became so much increased and gave the patient so much discomfort that she returned to her medical attendant, who is said to have thought that there was fluid in it, but he did not want to perform any further operation unless it was absolutely necessary. No further steps were then taken. Recently there has been again some external swelling, which has now subsided, with a good deal of shooting pain in the throat extending to the jaws and to both ears. All this is again better now. The patient has not recently lost flesh, and has never had any dysphagia. Her voice is so surprisingly clear and strong, although she still wears a tracheal cannula, that the history, as given above, was listened to with a certain amount of incredulity. The

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result of the objective examination, however, was very surprising. Externally the small tumour in the left submaxillary region was tender to the touch, and any pressure on it, unless extremely gentle, each time caused immediate retching and cough. It was, however, ascertained that it was not adherent to the skin, and somewhat mobile in various directions, although it seemed to be fixed to something very low down. No enlargement of lymphatic glands in its neighbourhood. On laryngoscopic examination a very surprising condition was seen. Whilst from the almost normal voice one would have expected a corresponding normal aspect of the larynx, it is seen that almost the whole laryngoscopic image is filled out by an enormous tumefaction of the left half of the larynx, which above extends to nearly the free border of the epiglottis and below to the left arytænoid cartilage. All the constituent parts of the larynx within that distance have perished, as it were, in the smooth round tumefaction, covered by apparently normal mucous membrane. Of the epiglottis itself not much more than the free border can be seen, which is twisted so that the epiglottis is looking towards the right. From this small remnant both on the dorsal and on the ventral aspect the tumefaction of the left side begins, which involves the ventricular band, the arytæno-epiglottidean fold, and the arytænoid cartilage. To the right of this tumefaction a small chink remains, which is bordered on the right by the right ventricular band. Neither of the vocal cords can be seen, and it can only be concluded from the integrity of the voice that the left vocal cord cannot be involved in the process. The right arytænoid cartilage moves well, the left half of the larynx is almost immoveable. On touching the tumefaction with the probe a feeling of an elastic resistance is encountered, similar to that experienced on pressing the external tumour.

The observer wished to have the opinion of the Society on this most uncommon condition, the like of which he did not remember having ever seen.

Dr. Newman regretted not having heard the history of the case, and judging merely from the clinical appearances he thought it looked like a sarcoma; the long history, however, was somewhat against this suggestion, and he should suggest it was a fibrous or fibro-cystic growth.

Dr. Spicer thought the tumour encapsuled, and that if the mucous membrane were divided it would shell out.

Mr. Symonds found difficulty in deciding what was the relation of

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BUTTERWORTH. SC

ad. Nat: del: E.B. Waggett

SIR FELIX SEMON'S CASE.

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the outside to the inside tumour. He thought the case might be surgically attacked, and without any great danger.

Mr. DE SANTI remarked that though very uncertain as to the nature of the tumour, he inclined to the opinion that it was a slowly growing fibro-sarcoma. With reference to Dr. Newman's remarks he would point out that the history of eight years' duration was not incompatible with a diagnosis of sarcoma. Recently he had had under his care a girl of twenty, who for eighteen years had had extensive tumours of the neck and scalp. Six years ago one of the largest was removed by one of his colleagues, and Dr. Hebb, a well-known pathologist, reported it to be a fibro-sarcoma. Four and a half years ago another was removed, and also reported to be a fibro-sarcoma. Last summer Mr. de Santi made a clean sweep of all the tumours, some thirty or forty, and those, microscoped by Dr. Hebb, showed almost pure fibrous structure The girl got quite well, but some ten months after died with supposed secondary growths in the lungs. He hoped to hear soon from the medical man who did the post-mortem whether there were definitely secondary growths or not. At any rate the case showed the very slow malignity of some of these cases of sarcomata.

Mr. BUTLIN thought that possibly the tumour was glandular in nature, and might be an extension or outgrowth of the thyroid gland, and pointed out that the external tumour moved with the hyoid on swallowing. He thought that an operation for removal might be attempted, and with prospects of success.

Sir FELIX SEMON was glad to hear the suggestions which had been made relative to active interference with the tumour, but he could not yet make up his mind as to whether he should advise the patient to undergo the risks of such a severe operation as the case would necessarily entail. At present the patient is comfortable, her voice is good, she has no trouble with the tracheotomy tube, and the tumour is obviously a very slowly growing one. On the other hand, an operation, the extent and limits of which we cannot foretell, has been suggested for a tumour of whose nature we are ignorant, and which is probably closely connected with the vagus, an operation which, therefore, is necessarily of a very serious nature. At present he thought he would watch the case a little longer, and report later to the Society as to what course, if any, had been adopted, and its results. The Society is indebted to Mr. Ernest Waggett for the accompanying sketch of the tumour.

LOCALISED THICKENING OF INTERARYTÆNOID FOLD OF TUBERCULAR ORIGIN.

Dr. BRONNER (Bradford) showed a microscopic specimen of hypertrophy of the mucous membrane of the interarytænoid fold of eleven years' duration. The patient, æt. 34, was first seen in November, 1894. She complained of hoarseness and occasional loss

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of voice for over seven years. The symptoms were not increasing in severity. There was the well-known thickening of the interarytænoid fold. Sprays, insufflations were tried. The parts were then removed with cutting forceps several times; they always grew again. The use of the galvano-cautery was equally ineffectual. The patient was under treatment for nearly two years. The present appearance of the parts was just the same now as it had been four years ago. The Clinical Research Association had reported, "There are several distinct tubercles having a nodular outline, and large giant-cells. Other pieces consist of ulcerated mucous membrane, the raw surface being covered with granulation tissue. The evidence points to the existence of tuberculous laryngitis."

The mother of the patient had died of phthisis, and patient had nursed her for some months. There were no other symptoms of tuberculosis.

Dr. Bronner wished to have the opinion of the meeting—(1) if many cases of chronic thickening of the interarytænoid fold, without any apparent cause, were of tubercular origin; (2) if there was any danger of the disease spreading.

Dr. Herbert Tilley referred to a case which he had shown the Society nearly twelve months ago. He pointed out that there were two distinct forms of thickening found on the anterior face of the arytænoid commissure. (1) Tubercular granulation tissue such as was shown at the last meeting by Mr. Lake. The granulations were soft, easily removeable, and tended to recur rapidly. Associated with this condition one found signs of tubercle in the lung or in the larynx. (2) That form which is found in cases of chronic laryngitis, especially in alcoholics, and not in any way associated with tubercle. The growth is a tough, fibrous hyperplasia covered with epithelium natural to the part. Often there is a vertical fissure in it, and then there is usually sharp pain on swallowing. He did not know what was the best treatment for such a condition, though galvano-cautery, lactic acid, and removal of pieces by forceps (cutting) only seem to give temporary relief, and he was inclined to believe that such cases did best when left alone.

Mr. Spencer also thought that such a condition would not increase if it was left alone.

Dr. Jobson Horne observed that the section of the part removed showed, under the microscope, an increase in the breadth of the epithelium, with papillæ passing into the subepithelial layer. Accompanying this hyperplasia there was a metaplasia of the cells constituting the condition of pachydermia. He attributed the condition to the chronic irritation caused by the subjacent tubercle.

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Extensive Syphilitic Adhesions of Soft Palate.

Mr. de Santi showed a woman on whom he had operated for extensive syphilitic adhesions of the soft palate to the posterior wall of the pharynx. The patient's mother had suffered from syphilis, the woman herself had inherited the disease, yet after marriage she contracted the disease again, and her child had congenital syphilis. The whole of the naso-pharynx was cut off from the oropharynx by the dense adhesions, and recently patient had had intense pain in the right mastoid and ear. There were old perforations of both drums, and the patient was deaf to both air and bone conduction. The pain in the ear and mastoid always started from the throat. Mr. de Santi operated by thoroughly separating all the dense adhesions with scissors and knife as close to the pharynx as possible. There was but little bleeding; on the left side no soft structure could be detached, but on the right side a fair amount of tissue was separated and then stitched forwards to the muco-periosteum of the hard palate, according to Mr. Spencer's method. The case did very well, re-adhesion did not take place, and the patient became entirely free from the mastoid and ear pain. She also now is able to speak better, and all post-nasal discharges pass down the normal way. She is able to blow her nose and breathe with her mouth shut.

Ivory Exostosis of Frontal Sinus causing Pressure Symptoms.

Mr. de Santi also showed a case of a man suffering from an ivory exostosis involving the right frontal sinus, and which had by pressure caused a suppurating mucocele. The man had had the exostosis for over five years, but beyond the disfigurement had not troubled about it until within the last ten days, when the whole of the parts at the inner canthus of the eye began to swell and cause pain. The exostosis was a very hard, large, and sessile one, and Mr. de Santi dealt with the abscess only by incision and scraping, and proposed to operate on the exostosis a little later. If left alone it would probably destroy the right eye.

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Syphilitic Periostitis of Forehead.

Mr. de Santi also showed a case of a man with a syphilitic periosteal swelling in the mid-frontal region of the head, just above the articulation of the frontal bone with the nasal bones. It was of interest because the patient two years ago had been shown by his colleague, Mr. Spencer, for symmetrical enlargement of both parotid glands. Some of the members of the Society, notably Dr. Lack, had considered the case to be syphilitic parotitis. At any rate, under iodide of potassium both parotids soon resumed their normal size. It was, however, of interest to note that concomitant with the diminution in size of each parotid gland there was a yellow discharge from each ear. This discharge did not last long, and there is no sign of perforation recent or old to be seen in the membranæ tympani. Nor at the time of the enlargement of the parotids was there any "dry mouth" or symptom of obstruction of the parotid ducts.

Tumour of Lower Lip.

Mr. Lawrence showed a case of tumour in middle line of lower lip in a man æt. 61. Disease of a warty character, and hard and ulcerated. No history of previous disease and no loss of flesh. There was little doubt but that it was malignant.

Enlargement of Tonsils after Tonsillotomy.

Mr. Lawrence showed a young woman æt. 22, who had been "troubled with her throat" for twelve years. Tonsils were removed last November. Since then they have grown considerably, and there are masses of large glands behind and below the angles of the jaw.

Mr. Butlin and Sir Felix Semon thought the case was one of syphilis occurring in a tubercular subject, an opinion generally concurred in by other members.

Mr. Spencer thought it was possibly a slow diphtheritic growth, and suggested that a bacteriological investigation should be made.

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Cutting Laryngeal Forceps.

Mr. R. Lake showed a pair of punch forceps for use in double curetting of the larynx in tubercular laryngitis.

Gumma and Perichondritis of Nose.

Shown by Mr. Atwood Thorne.

Bilateral Abductor Paresis of Vocal Cords—for Diagnosis.

Shown by Mr. Atwood Thorne.

Case of Phthisis and Healed Laryngeal Tuberculosis.

Shown by Dr. Lambert Lack. The patient, a girl æt. 19, came under his care in July, 1896, complaining of hoarseness and cough. The symptoms pointed to an acute but early phthisis, the lung signs being most marked at the right apex. The sputum was crowded with tubercle bacilli, there was a history of night sweats, cough, &c., for three months, but not much interference with the general nutrition. On laryngeal examination the right ventricular band was seen to be much swollen, and in its anterior two-thirds covered with pale fleshy granulations. The anterior third of the left ventricular band and the intervening area of the anterior part of the larynx were similarly affected. The vocal cords were congested, but the rest of the larynx appeared normal. The whole of the apparent tubercular tissue in the larynx was removed with the cutting curette in some three or four sittings; on each occasion chromic acid fused on a probe was applied to the resulting raw surface. This somewhat extensive surface healed readily, lactic acid being occasionally applied to stimulate it. After about two months' treatment the larynx was entirely healed, and the patient's general condition had considerably improved. Now for more than eighteen months the patient has had no further treatment, the disease in the chest has quieted down, and the general health remains fairly good, although the patient has unavoidably continued work as a waitress in London.

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The larynx remains healed, the absence of the right ventricular band disclosing a large part of the upper surface of the right vocal cord.

Dr. CLIFFORD BEALE agreed that healing had taken place in this case, but pointed out that there was still a good deal of difference on the two sides. The patient's throat showed none of the characteristic anæmia of tubercular disease, the mucous membrane looking particularly well nourished—an important point in the selection of cases for operation. He thought that surgical wounds of the ventricular bands were more likely to heal than those made in the interarytænoid space, as being less likely to become infected by secretions from above or below. He congratulated Dr. Lack on the results obtained. The successful removal of foci of active disease from the larynx showed a distinct advance in treatment.

ERRATUM.

In the report of the discussion of Mr. Spencer's case of "Carcinomatous Tumour of the Epiglottis," the statement is ascribed to Sir Felix Semon ('Proceedings,' February 9th, 1898, p. 50, line 26) that he could recall no case which had recovered after subhyoid pharyngotomy. This statement is due to an error on the part of the reporter. What Sir Felix Semon said was that, according to Sendziak, in more than 50 per cent. of the cases of laryngeal cancer, in which subhyoid pharyngotomy had been performed, death had ensued.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *April 13th*, 1898.

HENRY T. BUTLIN, Esq., F.R.C.S., President, in the Chair.

HERBERT TILLEY, M.D., } Secretaries.
WILLIAM HILL, M.D., }

Present—26 members and 1 visitor.

The minutes of the previous meeting were read and confirmed.

The following gentleman was nominated for election at the next meeting:

Arnold Fergusson, F.R.C.S.E., 34, Canfield Gardens, Hampstead.

CYST OF THE EPIGLOTTIS.

Shown by Mr. WYATT WINGRAVE. Girl æt. 13 complained of sore throat and occasional deafness for six years, on and off, following scarlet fever. Her tonsils were removed four years ago, when nothing wrong with her throat was noticed.

On examination a mass is seen attached to the left half of the laryngeal aspect of the epiglottis, resembling a small white-heart cherry in size and colour. The only symptom is occasional pain on swallowing, her singing and speaking voice being normal.

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Dr. Law said that he had often noticed these cases following excision of the tonsils for chronic hypertrophy, and questioned whether a traumatism might account for them.

Case of Chronic Pharyngitis.

Shown by Mr. Wyatt Wingrave. Man æt. 26 has been under treatment for chronic suppurative middle ear disease for six years.

Suspecting adenoids, his pharynx on examination showed a symmetrical flesh-like thickening, which commenced behind the posterior pillars and met in the middle line above the level of the soft palate, extending upwards into the naso-pharynx. This tissue proved tough on attempting to scrape with finger-nail.

There is a doubtful history of hereditary syphilis.

Is the condition due to asymmetrical hypertrophy of the lymphoid tissue? or is it of inflammatory origin?

Dr. Spicer called attention to the adhesion in this case between the salpingo-pharyngeal fold and the pharyngeal wall, as had been observed in connection with Tornwaldt's disease.

Dr. Grant ascribed the condition to hyperplasia of the salpingo-pharyngeal folds, which had become adherent to each other at a lower level than the choanæ.

Mr. Spencer advised removal of the bands on account of deafness.

Dr. Hill suggested that it was a case of adhesion of the lower portion of the hypertrophied salpingo-pharyngeal fold to the posterior pillar of the fauces.

Dr. Edward Law thought it resembled a gummatous condition of the lateral pharyngeal wall.

Dr. StClair Thomson suggested that the condition might be an hypertrophy left by a syphilitic process. He had seen a gumma in the region of Luschka's tonsil break down in the upper part, but leave a thickening across the pharyngeal wall—at the level of the soft palate,—and uniting with a hypertrophic lateral pharyngitis of both sides. This condition had remained unaffected by antisyphilitic remedies. In the present case some further help might be obtained by the microscopical examination of a portion, which could easily be removed for that purpose.

Mr. Wingrave in reply said that on digital examination the finger simply passed between the soft palate and the deposit, upwards to a free and well-defined vault. The deposit did not *hang* in front of the posterior pharyngeal wall, but was flush with it. There was a doubtful history of congenital syphilis which suggested a possible pre- or post-natal inflammatory process.

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Modification of Baratoux' Electrical Laryngo-phantom.

Shown by Dr. Dundas Grant. In the original instrument there is a model of the larynx, with a number of metallic points at definite positions. Each of these points has, in communication with it, a flexible wire and a pin, to which a numbered label is attached. In front of a machine is a tracing of the larynx, on which the corresponding points are numbered.

When the student wishes to exercise himself in touching with the laryngeal probe any given point in the larynx, the pin corresponding to that point has to be selected by its numbered label (the number having been discovered by examination of the aforesaid tracing), and is then fixed in a screw connection. When this is done, and the probe is made to touch the correct spot—and no other spot—a loud electric bell rings. A considerable time is spent in seeking out the proper number, label, and pin, and the present modification has been devised by Dr. Grant to minimise this trouble.

The pins and labels are removed, and in the place of them there are small pieces of brass tubing. These are inserted in the appropriate places in another tracing of the larynx on an ebony plate. All that is then necessary is to insert the single pin into the appropriate hole on this tracing, and the necessary connection is at once complete.

(The instrument in this form was tested by many of those present at the meeting, and was highly approved by them. The original instrument is manufactured by Gaiffe, of Paris, and the modification has been effected by Mr. Trood, of London.)

A Case of Empyema of the Frontal Sinus cured by the Ogston-Luc Operation.

Shown by Dr. Dundas Grant. The patient was a man æt. 40, who had suffered from fœtid purulent discharge from his left nostril, accompanied by pain in the left frontal region, which he alleges to have been only of six months' duration. The discharge was traced to the middle meatus, but by transillumination and exploratory irrigation, disease of the antrum was excluded. On transillumination of the frontal sinus there was found to be distinct comparative opacity

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on the left side. The anterior extremity of the middle turbinated body was considerably swollen.

Relief was afforded by cocainisation of the middle turbinal, followed by the use of Politzer's bag to the left nostril, while the opposite one was closed with the finger; both ears were stopped up, and the patient uttered the sound "ee." As a palliative measure this process was carried out for some time by his family attendant, and an alkaline antiseptic douche was employed to wash away the pus as it collected. The patient was laid up with an attack of gout, so that he disappeared for some time, but his nasal condition remained comparatively unchanged, and he came into hospital for operation by Luc's method—a free opening, thorough curettement, the insertion of an india-rubber drainage-tube through the infundibulum, and immediate closure of the operation wound by suture of the periosteum, and then of the superficial parts. The patient was kept in bed, and unfortunately had almost immediately a recurrence of his gouty or rheumatic joint affection, which involved his right wrist-joint. The wound in the eyebrow healed almost entirely by first intention, although there was on one occasion a slight temporary superficial oozing from the inner extremity, which, however, was not visible when Dr. Grant inspected it. The drainage-tube was extracted on the tenth day. A glass syringe was applied to the extremity of the drainage-tube which protruded from the nostril, and an extremely minute quantity of pus was withdrawn. This was repeated daily, and at the end of a week a fine intra-tympanic tube was pushed up through the drain, and the sinus was washed out with boracic acid, pressure being exercised over the wound during the process, a precaution also adopted whenever the patient wished to blow his nose. This was repeated on three successive days. By that time the patient's arthritis had disappeared, and he was allowed to return home. He is now free from pain and from discharge, there is no disfigurement, and the middle meatus of the nose is quite dry.

Microscopical Section of Tissue from Frontal Sinus. (Dr. Dundas Grant's Collection.)

Shown by Mr. Wyatt Wingrave. This consisted of small-cell or lymphoid tissue, containing nodules similar to ordinary adenoid growth.

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Dr. StClair Thomson directed attention to the fact that at that meeting there was a demonstration of the presence of adenoid tissue in the lining of the frontal sinus, and in the hypertrophies of the arytænoid bodies, while it was well known that adenoid tissue could be found in the hypertrophies of the inferior turbinals. He would like to ask pathologists—especially those whose practice was not limited to the upper air-passages—what their views were as to this distribution.

Mr. Spencer remarked on the development of lymphadenomatous tissue after chronic irritation, and considered the tissue in the frontal sinus to have been antecedent to the suppuration. He also referred to the difficulty of distinguishing diffuse forms of tubercular formation from lymphadenomatous tissue. In some cases histological examination did not solve the question, and the only thing would be the inoculation into animals.

Dr. Pegler thought the presence of normal lymphoid tissue in the section very remarkable. In sections made from a case of Dr. Tilley's the polypoid growths consisted entirely of granulated tissue, such as one finds in analogous growths from the antrum.

Mr. Symonds suggested that it might not be out of place to mention the possible dependence of the adenoid tissue in this case upon tubercle. He referred to one instance of persistent suppuration of the frontal sinuses, which resisted curetting and the use of iodoform, and subsequently died of pulmonary tubercle.

Mr. Wingrave in reply said he considered that it was not of a tuberculous nature, owing to the strong resemblance which it bore to ordinary pharyngeal tonsil tissue, and the regularity of the grouping of the lymphoid nodules.

Œdematous Hypertrophy of Arytænoids.

Shown by Mr. W. G. Spencer. More than a year ago Dr. de Havilland Hall showed the patient, a man æt. 47, to the Society. It was difficult to get a good view of the laryngeal condition, and the case was considered to be an unusual one of chronic laryngeal œdema. The history of the affection was mainly negative, merely a gradually increasing hoarseness and difficulty in breathing. After this Dr. Hall tried to remove some of the swelling by intra-laryngeal forceps under cocaine. But before he could do anything the patient had a bad fainting attack.

As dyspnœa was increasing the extra-laryngeal method became necessary. On retracting the alæ of the thyroid cartilages I found that each arytænoid had become a tumour of the size of the thumb, with a perfectly smooth surface, and that there was but very little change in the

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size of the larynx. Each tumour was seized with a volsella, and cut off with scissors, the line of division being through the apex of the cartilage. There was no important hæmorrhage. Healing occurred, and the patient has remained well for a year, except for an occasional catarrh. On examining the larynx now there is not much deviation from the normal, except that the arytænoids appear flat-topped.

Under the microscope the tumour is seen to be a soft œdematous fibroma, covered by normal stratified epithelium, and containing normal arteries, veins, and nerves, also groups of mucous glands embedded in it.

The peculiarity of the case lies in the situation of the affection, as it is evidently the same as the common hypertrophy of the inferior turbinal. It was clearly of inflammatory origin, not liable to recur.

Papilloma of the Septum Nasi.

Shown by Mr. Yearsley. E. B—, æt. 20, complained of pain in the right nostril, lasting three months. There was occasional slight bleeding on rubbing, picking, or blowing the nose. Latterly she had found some difficulty in breathing through the right side of the nose. On inspection the condition was as shown in the photograph, kindly taken for me by Dr. Fallows. The growth was situated upon the cartilaginous septum, about three quarters of an inch inside the vestibule. There was also some hypertrophic rhinitis and a small spur on the right side.

The growth was easily removed under cocaine with a cold snare, the hæmorrhage being very trifling.

The specimen shown under the microscope passes through the delicate fimbriæ, and shows the growth to be a papilloma.

Dr. Logan Turner showed one specimen before this Society on December 9th, 1896.* Another, in a man aged 82, was reported by Mr. De Santi in the *Lancet*.† A third case (that of a Roumanian woman aged 28) was brought before the American Laryngological Congress of 1895 by Wright. To Wright's and De Santi's papers I would refer members for other published cases.

* 'Proceedings of Laryngological Society of London,' vol. iv, p. 21.

† December 8th, 1894.

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CASE OF LARYNGEAL STRIDOR AND NASAL OBSTRUCTION.

Shown by Dr. LAMBERT LACK. The patient is a weakly child aged five months. Within a few hours of its birth it was noticed that respiration was accompanied by a crowing noise, and this has continued more or less since. The infant has almost complete nasal obstruction, and snuffles and snores a great deal. Also at the end of inspiration there is a higher pitched, much louder sound, which, as far as the ear can judge, is true laryngeal stridor. When the child is awake and breathing through the open mouth this stridor is very slight or quite inaudible, but it at once becomes marked if the mouth be closed as in suckling. Also in sleep the stridor is intensified, and sometimes the patient's rest is disturbed by severe suffocative attacks. There is recession of the chest walls on inspiration, apparently constant but varying in amount. The child is wasting, and seems to be much enfeebled. The case seems to be one of laryngeal spasm, probably due to adenoids. It is proposed to give an anæsthetic, to examine the throat thoroughly, and remove the adenoids or other cause of nasal obstruction.

Dr. HILL asked if Dr. Lack would accept the explanation that in this case the cause of the stridor was that the tongue in certain positions alluded to fell back on the pharynx, pushing with it also the epiglottis, and so causing partial collapse of the vestibule of the larynx.

Dr. SPICER thought the obstruction was intra-nasal rather than post-nasal, and recommended treatment in that direction.

Mr. SYMONDS called attention to the emaciation of the child and the appearances of general illness, and suggested that the difficulty of breathing when the mouth was shut might be due to the child not inspiring sufficient air into a diseased lung. He did not question the fact of post-nasal obstruction. He suggested a post-pharyngeal abscess as a cause of the child's illness, or possibly pulmonary tubercle.

In reply to questions, Dr. LACK said that there was no malformation of the upper aperture of the larynx in this case. Judging purely from the characters of the sound he thought the stridor was produced in the larynx, probably by the vocal cords, but there was no direct evidence of this. The air entered the chest badly, and there was probably some collapse of the bases of the lungs, but this was the usual condition in all cases of congenital laryngeal obstruction.

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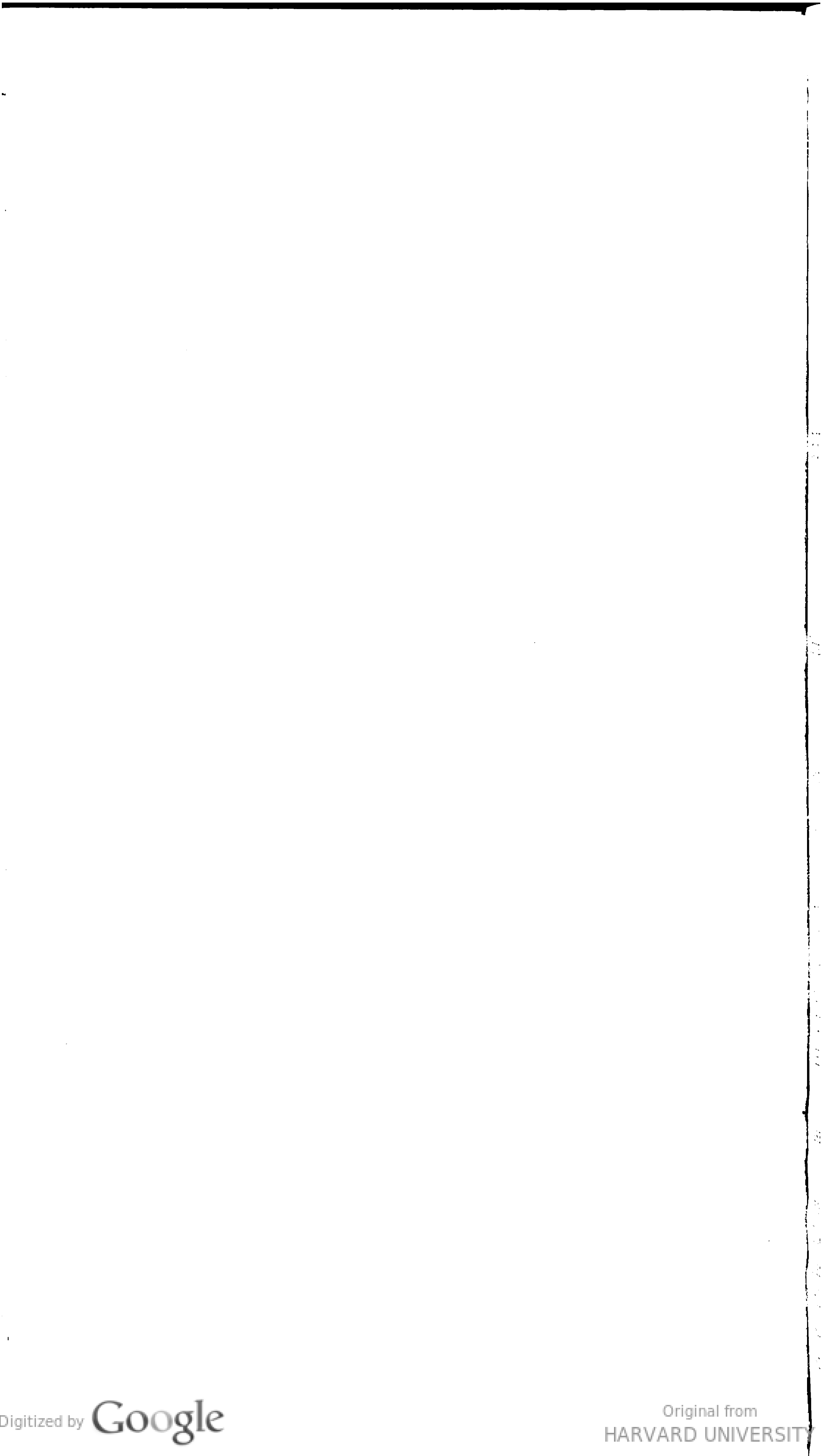

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *May* 11*th*, 1898.

HENRY T. BUTLIN, Esq., F.R.C.S., President, in the Chair.

HERBERT TILLEY, M.D., } Secretaries.
WILLIAM HILL, M.D., }

Present—38 members and 4 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were nominated for election at the next meeting:

Arnold Fergusson, F.R.C.S.E., 34, Canfield Gardens, Hampstead.
Claude C. Claremont, M.D., B.S. (Lond.), 57, Elm Grove, Southsea.
Francis J. Steward, M.S. (Lond.), F.R.C.S. (Eng.), 24, St. Thomas's Street, S.E.
Albert H. Burt, M.R.C.S. (Eng.), L.R.C.P. (Lond.), Throat and Ear Hospital, Brighton.

A CASE OF CARCINOMA OF LARYNX SUBSEQUENT TO LARYNGEAL TUBERCULOSIS.

Shown by Mr. H. BETHAM ROBINSON. E. D—, a single woman æt. 36. The first sign of any throat trouble was in 1878, when she was hoarse, and at times aphonic. She had no pain or difficulty in swallowing until August, 1882, after an attack of tonsillitis. In December, 1885, she saw Sir Felix Semon, who ordered daily treatment. This

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she did for three months, and then ceased attendance. After some months she returned with chronic laryngitis. She attended the hospital for some years with varying laryngeal symptoms, but since the beginning of 1893 she has been unable to speak above a whisper. In July, 1896, when she complained of weakness, shortness of breath, loss of appetite, and wasting, Sir Felix Semon said it was tuberculous laryngitis, and she had lactic acid applied twice a week. She gradually got worse, and in March, 1897, the extreme dyspnœa required tracheotomy done. Her condition improved, gaining flesh and speaking fairly up to November, since which time she has been only able to whisper. In December last the swelling on the right side of the neck was first manifest, and about the same time the margins of the tracheotomy wound were becoming prominent. Laryngeal examination showed that the subglottic space was completely filled with growth. Since this time it has extended, so that now the right pyriform sinus has become invaded and filled up, and both cords are almost completely obscured. The sprouting about the tracheotomy wound has increased. The growth on the right side of the neck has softened, so that a carcinomatous cyst has formed. During this time, however, her health has remained very good, and she has not lost flesh appreciably.

There is a history of consumption on both sides of the family, father and one sister in particular succumbing; there is also a history of cancer, both mother and grandmother dying of cancer of the womb.

The chest gives signs of excavation at both apices, especially on the right side, but the disease is now quiescent.

On microscopical examination of portions of the growth it proves to be a non-cornifying epithelioma, such as might arise from the glands of the laryngeal ventricle.

A Case of almost Fixed Cords from Syphilis simulating Bilateral Abductor Paralysis.

Shown by Mr. H. Betham Robinson. E. J—, a married woman æt. 50, has enjoyed good health except on occasions during the past few years. She has had five children, all healthy.

In October, 1886, she first attended St. Thomas's for laryngeal tumour, and the diagnosis was secondary syphilis. She complained then of sore throat, loss of voice for a few weeks at a time, and bronchitis. In May, 1887, she returned with similar symptoms, and was treated for

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a while. Five years ago she again sought advice for similar symptoms, which have continued since.

In February of this year she had influenza, followed by increased shortness of breath.

Early in April there was great dyspnœa, and on examination of larynx the present local condition was seen.

Present condition.—On inspiration the cords are seen almost meeting in the median line except in the interarytænoid region, the left cord being on a plane slightly superficial to the right; on expiration they recoil about to their normal position,—in fact, the appearance produced is suggestive of delayed innervation. On phonation the cords are adducted normally. There is no definite swelling of soft parts, but some appearance of thickening in the arytænoid region. The left cord is still injected.

The chest is normal, no swelling in the neck, and no signs of any bulbar or nerve affection. Her pupils and knee-jerks are normal.

The question in this case seems to be whether the local laryngeal signs are dependent on nerve lesion or on an old syphilitic infiltration causing some hampering of the movements at the crico-arytænoid joints and muscular degeneration. There has probably also been some perichondritis in addition in posterior part.

The muscular wasting and altered tension of the cords fully explain the appearance produced on inspiration.

With the disappearance of the catarrh her voice and dyspnœa have nearly gone.

For general treatment she has had iodide of potassium, but owing to the great discomfort produced this has been given up.

Kirstein's Autoscope.

Mr. Cresswell Baber showed the latest form of instrument used by Dr. Kirstein, which consists of a strong rectangular metal tongue depressor. The blade of the instrument measures about 11 centimetres by 51 millimetres, and is 3 millimetres thick. For a distance of 5 centimetres from the tip the blade is curved, forming a segment of a circle of 13·5 centimetres radius. The end has a slight depression to receive the middle glosso-epiglottic ligament, and the edges are carefully rounded. For illumination the ordinary forehead mirror or Kirstein's electric frontal lamp may be employed. This is all that is

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required for examination; for demonstration the electric autoscope is used.

The method of using the instrument was explained, and the opinion expressed that direct inspection of the larynx and trachea as employed by Kirstein was worth practising by laryngologists for use in suitable cases, as a supplementary means of examination, not as a substitute for laryngoscopy.

Case of Malignant Disease of the Laryngo-œsophageal Region.

Shown by Dr. Pegler. R. D—, æt. 37, married, complained of swelling in the throat and difficulty, but not pain, in swallowing.

Examination showed extensive thickening and ulceration of the œsophageal aspect of the arytænoid region and interspace, and ary-epiglottic folds. A broad-based neoplasm projected towards the middle line from the left arytænoid, and obstructed the view of the larynx. It was ulcerated on the surface. A mass of hypertrophied glands, the uppermost of which was breaking down, and on the point of discharging through the thinned epidermis, was conspicuous on the left side of the neck. Others were commencing to enlarge on the right side. The throat trouble dated from about a year. From the laryngoscopical appearance and history there seemed at first some chance of the disease being syphilitic, or at all events of its being a mixed case, but sections of the neoplasm, part of which had been removed with a snare for the purpose, displayed every characteristic of epithelioma, and scrapings from the broken-down gland cavity yielded epithelial squames only, and no tubercle bacilli. The interior of the larynx was healthy so far as could be seen after removal of the growth.

Constant spitting of an abundant watery secretion was the chief trouble besides the dysphagia, and it was very desirable that some means should be found to relieve this.

Dr. Bond stated the same patient had attended his clinique at Golden Square for some weeks. She had then an enlarged gland externally and ulcerating growth on left side of pharynx, extending behind arytænoids. Although there was some slight improvement under iodide at first, the malady afterwards steadily progressed, and was

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thought to be malignant. Dr. Bond recommended palpation of the growth in such cases as an aid in diagnosis.

Mr. SPENCER suggested the use of atropine pills to check the excessive salivation.

Dr. PEGLER inquired whether the high palate he observed in this as well as in some of his own cases might have anything to do with the speech disability. Removal of the nasal obstruction, primarily responsible for the paresis of the soft palate, did not improve matters much, as more air passed through the nose than before. When this patient's nostrils were closed she pronounced the "s" in "kiss" very fairly. He thought the elongated uvula in this case rather aggravated the paresis.

A CASE OF RECURRENT MULTIPLE PAPILLOMATA OF THE LARYNX.

Shown by Dr. DUNDAS GRANT. The patient, a female æt. 20, whom he first saw in February, 1895, had then several large papillomata in the larynx. These were removed by means of the forceps, but recurred repeatedly. Various chemicals were applied, among others chloride of zinc, absolute of alcohol, tincture of thuja, and perchloride of iron, but none had any effect until in October, 1896, salicylic acid dissolved in alcohol was applied daily by means of a fine laryngeal probe coated with cotton wool, in strength gradually from 1 up to 10 per cent. Under this treatment the stumps shrivelled up and the recurrence was permanently stopped.

NODAL AGMINATION OF SECRETION ON THE VOCAL CORDS OF A SINGER. ? INCIPIENT NODULES.

Shown by Dr. DUNDAS GRANT. The patient, a female æt. 21, a student of singing, complained of want of timbre in the voice. There was a frequent accumulation of white secretion at the junction of the anterior and middle thirds of both vocal cords, the seat of election of "singer's nodules." On the removal of the secretion a tiny acuminate projection could be seen at the spot, but this was so small that it was doubtful whether it amounted to a morbid condition at all, or whether it was the earliest stage of a nodule. There had been considerable nasal obstruction, which had been removed by treatment, and since then the secretion on the vocal cords had very greatly diminished.

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Dr. Bennett said he could only see a trace of a nodule, and thought the patient might resume her studies without any risk of permanent damage to the larynx.

Case of Sigmatic Dyslalia.

Dr. Dundas Grant brought forward the case of a female æt. 30, who complained of stuffiness in the nostrils, and a defect of speech resembling that produced by cleft of the palate. In particular, there was absolute inability to produce the hissing of the letter "s," for which was substituted the guttural "k." The palate was somewhat paretic, and the turbinated bodies hypertrophied. On contraction of the latter by means of cocaine the feeling of discomfort in the nose was removed, and utterance of the letter "s," in spite of the increase of nasal freedom, became more easy. When the nostrils were compressed hissing became easier still. The turbinated bodies were cauterised, and the patient instructed in the method of exercising herself in the utterance of the hissing sound.

Note.—Since the exhibition of the case Dr. Dundas Grant has found that the letter "s" is more easily produced when the patient projects the lower jaw forwards, and she is exercising herself in this movement.

Sessile Papilloma of the Left Tonsil associated with Pedunculated Papilloma of the Left Posterior Faucial Pillar.

Shown by Dr. Sharman. F. H—, a boy of 15, came to the hospital on April 25th, 1898, complaining of difficulty in swallowing and in breathing through the nose of about one year's duration. He was found to have chronic enlargement of both tonsils, a central pad of post-nasal growth, some enlargement of both inferior turbinates, and some slight chronic laryngitis. On the surface of the left tonsil is an apparently sessile papilloma, the size of half a small split pea; and behind the tonsil, growing from the left posterior pillar of the fauces, is a small pedunculated papilloma rather larger in size. Dr. Sharman thought the case worth showing in view of previous remarks at the Society this session on the subject of the rarity of benign growths of

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the tonsil, and also in view of Dr. Rose Paterson's theory that such papillomata really grow not from the tonsil proper, but from the plica triangularis. The tonsil will probably be removed, but the boy's throat up to the present has not been subjected to any surgical interference whatever.

Patient with Laryngeal Paralysis (previously shown at March meeting) who has recently had several Epileptiform and Vertiginous Attacks associated with Laryngeal Spasm and Irritation.

Shown by Mr. Atwood Thorne for Dr. Hill. The case, a man æt. 38, was shown at the March meeting of the Society as a case of paresis of both vocal cords of doubtful origin, but no definite opinion of its cause was expressed at that meeting. At that time it was not known that he had had any attacks of giddiness.

On April 7th, while assisting in loading a barge, he felt queer in his head, gave a cough, and fell head over heels into the barge, striking his head in falling. He remained unconscious for an hour and a quarter. (Probably the length of unconsciousness was due to the blow received while falling.)

He has had in all six attacks of unconsciousness, each immediately preceded by a feeling of constriction in the throat, with inspiratory whoops and deep coughs. He has remained unconscious (except when he struck his head) for two to six minutes each time.

At different times the abduction of the cords has been very feeble, and he has suffered from marked stridor, and the question of tracheotomy has been discussed. At the meeting, however, the cords moved fairly well.

There are no signs or symptoms of locomotor ataxy, and examination of the chest gives no hint as to the cause of the paresis.

Dr. Beale questioned whether the infantile shape of the epiglottis, to which attention has recently been drawn in cases of infantile laryngeal spasm, had anything to do with the stridorous attacks.

Drs. Hill, Spicer, and Thomson also briefly discussed the case.

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Case of Pharyngo-mycosis.

Shown by Dr. Edward Law. The patient was first seen December 13th, 1897. She complained of her throat aching, and of the sensation of crumbs and roughness in swallowing, which sometimes produced a feeling of sickness; occasionally of a disagreeable taste in the mouth, but never of an offensive smell. She had never used her voice excessively, and her teeth were in a most satisfactory condition. She considered her general health to be good.

In September she lost her voice for a few days after bicyling a long distance, and a week later noticed throat irritation with numerous white patches and excrescences upon the nostril, which she attributed to having eaten bad oysters. Her doctor, who scraped the tonsillar crypts, applied various antiseptic remedies, and prescribed suitable gargles and tonics. The outgrowths quickly returned after removal. On examination the tonsils were found to be large and covered with numerous white patches, which varied considerably in size and shape. With the laryngeal mirror, numerous excrescences could be seen between the tonsils and anterior pillars to pass to the side of the tongue, and resembling in appearance rows of small incisor teeth. The lingual tonsil was largely developed, and studded all over with white elongated projections, especially at the sides. A few very small isolated points could be recognised in Rosenmüller's fossa, on the posterior lip of the left Eustachian tube, and three or four white dots were also visible on the posterior pharyngeal wall.

The galvano-cautery was very freely applied on several occasions to both tonsils after curetting away the soft but firmly adherent masses; various antiseptic pigments and gargles were employed, and iron and arsenic given internally. No improvement was noticed from the local and constitutional remedies, so the patient was sent to Margate for ten weeks in order to get away from a damp bedroom, and to be placed under the best climatic surroundings.

She returned in excellent health, but with only slight improvement in her throat symptoms.

Since her return to London the local trouble has greatly improved, although absolutely no treatment has been employed.

Dr. Waggett has very kindly made the drawings which were handed round, but these sketches unfortunately only represent the condition after great improvement had taken place.

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The case is interesting on account of the great number and extent of the excrescences, and as showing the inefficacy of the treatment employed.

Dr. HERBERT TILLEY strongly recommended a solution of salicylic acid in absolute alcohol (salicylic acid one part, absolute alcohol four parts) for these cases. He had recently tried it in two cases in which other remedies had entirely failed, and in which the general health was good, and from the rapid improvement noticed he concluded that the latter was due to the application, and not to a natural cessation of the disease. The preparation is a strong one, and should be used cautiously; it whitens the surface to which it is applied, producing an appearance similar to that of the galvano-cautery. Small surfaces should be dealt with at a time, and the comparison of such a surface with that which has not been treated would, he thought, quite convince members of the efficacy of the application. Where possible a probe tightly wrapped round with wool and dipped into the solution should be screwed into the crypts from which the white masses protrude.

Dr. GRANT said that such applications were also useful in pachydermia of the larynx.

Dr. WILLIAM HILL said that, considering the nature of the disease, we might *a priori* expect salicylic acid to be useful, as in keratinous growths in other parts of the body, *e. g.* corns, warts, &c.

In reply Dr. LAW stated that he had only read Dr. Kelly's very valuable paper on keratosis pharyngis after cauterising the tonsils, otherwise he would have had sections made in order to examine the cornification of the epithelium of the crypts. Remembering the usefulness of boric acid in alcohol in cases of otomycosis, he tried it in this case, but without success. He would try salicylic acid in absolute alcohol, but would hesitate to rub into the lingual tonsil such a strong solution as 1 in 8.

The following report has been received of a small piece which was recently punched out of the tonsil:—"The sections show sufficient to confirm the statement that the crypts in the mucous membrane are filled with keratinised epithelium. The adjacent submucous tissue is unduly vascular, and shows round-celled infiltration."

SYPHILITIC ULCERATION WITH PERICHONDRITIS OF THE LARYNX.

Shown by Mr. SYMONDS. The patient is a man æt. 35. The disease was confined to the left side, and appeared chiefly as a thickening with an outgrowth about the site of the ventricular band. There was a four months' history of hoarseness, and a well-marked syphilitic scar on the neck and chest.

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Case of Sessile Fibroma of Vocal Cord.

Shown by Mr. Symonds.

Frontal Sinus Disease.

Shown by Mr. Morley Agar. Patient was a man æt. 27, who for a year had suffered from pains and a "cold sensation" over the lower and middle part of the frontal region. There were no objective symptoms beyond some hypertrophic rhinitis. This had been treated several times with slight relief. However, there still remained some nasal obstruction on both sides. Iodide and mercury had been thoroughly tried on the suspicion that the frontal symptoms were due to a syphilitic periostitis, but without result. Phenacetin or antipyrin did not give even temporary relief. The case was shown to obtain the opinion of members as to "the justifiability of exploring for an exostosis," or as to "the propriety of treating the hypertrophic rhinitis more energetically, on the supposition that the symptoms were due to exhaustion sinusitis." The patient suffered so much distress that he was anxious for something to be done.

Mr. Cresswell Baber did not think that there were any distinct signs in this case of abscess in the frontal sinus.

Dr. Hill thought it was a case of exhaustion sinusitis, and that there was no indication for opening the frontal sinus.

Section of Tubercular Epiglottis removed by the Galvano-cautery Snare.

Shown by Mr. R. Lake. The epiglottis in this case was removed in the manner indicated in the title for two reasons,—its extreme vascularity, and on account of its very horizontal position. It healed well, there was neither primary nor subsequent hæmorrhage, there was immediate relief to dysphagia, and one was able to see definitely the extent of the diseased surfaces, and apply treatment with better prospect of success. Tubercle bacilli are scarce in the sections, and not to be found in all. The sections were cut by Dr. Cobbledick.

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In reply to Mr. BUTLIN, the piece was about a third of an inch in thickness at its base, but was all cut up and destroyed in section cutting.

CASE OF SUBGLOTTIC SWELLING.

Shown by Mr. LAURENCE for Mr. BUTLIN. C. M—, æt. 55, has had "throat trouble" since Christmas, 1896. Some ill-defined attack of dyspnœa in July, 1897. Since then more or less hoarseness of voice and noisy respiration.

Condition in January last, 1898: both vocal cords white, the right cord very limited in motion. A pinkish subglottic swelling on each side, greatly narrowing the opening into the trachea. Some pain radiating to the right ear, and also involving the left side of the chest.

This condition has continued with very little variation to the present time. The patient is not losing flesh or strength, and she was shown with a view to diagnosis.

Mr. SPENCER said it was a case of malignant disease, and that some glands in the neck were becoming infected. As in his case, there was no ulceration of the subglottic swelling, but soft, breaking-down glands were found over the jugular vein. The appearances in the two cases were almost identical.

Sir FELIX SEMON and the PRESIDENT said that they could not convince themselves of a tumour being present, and thought that possibly some chronic perichondritis with chronic laryngeal inflammation would account for the appearances. Iodide of potash and Leiter's coil were recommended.

PARESIS OF THE RIGHT DIVERGENTS OF THE LARYNX.

Shown by Dr. BENNETT. Mr. J—, æt. 45, complained at the end of 1895 of a feeling of weakness in the larynx after any use of the voice. He attended a few times at a London hospital, but no weakness of the muscles was noted at that period. In May, 1896, I found the right half of the larynx irregular in its movements; one moment it would remain stationary during inspiration, and the next it would move, but more sluggishly than the left half. Faint sibilant rhonchi were occasionally noticed at the right apex, but nothing else abnormal. In June the right half remained completely stationary.

Although there was no history of syphilis iodides were given for

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some time. Before the end of 1896 the movements had again become complete, though somewhat sluggish. During this period of recovery it was interesting to note that marked changes occurred in the course of an examination, as if the nerve could only permit the stronger impulses to pass, whilst the ordinary inspiratory efforts were not sufficient to affect the contraction of the muscles. During 1897 he felt perfectly well, and called to see me recently to say that he was quite better. I found the right half of the larynx again stationary, but this condition is now once more passing off. No intra-thoracic growth can be detected.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *June 8th*, 1898.

HENRY T. BUTLIN, Esq., F.R.C.S., President, in the Chair.

HERBERT TILLEY, M.D., } Secretaries.
WILLIAM HILL, M.D., }

Present—33 members and 1 visitor.

The minutes of the previous meeting were read and confirmed.

Albert H. Burt, M.R.C.S. (Eng.), L.R.C.P. (Lond.);
Claude C. Claremont, M.D., B.S. (Lond.), M.R.C.S. (Eng.), Southsea;
Arnold Fergusson, F.R.C.S. (Ed.), Hampstead;
Francis J. Steward, M.S. (Lond.), F.R.C.S. (Eng.), of London,
were elected ordinary members of the Society.

The following gentlemen were nominated for election at the next ordinary meeting:

A. J. Dixon, M.B., B.C. (Cantab.), Welbeck Street, W.
Frederick Spicer, M.D. (Durham), Devonshire Street, W.

ŒSOPHAGEAL TUMOUR REMOVED BY SUBHYOID PHARYNGOTOMY.

Dr. PERMEWAN showed a tumour removed from the œsophagus by the above operation. The tumour was of a benign character, and was very easily shelled out and removed. The patient, however, died on the tenth day from septic pneumonia, three days after the removal of

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the tracheotomy tube. Dr. Permewan raised the question of the liability of a fatal issue in these cases, and suggested that they should be treated on the principles advocated by Mr. Butlin in thyrotomy, viz. that the wound should be left open. He compared the wound made in this operation with that in an ordinary cut throat, in which septic symptoms very rarely developed, and believed that the favorable course of the latter case was due to the fact that they usually healed by granulation.

Mr. Symonds said that with regard to the fatality of these operations, which was well known, he attributed the result to infection of the connective-tissue planes. He had successfully removed the epiglottis by this operation. He advised that after suture of the mucous membrane the wound should be packed for two days with iodoform gauze, as the best means of excluding this danger.

Case of Tubercular Ulcer of the Nasal Septum.

Shown by Mr. Lake. Patient, a man æt. 28, suffers with pulmonary tuberculosis of about four years' duration, and has had several attacks of hæmoptysis. The nose began to bleed about twelve months ago from the right side.

The ulcer on the septum was scraped and treated with lactic acid on May 24th, since when the acid has been applied eleven times, and insufflations of iodoform employed constantly.

Dr. StClair Thomson thought it was open to question if the ulcer in this case was not a simple traumatic ulcer, produced by the patient picking his nose. It had not the thickened, indolent margin of the tuberculous ulcer, and the hæmorrhagic and slightly inflamed base was more suggestive of traumatism.

Dr. Bond asked if members had ever noticed the marked supervention of general tubercular symptoms after removing small tubercular growths.

Mr. Lake stated that the subject had been investigated by Clark, who concluded that such a complication was not usual—an experience which was corroborated by Dr. Watson Williams, who thought these cases generally improved after operation.

Case of Tuberculoma on the Right Vocal Cord.

Shown by Mr. Lake. This was a small tumour on the right vocal process, which had been present about two weeks. It has been treated with lactic acid applications, and is now very much smaller than when he first saw the case.

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Cured Case of Laryngeal Tuberculosis.

Shown by Mr. Lake. The patient, a man æt. 35, was under treatment the early part of 1897, and was discharged cured on May 8th, 1897. When first seen he had redness and congestion of both cords, an ulcer on each towards the anterior extremity, and an irregular ulcer on the anterior part of the cricoid cartilage. The treatment consisted of daily intra-tracheal injections of a solution of naphthalene, 3 per cent., oil of cinnamon ½ per cent., in parolene.

Epithelioma of the Epiglottis.

Mr. Symonds showed a man (æt. 65) with epithelioma of the base of the epiglottis, also involving the tongue. The man came to the out-patient department at Guy's Hospital for the lump in his neck. The case was beyond operation on many grounds, and was exhibited to illustrate the large glandular infection in these cases; the patient has only recently complained of dysphagia, and noticed the glandular swelling two months before the dysphagia began.

Dr. Bond drew attention to the comparative frequency with which patients sought relief for glands in the neck secondary to malignant disease in the larynx before complaining of inconvenience due to the primary growth.

Mr. Waggett pointed out the value of "orthoform" in relieving the pain in advanced ulceration of the larynx, due to malignant disease.

Dr. Herbert Tilley had had similar experiences in the application of this remedy to relieve the dysphagia of tubercular ulceration of the pharynx and larynx. In a very advanced case in which he had recently used it, where the patient was literally starving to death, the insufflation of ten grains of orthoform enabled him to eat solid food with comfort, and the effect of one insufflation lasted nearly twenty-four hours. He had not met with any toxic effects, and compared with the drawbacks of morphia and the temporary anæsthesia of cocaine he thought the remedy was of very great value.

Dr. MacGeagh had found it very valuable in relieving the pain of an ulcer of the leg, and Mr. Lake pointed out that in order to obtain its good effect a breach of surface was necessary.

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Case of Removal of Small Fibroma of Vocal Cord with extremely Pendulous Epiglottis.

Shown by Dr. Dundas Grant. The patient, a young man, had been hoarse for about fifteen months, the epiglottis was extremely pendulous, and the cords could only be seen with great difficulty. A small growth could be detected at the junction of the anterior and middle third of the right vocal cord, and Dr. Dundas Grant's endolaryngeal forceps were introduced *à l'aveugle.* On the first occasion a small piece of the mucous membrane of the ventricular band was cut off, leaving a superficial sore which speedily healed. On the next occasion the growth was alone removed in its entirety. The exhibitor thought it would have been almost impossible to remove the growth with an unguarded instrument.

Dr. Herbert Tilley gave details of an identical case at present under his treatment. The patient was a clergyman with a soft fibroma on the anterior third of the left vocal cord. It was impossible to get any view of the larynx without cocainising the posterior surface of the epiglottis, and then holding it forwards whilst the other hand held the laryngoscope. The patient himself could only exhibit the arytænoids when phonating an *e.* The speaker had successfully removed nearly all the growth by means of Grant's forceps, and like that operator had been obliged to introduce them "in the dark," so to say. He raised the question as to whether in these particular cases, where one has to adopt such a method and it fails to remove the growth, one is justified in advising external operation, *e. g.* splitting of the thyroid. He was aware there was the difficulty of getting accurate apposition of the cords after the operation, but thought it not an insurmountable one. A tracheotomy would scarcely be necessary. He asked if members had had any experience of the operation; he himself had none. In cases of tubercular ulceration of larynx in suitable early cases he thought the operation was advisable, and should perform it when opportunity offered itself, but of course these cases were on a different footing from those of simple growth.

Dr. Bond cited two cases of tubercular laryngitis in which he had performed laryngo-fissure, one of which was successful.

Dr. StClair Thomson observed that the last remarks were in reference to laryngeal conditions which could not be reached *per vias naturales.* With regard to simple tumours of the larynx, he believed that in the last four years, at least, no case had presented itself in the clinic of any member of the staff of the Throat Hospital, Golden Square, which had not been successfully dealt with through the mouth. As to the question of laryngo-fissure for such cases, he quoted the publications of Professor Massei of Naples, who had had an extensive experience, and had recently published the statistics of

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his 500 cases of laryngeal neoplasms. Dr. Massei protested strongly against external operation for simple growths, as being never quite free from danger, and often productive of damage to the voice.

Mr. Symonds said he would hesitate to advise the external operation where he had failed to secure a growth by forceps without asking the assistance of some colleague whose dexterity might be greater than his own. In two cases recently he was happy to see the patients relieved in this way. We were not all equally gifted with the manual dexterity requisite for such operations. With regard to the accuracy with which the cords can be adapted after thyrotomy, he would point out that perfect adaptation of the divided edges of the thyroid cartilage does not necessarily include complete restoration of the position of the cords. He pointed out that even in the most careful hands it was not always possible to make the section exactly between the cords, and he had seen a cord divided in very experienced hands. Therefore he would strongly oppose external operation in simple growths until the most skilled help at disposal had failed. He had known a case recently of complete recovery after external operation had been proposed by another operator who had failed to remove intra-laryngeally. In tubercle he had operated in two cases, only to make the patient much worse. In the early stages, where inaccessible to forceps, it might be advisable.

Mr. Waggett thought that in discussing this question consideration should also be taken of the formation of granulations on the posterior aspect of the wound. Such formations might cause as much functional disturbance, and give as much trouble in their treatment, as the original growth.

Dr. Permewan could not see the justifiability of thyrotomy in these cases of innocent growths. Loss of voice was the only inconvenience, and owing to the difficulty of exactly hitting the middle line in splitting the thyroid, and to the formation of granulations and cicatrices in healing, the voice was very unlikely to be improved by the operation. But in tubercular disease he thought thyrotomy had a future before it, and he personally would not hesitate to do the operation in a suitable case. But, as a matter of fact, so much could be done by intra-laryngeal surgery that there was seldom any necessity or indication to do more.

Dr. Dundas Grant, in replying, contended for patience in the use of endolaryngeal instruments in cases of non-malignant disease, and protested against the too ready performance of thyrotomy for the relief of conditions which impaired the voice without threatening life. In malignant disease, on the other hand, the justifiability and necessity for early thyrotomy were unquestionable.

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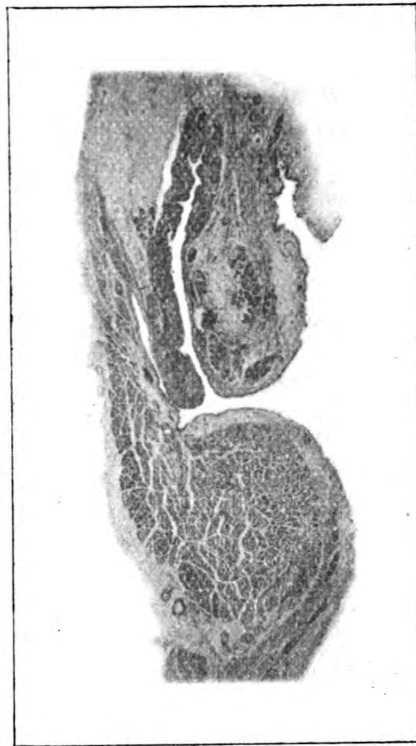
Microscopic Preparations of a Growth within the Ventricle of a Larynx: its Nature considered with reference to the Condition of "Hernia" or "Prolapse" of the Ventricle.

Dr. Jobson Horne showed the right half of a larynx cut into a series of microscopic sections to demonstrate the topography and nature of a tongue-like growth dependent from the roof of the ventricle.

Dr. Horne considered that the specimen perhaps threw light upon the histology of some of those tumours variously described as pro-



lapsus, procidentia, or hernia ventriculi, or fibroma ventriculi; and if seen during life it would probably have been described under one or other of these terms.

The growth was more fully developed in the middle third of the ventricle, and a microphotograph of a section in this region that was shown is reproduced. Under the microscope the tongue-like excrescence was seen to be very similar in structure to the adjacent ventricular band. It was covered from root to tip with a columnar epithelium, which at points of pressure had been worn away, but had undergone

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no metaplasia. Immediately subjacent to these points of detrition there was some small-cell proliferation, and this, in the absence of any specific irritant, Dr. Horne was inclined to attribute to traumatism, occasioned by compression of the growth within the sacculus. The growth, taken as a whole, suggested a duplication of the ventricular band.

In reply, Dr. Horne regretted he was unable to say what clinical symptoms, if any, the condition described had given rise to during life. For the larynx he was indebted to Professor Kanthack. Sections were cut on account of some plication of the epithelium about the vocal processes, and the growth was then met with. Such a growth he thought might readily become the site of tubercular disease in a predisposed subject. From the ventricles of larynges removed from persons that had died of pulmonary tuberculosis, but which presented no macroscopic evidence of laryngeal tuberculosis, he had frequently been able to obtain tubercle bacilli; and in sections cut from such larynges he had found the disease commencing in the posterior and inferior parts of the ventricular band. Minor spurs and excrescences springing from the roof of the ventricle he had met with, but not with such a growth as the one here described.

Laryngeal Forceps.

Dr. Watson Williams showed a pair of laryngeal forceps which had been made from his design. By means of two finger openings in the lower handle, greater steadiness in manipulation is obtainable than in many of the ordinary patterns in use.

Papilloma of Uvula.

Mr. Lawrence showed a case of papilloma springing from the juncture of the uvula and soft palate on the left side, in a boy æt. 15. There was no history of its duration. It caused no symptoms, and was noticed in treating the patient for other throat trouble.

Case of Dislocation of the Triangular Cartilage of the Septum.

Shown by Dr. Pegler. H. J—, æt. 27, received a blow on the nose from a cricket ball last September. The impact occurred from below. The patient entered a provincial hospital, and after the swell-

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ing had subsided some operation was deemed advisable, as the scar of an incision is now visible on the dorsum just below the nasal prominence. This disfigurement, together with that resulting from the sunken cartilage, induced the patient to seek further advice. A secondary source of trouble is obstruction to breathing through the nose. On introducing the index fingers into the nasal cavities a sensation as of splitting of the triangular cartilage is felt above at the osseo-cartilaginous juncture. The two lateral halves seeming to separate again when the pressure is taken off, the nasal obstruction is caused by a prominent acuminated cartilaginous spur in the left fossa, and a smaller basal spur in the right one.

Dr. StClair Thomson was not sure that the cartilages seen in each nostril were the displaced lateral cartilages. He was of opinion that what was seen was the broken and dislocated triangular cartilage, for on placing a finger in each nostril it was easily felt that there was no cartilage in the ordinary position, the anterior part of the nostrils being only separated by a septum of mucous membrane. With regard to treatment he advised avoidance of interference in such cases for merely cosmetic reasons. In numbers of these affections of the nose the cause of the collapse of the bridge was not simply the absence of the support of the septum, but the retraction of scar tissue. Surgical interference in this case would possibly only lead to more cicatrisation, and therefore a more saddle-backed nose. He had recently operated on a case where he had been successful in restoring a perfectly upright septum, but the external disfigurement remained. In the present case he suggested that the patient might always wear at night, and possibly by day, the hollow vulcanite splint used in Asch's operation. It would prevent further collapse.

Dr. Dundas Grant had been unable to follow Roe's description of his operations for relief of deformity in similar cases. He thought improvement could be effected by making a median incision and removing the more prominent portion of the nasal bones. In reply to Dr. StClair Thomson, Dr. Dundas Grant pointed out that it was in syphilitic disease that cicatricial contraction was especially accountable for deformity, but that in a traumatic case like the present the same principle was not so applicable.

Dr. Permewan could not see any great need for any surgical interference in this case, and would limit himself to cutting off the projecting pieces of cartilage without regard to their exact anatomical position. Like Dr. Grant, he had found it rather difficult to follow Dr. Roe's methods of subcutaneous operation, though he had been much struck by his excellent results, as shown at Montreal last year.

Dr. Pegler said he gathered that the consensus of opinion was in favour of letting the case alone. He would, however, restore the obstructed breathing way, think over the suggestions that had been made for curing the deformity, and report the result if any operation were undertaken.

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Case of Tubercular Laryngitis.

Shown by Dr. Snell. Patient is a married woman 21 years of age. Hoarseness commenced about twelve months previously, shortly before confinement, and has continued to the present time, while some dysphagia and much irritable cough are now present. There is some tubercular taint on her mother's side. There are dry cavities at the apex of right lung. General health is fairly good.

In the interarytænoid region there is a papillomatous-looking mass, probably a tuberculoma, and this was at first almost the only lesion observable, but recently some thickening of the arytæno-epiglottidean folds has appeared, and they are of a dark red colour. There is also some swelling of the false cords. A shallow ulcer is present on the surface of the right cord.

The chief interest in the case is the initial interarytænoid swelling, without other pathological appearances usually characteristic of early tubercular laryngitis.

Dr. StClair Thomson pointed out that the anæmic condition of the larynx, the situation of the hypertrophy in the interarytænoid region, and especially the marked subglottic thickening, all pointed to the case being undoubtedly tubercular. He would not recommend active local treatment.

Tumour of Right Vocal Cord—Case for Diagnosis.

Shown by Mr. H. Betham Robinson. F. G—, æt. 38, complained of hoarseness in 1892, when a growth on the first vocal cord was diagnosed by his medical attendants. Not improving under treatment he applied to St. Thomas's Hospital early in 1893, where the presence of a growth was corroborated and it was painted with acid, which resulted in his getting quite well. He remained quite well till early in May, 1898, when the hoarseness returned, and on June 2nd he again became a patient at St. Thomas's under Mr. Robinson. Examination showed a small sessile swelling a little in front of the middle of the right cord. Its size is about that of a split pea, and it springs from the margin of the cord; it is white in colour, convex on the surface, and evidently is affected by compression on approximation of the cords. The tissues around its base are infiltrated, but the rest of the cord and larynx

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appear healthy. There is no pain or cough, but there is a family history of tuberculosis, and the patient himself shows old cicatrices in the neck, but his chest is normal. There is no history of syphilis.

Dr. StClair Thomson thought the growth might be taken as a fibroma, but strongly suspicious of malignancy. In support of the latter was the situation of the growth in the middle of the cord (too far backward for speaker's nodule, and too far forward for pachydermia), its white appearance, and the way in which it seemed to infiltrate the cord, although the latter moved freely. Still, it would be easy to remove a good portion with the forceps, and obtain a satisfactory microscopic specimen.

Dr. Jobson Horne also considered that the position of the growth was not that typical of pachydermia verrucosa laryngis.

Mr. Symonds suggested that this might be a case of pachydermia because of the pyramidal shape, the white summit, and the way in which it was reduced by the pressure of the opposite cord in phonation. The short history of hoarseness, he thought, also supported this view. It was not typical, but resembled pachydermia more than any other formation. He would suggest that the case be watched without any active interference.

Dr. Dundas Grant thought the site was unusual, being neither at the junction of the anterior and middle thirds nor at the vocal process. He recommended removal by means of a suitable instrument —for example, his own endolaryngeal forceps,—and the subsequent application of salicylic acid. The surface of the growth suggested that it was of a warty nature.

Difficulty of Swallowing in an Infant.

Shown by Dr. Bond. Patient, a female infant of 10 months, has always had a great difficulty in swallowing fluids. The child chokes on trying to swallow, makes an attempt many times, and finally swallows a little fluid, generally with a crowing inspiration. Occasionally some of the fluid gets into the nose. There is no history of diphtheria.

Tuberculosis of Larynx and Fauces.

Dr. Jobson Horne showed a case of tuberculosis extensively involving the larynx, soft palate, and left tonsil, occurring in a young man æt. 21, who had sought relief for dysphagia and aphonia.

The patient dated the onset of the disease from an attack of hæmoptysis some eighteen months previously, whilst in his usual health, and free, as he thought, from any lung affection. Hoarseness quickly

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followed the hæmoptysis. When the man came under treatment some three months ago the epiglottis was considerably thickened and turban-shaped, and the free border along the right side was ulcerating. The dysphagia was intense. The laryngeal mucosa was universally infiltrated, and in places ulcerating. The disease had also attacked the soft palate about the base of the uvula and the palatine arches.

The apices of both upper lobes of the lungs were infiltrated. The epiglottis was curetted and the larynx treated with lactic acid. The dysphagia was considerably relieved, and the patient went to the seaside for a while, where he materially improved. He had now returned with the disease spreading about the left palate and left tonsil, which was excavated, and Dr. Horne was desirous of receiving suggestions as regards further treatment. Although no tubercle bacilli had been detected in the tissue removed from the epiglottis, it was undoubtedly of a tubercular nature.

Correction.

In 'Proceedings' of May 11th, p. 85, Dr. Pegler's remarks should follow Dr. Grant's case of "Sigmatic Dyslalia," p. 86.

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1895 *MACGEAGH, T. E. FOSTER, M.D., M.R.C.S., L.S.A., 23, New Cavendish street, W.

1898 McILRAITH, CHAS. H., M.D., 17, Stradella road, Herne Hill, S.E.

1894 MACKENZIE, HECTOR WILLIAM GAVIN, M.D., F.R.C.P., 59, Welbeck street, W.

1897 PAGET, STEPHEN, F.R.C.S., 70, Harley street, W.

1893 *PEGLER, LOUIS HEMINGTON, M.D., 27, Welbeck street, W.

1895 PERKINS, J. J., M.B., Hospital for Consumption, &c., Brompton.

O.M. POLLARD, BILTON, F.R.C.S., 24, Harley street, W.

1894 POTTER, EDWARD FURNISS, M.D., 27, New Cavendish street, W.

1894 POULTER, REGINALD, 4, Gordon mansions, Francis street, Gordon square, W.C.

1897 RAMSAY, HERBERT, F.R.C.S., 35A, Hertford street, Mayfair, W.

O.M. REES, JOHN MILSOM, F.R.C.S.Ed., 53, Devonshire street, Portland place, W.

1898 ROBINSON, H. B., M.S., F.R.C.S., 1, Upper Wimpole street, W.

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1893 SANTI, PHILIP ROBERT WILLIAM DE, F.R.C.S., 91, Harley street, Cavendish square, W.

1896 SCHORSTEIN, GUSTAVE, M.A., M.B., F.R.C.P., 11, Portland place, W.

O.M. *SEMON, SIR FELIX, M.D., F.R.C.P., 39, Wimpole street, W. *P. V.-P. C.*

1894 SHARMAN, HENRY, M.D., 16, Frognal, Hampstead.

1893 SPENCER, WALTER GEORGE, M.S., F.R.C.S., 35, Brook street, Grosvenor square, W.

1898 SPICER, FREDK., M.D., 57, Devonshire street, W.

O.M. SPICER, SCANES, M.D., 28, Welbeck street, Cavendish square, W. *S. C. V.-P.*

1895 STEPHEN, G. CALDWELL, M.D., L R.C.P., 54, Evelyn gardens, South Kensington.

1898 STEWARD, FRANCIS J., M.S., F.R.C.S., 24, St. Thomas's street, S.E.

O.M. STEWART, WILLIAM ROBERT HENRY, F.R.C.S.Ed., 42, Devonshire street, Portland place, W. *S. C.*

O.M. *SYMONDS, CHARTERS JAMES, M.S., F.R.C.S., 26, Weymouth street, Portland place, W. *C. V.-P.*

1894 *THOMSON, STCLAIR, M.D., 28, Queen Anne street, Cavendish square, W. *S.*

1896 THORNE, ATWOOD, M.B., M.R.C.S., L.R.C.P., 10, Nottingham place, W.

1893 TILLEY, HERBERT, M.D., B.S., F.R.C.S., 101, Harley street, W. *S.*

1893 WAGGETT, ERNEST BLECHYNDEN, M.B., 45, Upper Brook street, Grosvenor square, W.

O.M. WALSHAM, WILLIAM JOHNSON, F.R.C.S , 77, Harley street, W. *T.*

1896 WHAIT, J. R., M.D., C.M., L.R.C.P., M.R.C.S., Charltons, Fairhazel gardens, South Hampstead.

O.M. WHISTLER, WILLIAM MACNEILL, M.D., M.R.C.P., 18, Wimpole street, W. *V.-P. C.*

1893 WHITE, WILLIAM HALE, M.D., F.R.C.P., 65, Harley street, W.

O.M. WILLCOCKS, FREDERICK, M.D., F.R.C.P., 14, Mandeville place, Manchester square, W.

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1897 WINGRAVE, V. H. WYATT, M.R.C.S., 11, Devonshire street, W.

1897 YEARSLEY, P. MACLEOD, F.R.C.S., 33, Weymouth street, W.

COUNTRY.

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1896 AGAR, MORLEY, M.R.C.S., L.R.C P., Ponder's End, Middlesex, and 70, Wimpole street, W.

O.M. BABER, EDWARD CRESSWELL, M.B., 46, Brunswick square, Brighton, and 57, Wimpole street, W. *C. V.-P.*

1895 BARK, JOHN, F.R C.S.Ed., M.R.C.P.I., 54, Rodney street, Liverpool.

1895 BARON, BARCLAY J., M.B., 16, Whiteladies road, Clifton.

1897 BEAN, C. E., F.R.C.S., 19, Lockyer street, Plymouth.

O.M. BENNETT, FREDERICK WILLIAM, M.D., 25, London road, Leicester. *C.*

1895 BRADY, ANDREW JOHN, L.R.C.P.&S.I., 3, Lyons terrace, Hyde park, Sydney, New South Wales.

O.M. BRONNER, ADOLPH, M.D., 33, Manor row, and 8, Mount Royd, Bradford. *C. V.-P.*

1894 BROWN, ALFRED, M.D., Sandycroft, Higher Broughton, Manchester.

1898 BROWN, ERNEST R., M.D., C.M., Montreal, Canada.

1898 BURT, ALBERT H., M.R.C.S., L.R.C.P., Throat and Ear Hospital, Brighton.

1893 CHARSLEY, ROBERT STEPHEN, M.R.C.S., L.R.C.P., The Barn, Slough, Bucks.

1898 CLAREMONT, CLAUDE C., M.D., B.S., 57, Elm grove, Southsea.

1893 **DAVISON, JAMES**, M.D., M.R.C.P., Streate place, Bath road, Bournemouth.

1895 DOWNIE, J. WALKER, M.B., 4, Woodside crescent, Glasgow.

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1893 Embleton, Dennis Cawood, M.R.C.S., L.R.C.P., St. Wilfrid's, St. Michael's road, Bournemouth.

1893 Foster, Michael, M.B., Villa Annita, San Remo.

1895 Fourquemin, George Vincent, L.R.C.P., care of Messrs. Buchanan, Forsyth & Co., West street, Durban, South Africa.

1898 Foxcroft, F. W., M.B., 33, Paradise street, Birmingham.

1898 Frazer, Wm., L.R.C.P., Johannesberg, South Africa.

1897 Herdman, Ronald T., M.B., C.M., Gwélo, Rhodesia, South Africa.

O.M. Hodgkinson, Alexander, M.B., 18, St. John street, Manchester. *V.-P.*

1894 Hunt, John Middlemass, M.B., C.M., 55, Rodney street, Liverpool.

1898 Hutchinson, A. J., M.A., M.B., 225, Bath street, Glasgow.

O.M. Johnston, Robert McKenzie, M.D., F.R.C.S.Ed., 2, Drumsheugh gardens, Edinburgh. *C.*

O.M. *Kanthack, Alfredo Antunes, M.D., F.R.C.S., Pathological Laboratory, Cambridge.

1898 Kelly, A. Brown, M.B., C.M., 26, Blythswood square, Glasgow.

1895 Lindsay, David Moore, L.R.C.P., L.R.C.S.I., 373, Main street, Salt Lake City, Utah Territory, U.S A.

1895 Macintyre, John, M.B., C.M., 179, Bath street, Glasgow.

1894 Mackern, George, M.D., Buenos Ayres, Argentina.

O.M. *McBride, Peter, M.D., F.R.C.S.Ed., 16, Chester street, Edinburgh. *V.-P.*

1898 **Marsh, F.**, F.R.C.S., 34, Paradise street, Birmingham.

1893 Milligan, William, M.D., 28, St. John street, Manchester.

O.M. **Newman, David**, M.D., 18, Woodside place, Glasgow. *C.*

O.M. *Parker, Charles Arthur, M.R.C.S., High street, Rickmansworth, Herts.

O.M. Paterson, Donald Rose, M.D., M.R.C.P., 18, Windsor place, Cardiff.

1893 Permewan, William, M.D., F.R.C.S., 7, Rodney street, Liverpool.

1895 Reynolds, Arthur R., M.D.(New York), 36, Washington street, Chicago, U.S.A.

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1895 Ridley, W., F.R.C.S., Ellison place, Newcastle.

1895 *Sandford, Arthur W., M.D., M.Ch., 13, St. Patrick's place, Cork, Ireland.

1898 Scatliff, J., M.B., M.R.C.S., 11, Charlotte street, Brighton.

1897 Sendziak, Dr. Johann, 139, Marszatkowska-Strasse, Warsaw, Russian Poland.

1898 Snell, Sydney, M.D., Shaftesbury House, Grays, Essex.

1896 Tomson, W. Bolton, M.D., M.R.C.S., L.R.C.P., Park street West, Luton, Beds.

1896 Turner, A. Logan, M.D., F.R.C.S.Ed., 20, Coates crescent, Edinburgh.

1893 Walker, Charles Rotherham, M.D., Glenfield, Silverdale road, Eastbourne.

1897 Walker, Henry Secker, F.R.C.S., 44a, Park square, Leeds.

O.M. Walker, Thomas James, M.D., 33, Westgate, Peterborough.

1895* Warner, Percy, M.R.C.S., L.R.C.P., Woodford.

1893 **Williams, Patrick Watson**, M.D., 2, Lansdowne place, Victoria square, Clifton, Bristol. *C.*

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LIST OF EXCHANGES.

PERIODICALS:

The Journal of Laryngology, Rhinology, and Otology (London).
The Laryngoscope (St. Louis, U.S.A.).
The Annals of Laryngology, Rhinology, and Otology (America).
Annales des Maladies de l'Oreille, &c. (Paris).
Archives Internationales de Laryngologie (Paris).
Revue de Laryngologie, &c. (Bordeaux).
Revue Internationale de Laryngologie, &c. (Paris).
Centralblatt für Laryngologie
Archiv für Laryngologie (Berlin).
Monatsschrift für Ohrenheilkunde, &c.
Archivio Italiano di Otologia (Turin).
Bollettino delle Malattie dell' Orecchio, &c. (Florence).
Archivii Italiani di Laringologia (Naples).

TRANSACTIONS OF THE FOLLOWING SOCIETIES:

British Laryngological, Rhinological, and Otological Association.
American Laryngological Association.
American Laryngological, Rhinological, and Otological Society.
Société Française de Laryngologie, &c.
Société Parisienne de Laryngologie, &c.
Gesellschaft der Ungarischen Ohren- und Kehlkopfärzte.

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Vol. 6

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *November 4th*, 1898.

HENRY T. BUTLIN, Esq., F.R.C.S., President, in the Chair.

HERBERT TILLEY, M.D., } Secretaries.
WILLIAM HILL, M.D., }

Present—36 members and 3 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were elected members of the Society:

F. J. Dixon, M.B., B.C., Welbeck Street, W.
Frederick Spicer, M.D., Devonshire Street, W.

LUPUS OF THE LARYNX (WITH MICROSCOPICAL SECTIONS AND DRAWINGS FROM A CASE).

Shown by Professor FERDINAND MASSEI, Naples (Honorary Fellow of the Society). A girl æt. 10 was seen last year by Professor Massei suffering from typical lupus of the larynx. A year previous the case had been sent to him as one of syphilis, the cutaneous manifestations having been diagnosed as such by a competent dermatologist. In spite of energetic antisyphilitic treatment matters underwent no amelioration, and whatever change took place was for the worse. Professor Massei then decided that the affection of the larynx was lupus, and the cutaneous appearances confirmed this diagnosis. The lungs were normal. Sections of tissue removed from the epiglottis showed giant-cells around which were disposed

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epithelioid cells in the manner characteristic of tubercle. Inoculations of guinea-pigs were, however, unfruitful, but recently the patient presented symptoms of pulmonary phthisis.

He proposes to do away with the distinction between tuberculosis and lupus, holding that they are identical, as shown in this case by the microscopical appearances and the recent development of consumption. The negative result of inoculation is not, in his opinion, a disproof, because it goes along with the extreme scantiness of the bacilli in lupus tissue, which is so well recognised.

(Professor Massei has presented to the Society the sections from this case, and they may be seen on application to the Librarian.)

Mr. Wyatt Wingrave thought that the non-differentially stained specimen presented by Professor Massei was hardly sufficient evidence of the pathological identity of lupus and tubercle; and since there was much difference of opinion as to their respective histological details, a demonstration of bacilli would have proved of great interest and importance.

Sir Felix Semon said that he thought it was generally agreed that lupus and tubercle were essentially the same, but that the former was characterised by its chronic course and the paucity of tubercle bacilli, whereas comparatively opposite conditions held in tubercle.

Man aged 51 with Hypertrophic Laryngitis of Doubtful Nature.

Shown by Dr. StClair Thomson. The patient, J. H—, æt. 51, had been hoarse for eight months. There was no specific history; the lung-sounds were normal; and the patient confessed to having taken very freely of alcohol. He has been under iodide of potassium for over a month without any improvement. There is an irregular growth on the right processus vocalis; the right cord is decidedly impaired in its movement. There is thickening of the opposite (left) processus vocalis and general hypertrophic laryngitis. No glands are to be felt. The patient has not lost flesh. There is a good deal of chronic rhinitis.

Sir Felix Semon was not certain that the case was simply hypertrophic laryngitis; there was some defective mobility of the right vocal cord, and a small excrescence on the vocal process.

This suggestion of malignancy was also endorsed by Dr. Bond, who thought that the absence of any intervals of improvement (which were frequent in simple chronic laryngitis) rather favoured the idea of grave disease.

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Mr. LAKE had seen the patient some time before, and on account of the rapid loss of weight and suspicious appearance had suggested exploratory laryngo-fissure.

Dr. STCLAIR THOMSON proposed to remove a portion of the growth from the right processus vocalis, and report to the Society as to its microscopical characters.

EPITHELIOMA OF LARYNX.

Shown by Dr. BARCLAY BARON (Bristol). Patient male æt. 64. About twelve months ago he found him suffering from extensive growth affecting the front parts of both vocal cords, especially the right and the anterior commissure. This was removed at several sittings by means of forceps and curette. The growths were multiple, not ulcerated, and there was no redness or swelling of surrounding structures, and the case was regarded as probably a non-malignant one. Some months ago he again came to the hospital, and the whole larynx was filled with warty growth, with redness and swelling of the right ventricular band. This was removed by a surgical colleague after thyrotomy, and proved to be epithelioma, and it has extensively recurred since the operation last June. Dr. Baron queried if this is not a case of transference of a benign into a malignant growth.

Sir FELIX SEMON rather questioned whether the papillomatous nature of the growth in the first instance was not more apparent than real. The warty appearance might be merely superficial, the separate papillomata growing from a common base. The man's age, again, was not in favour of a benign growth. Under all circumstances he thought the supposed transformation could not be classified otherwise than "extremely doubtful." He himself had hardly any doubt that the disease was malignant from the first.

SARCOMA OF NOSE.

Dr. BARON also showed a case of growth in the right nostril of a woman æt. 34 years. Three months ago she found some epiphora; an attempt was made to pass a probe through the lachrymal duct by her medical adviser, but he was unable to reach the nose. Since then there has been much pain over the eyebrow and roof of nose, some discharge from the nostril, and a gradual obstruction of it. She was seen in consultation, and the whole nostril found to be filled with a greyish growth which projected into the naso-pharynx. It bled freely

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on probing, and removal of a piece with a snare caused very free hæmorrhage. She also said that she had bled freely three times in a fortnight. There was a soft elastic swelling at the inner angle of the eye. Microscopically the growth appeared to be a mass of round cells, and the clinical history and appearance were believed to point to sarcoma.

Mr. SPENCER did not think that there were definite evidences of sarcoma present. The mass of granulations bathed in muco-pus might have an inflammatory origin, *e.g.* be gummatous, or have arisen in one of the sinuses. He advised that the nose should be first of all cleared out by curetting under an anæsthetic with the head hanging low, and then be plugged. In a day or two, on the removal of the plug, it would be possible to examine the interior of the nose and naso-pharynx completely. The subsequent course of the case would then enable a diagnosis to be made.

The PRESIDENT agreed entirely with Mr. Spencer as to the course of treatment he had suggested, and thought the mass had more the appearance of a benign than a malignant growth. He thought it would be very difficult to differentiate microscopically between a chronic inflammatory mass of this kind and a small round-celled sarcoma.

Mr. WAGGETT thought the microscopic specimen could not be distinguished from a mass of granulation tissue.

Dr. HILL had a similar case under his care eight years ago; as the pathological report declared a portion removed for microscopy to be undoubtedly malignant, he handed the case over to Mr. Page, who cleared the nose out by Rouge's operation. Slight recurrence took place from time to time, but the patient was still living and well, and the speaker had long ago been compelled to recognise that the case was really one of granulomatous growth associated with suppuration from the sinuses.

Mr. ROBINSON thought that there was a possibility of the lesion being tuberculous, the nose becoming infected subsequent to the injury. The crusted, dry appearance, and its localisation to one cavity, did not seem to favour the view of its sarcomatous nature.

The PRESIDENT thought that the smoothness of the swelling outside, and the ulceration inside, seemed to point more to an infective disease than to a new growth.

NASAL CASE FOR DIAGNOSIS.

Dr. BARON also showed a young man who had a blow on the nose six months ago. Three weeks afterwards he noticed a swelling on the outside of the nose, and this has increased steadily. It is red and hard, and presents no fluctuation. There was no discharge until

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about three weeks ago, when some pus came from the nostril, and Mr. Morton, under whose care the case was admitted at the Bristol General Hospital, took away a piece of necrosed cartilage. There is no history of syphilis, but he has taken antisyphilitic doses of iodide of potash for a month or so with no effect. There is some history of tubercle in the family, but the man is quite healthy excepting for the nose trouble.

The case was shown to get the opinion of the members as to the nature of the swelling, Dr. Baron believing it to be inflammatory, with necrosis and sequestrum of cartilage as the cause of it.

Cancer of Œsophagus with Paralysis of one Vocal Cord.

Shown by Dr. Watson Williams. W. D—, male, æt. 64, complained July 1st, 1898, of difficulty in swallowing, but early in the previous January he had noticed some difficulty in swallowing a piece of meat, which had increased gradually until he could only swallow soft food. He lost flesh considerably—nearly three stone in weight. In August, 1897, his voice had become slightly thickened and hoarse, and remained so since.

Laryngoscopic examination showed the right vocal cord in the cadaveric position, and pointed to a right recurrent nerve paralysis. There was no obvious cause for this, neither were physical signs in the chest indicative of organic lesions found. A No. 20 œsophageal bougie was easily passed into the stomach. No history of syphilis. Rest in bed and small doses of iodide of potash were followed by rapid improvement in swallowing powers and in his general health.

In five weeks' time marked inspiratory dyspnœa developed, increasing so rapidly that a low tracheotomy was performed with relief. He now expectorated quantities of mucus, and, rapidly sinking, died four days after the operation.

Post-mortem examination disclosed a circular perforation in the trachea two inches above the bifurcation, three quarters of an inch in diameter, and communicating with the gullet. The right posticus muscle was atrophied. The anterior gullet wall was invaded by an epitheliomatous growth, which involved also a post-tracheal gland. The right recurrent laryngeal nerve was involved in the growth and compressed. Old caseating tubercular deposits were found in both pulmonary apices, and the bases were affected with septic pneumonia.

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Dr. Williams pointed out that the value of recurrent paralysis as a symptom of malignant disease of the gullet depends much on the presence or absence of signs of organic disease in the chest cavity, which might also produce a similar paralysis. The early improvement under treatment in this case certainly might have at first suggested a thoracic aneurysm. It is worthy of note that the right cord was probably paralysed five months before he suffered from dysphagia.

Sir Felix Semon thought that in all cases where a patient died with paralysis of a vocal cord the laryngeal muscles should be carefully examined for varying degrees of degenerative changes, so that we might gain further and more exact information as to the question whether in organic progressive disease of the recurrent laryngeal nerve the abductor muscle was the first to succumb. Dr. Friedrich's descriptions of such cases had been most valuable.

A Case of Paroxysmal Sneezing associated with Great Hypertrophy of Tissues in Neighbourhood of the Septal Tubercle (shown at June Meeting).

Shown by Mr. Arthur Cheatle. A man complained of nasal obstruction and violent attacks of sneezing. On the right side a pink soft mass, springing from the septum opposite the middle turbinal, extending downwards and forwards, having a broad base with slightly overhanging lower edge, quite obscured the middle meatus and reached down to the inferior turbinal. The same condition existed on the left side, but to a much less degree, the mass being pale.

With a cold snare a large portion of the mass on the right side was removed. Sections showed great hypertrophy of the normal tissue; numerous glands, giving an almost adenomatous appearance with large blood-spaces, and great increase of connective tissue.

Dr. Pegler thought one would be scarcely justified in designating this case an adenoma of the septum, because, although the microscopic sections displayed an abundance of racemose glands, this was a common condition in mucous membrane hypoplasiæ of the septum and turbinals.

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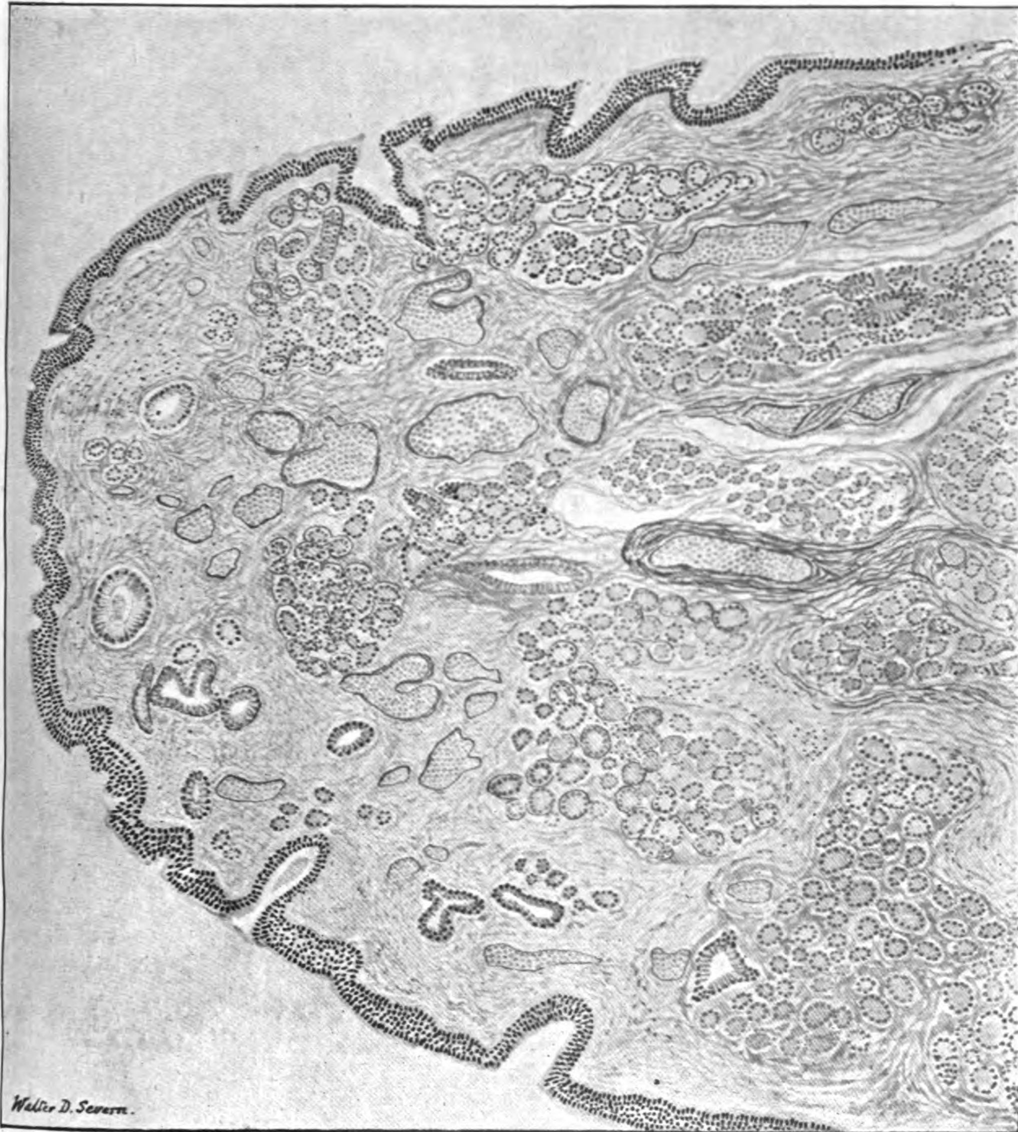

MR. ARTHUR CHEATLE'S CASE.

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GROWTH IN ANTERIOR COMMISSURE HAS BEEN REMOVED, BUT PARESIS OF RIGHT CORD REMAINS (PATIENT SHOWN AT MARCH MEETING).

Shown by Dr. PEGLER. The small commissural fibroma of left cord was removed with forceps six months ago, *i.e.* immediately after patient was shown to the Society.

All trace of the growth has now disappeared, but the abductor paresis of the opposite (right) cord remains unchanged.

The voice is much improved.

CASE OF LARGE ANGIOMA OF LARYNX.

Shown by Dr. BOND. Patient male æt. 55. When a boy he used to shout tremendously. He has had hoarseness for about twenty-eight years; some twenty years ago he was under Sir M. Mackenzie, who found and treated the tumour in larynx. Since then the patient has occasionally attended at Golden Square. An account of the case was published by Dr. Wolfenden in 1888 in the 'Journal of Laryngology.' At various intervals patient has spat up blood, and when seen by me in March last was coughing up blood and phlegm freely.

He has a dark bluish tumour on right ventricular band, covering quite two thirds of it; there is a separate little offshoot above, and a third one on left ventricular band in front. The cords are apparently free.

Patient says that he used to be treated weekly with the galvano-cautery. It is a question, considering the severe hæmorrhage last March, whether one should not do a more radical operation, and the opinion of the Society on this point was desired.

Mr. SPENCER supported the proposal of Dr. Bond to perform thyrotomy and freely excise the disease. He noted that the cord on the right side moved very little, and there was a small glandular enlargement in front of the carotid on that side. It was possible that the growth was tending to show malignant characters.

The PRESIDENT concurred with the suggestion of surgical interference.

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? Epithelioma of Larynx.

Shown by Mr. Steward for Mr. Symonds. D. H—, æt. 55, attended at Guy's Hospital on August 5th, 1898, for partial loss of voice and pain in the throat and below the right ear. The loss of voice began in December, 1897, after an attack of influenza, and since that time has been gradually increasing. Examination showed an irregular thickening of the right vocal cord, which, however, was distinctly moveable. Iodide of potassium was prescribed. A fortnight later the right cord was found to be fixed, and some irregularity of the false cord was noticed.

On September 23rd the growth was distinctly larger, and some blood had been coughed up. A small piece of growth was removed, and reported, after examination by the pathologist, to be inflammatory. After this some improvement in symptoms took place, for on October 23rd the patient reported that he was free from pain, and that he could speak with less effort. There was, however, no change in the laryngoscopic appearances.

Drs. Spicer and Grant thought the case was malignant.

Sir Felix Semon could not, however, satisfy himself that the ulceration described by the first speaker was at all obvious.

Large Lipoma of Soft Palate.

Shown by Dr. Bond. Patient is a female æt. 49. She has a large semi-fluctuating tumour in soft palate on right side, extending on left beyond mid-line and on the right behind angle of jaw. Eight years ago he removed a large, many-lobed fatty tumour through external incision in parotid region. The mass removed weighed several ounces. The operation was followed by right facial paralysis, from which patient has almost recovered.

The original tumour was a parotid one; the present one has probably developed from some fragment left.

Six years ago her right breast was removed in one of the London hospitals.

The President thought that it would be possible to remove the tumour of the palate, which might easily shell out through a fair incision.

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Tubercular Laryngitis after Removal of Large Interarytænoid Mass.

Shown by Mr. Lake. The patient, a girl of 21, had been under treatment for eight months. When first seen she had bilateral ulceration of the vocal cords, great bilateral swelling of the arytænoid cartilages, and a very large interarytænoid mass. The arytænoids were treated by double curettage in April, and had not been enlarged since, and the cords were quite healed. The mass removed from the interarytænoid fold was shown, as also were Mr. Lake's forceps for the removal of such growths.

Dr. Herbert Tilley thought that Mr. Lake was not only to be congratulated on the excellent result attained in this case, but also for bringing the instruments to such perfection and making it a comparatively easy task to deal with such cases of tubercular laryngitis. He has seen great relief afforded patients by removal of these œdematous masses, and had no doubt that they would see many more in the immediate future.

A Case of Membranous Laryngitis.

Shown by Mr. Lake. The patient, a man æt. 25, was the subject of a laryngitis of combined tubercular and syphilitic origin. He had loss of voice of eight weeks' duration. On October 17th a white membrane was noticed on the posterior surface of the epiglottis, which had recurred after removal.

In reply to Dr. Thomson, Mr. Lake said that no bacteriological examination had yet been made, but a further report was promised.

Paresis of the Right Facial Nerve and of the Right Side of the Palate following Tympanic Suppuration.

Dr. William Hill showed a female æt. 24 exhibiting this unusual condition. Right tympanic suppuration followed measles eight years ago; a polypus was removed about four years later, and after this operation the right side of the face was said to be "drawn up;" two years ago, however, this side "got weak," and the face was drawn up on the opposite side. For a year she has experienced some difficulty in swallowing, especially solids, though fluids have occasionally passed into the naso-pharynx; she has continuously "felt a lump" in her throat.

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There is now, in addition to facial paresis, marked asymmetry of the palate, the arch being much higher on the left side; the right is flaccid, and the uvula is adherent to this side. The reflex, which is very active on the left side, appears to be absent on the right. There is reaction of degeneration in the right facial nerve, but for want of a suitable electrode this test has not yet been applied to the palate.

The view that the palate was partly supplied by the facial through the vidian and large superficial petrosal nerves has been taught by anatomists since the time of Sir Charles Bell down to the present decade; but neurologists have for several years, on clinical and experimental grounds, combated this teaching, pointing out that the true motor supply of the palate is from the medullary fibres of the spinal accessory. The case was therefore of great neurological interest, few reliable cases having been recorded, and it was desirable to ascertain the views of the members as to whether the asymmetry of the palate was actually due to motor paresis (and not to an acquired or congenital deformity); and if so, the further question had to be faced, whether the paresis of the facial muscles and of the palate were due to a common lesion within the temporal bone rather than representing an accidental association.

Dr. Dundas Grant was of the opinion that the median position of the dimple in the palate during phonation was a strong argument against the diagnosis of hemiplegia of the larynx. He considered the appearance, apart from the phonation, as inconclusive, and was inclined to think that the asymmetry then present was due to inflammatory changes in the pillars of the fauces, and not to nerve lesion.

Frontal Sinusitis.

Dr. Hill also showed a male æt. 40, on whom he had recently operated for chronic suppuration of the frontal sinus by the Ogston-Luc method. The chief points of practical interest in the case were: (1) the shortness of the skin incision along the brow; (2) the perfect æsthetic effect, as the scar was barely visible, and the previous displacement outwards of the eye had disappeared; (3) no drainage-tube was employed.

Dr. Herbert Tilley, in reply to a question as to what instrument was used to make a free passage into the nose, said that he had found a Krause's antrum trocar fulfil the object very well, the slight curve on the instrument being just that which was necessary.

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Case of (?) Œsophageal Pouch.

Shown by Mr. Cresswell Baber. F. G—, a butler, æt. 62. First seen at the Brighton Throat and Ear Hospital on October 24th, 1898. For over a year he had had a peculiar sensation in his throat as if his uvula were too long, and he brought up a quantity of phlegm. Seven or eight months ago he first noticed that he returned lumps of undigested meat which had been taken the day before. This usually happens in the morning after breakfast, when they return together with fragments of that meal. There is no marked difficulty in swallowing, but occasionally he has to make two efforts before the act can be accomplished. Solids are more troublesome to swallow than liquids. He feels satisfied after a meal, and is conscious that he swallows most of the meal without any difficulty. No vomiting or pain. He has a "croaking" or gurgling noise in his throat, especially when lying down and at meals, which is followed by the bringing up of quantities of phlegm. He often has to leave the table because of the discomfort.

On examination the pharynx is irritable and congested, and uvula thick. Larynx congested, especially the cords; otherwise it is normal. Much white frothy secretion is seen coming up behind the arytænoids. External examination shows a doubtful fulness in the left posterior inferior triangle of the neck, but I have not examined him after a full meal. Pressure with the fingers above the clavicles, especially at the left side, produces a gurgling noise, and escape of gas by the mouth; and after he has swallowed some milk and bread, pressure in this region causes it immediately to return. Liquid taken alone is partly returned when he stoops sharply forward. Patient is well nourished, and has not lost flesh to any extent. His weight, which on July 26th, 1898, was 12 st. 9½ lbs., and on August 30th 12 st. 13 lbs., is now (October 31st) 12 st. 11 lbs. I have passed two large-size elastic bougies down, and they both became arrested about nine inches past the teeth. The ends could not be distinctly felt in the left posterior inferior triangle. Chest normal, except a narrow patch with slightly impaired resonance under the left clavicle.

Dr. StClair Thomson suggested that the case afforded a useful field for the employment of the Röntgen rays. He had not himself had such a case, but it had occurred to him that if two metallic bougies were passed down the œsophagus, one into the pouch and

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the other into the stomach, and if an X-ray photograph were then taken of the neck and chest, we might get very useful information as to the situation and relationship of this pouch.

The PRESIDENT said that before operating to remove the pouch the patient should be carefully examined in order to ensure he was in a fit state of health, and that it should be clearly ascertained that there was no organic stricture of the œsophagus, a probe passing easily into the stomach as well as into the pouch.

AN EXCEPTIONAL CASE OF CLEFT PALATE.

Shown by Mr. MORLEY AGAR. The bony cleft was on the left side, and only showed the inferior turbinate in its whole length. There was also some deformity of the vomer.

Mr. ROBINSON was of opinion that this deformity was not very unusual. He explained it as a complete cleft from front to back, but to the left side of the mid-line, so that there was non-union on the left side of the maxilla to the pre-maxilla, and of the palatal processes of maxilla and palate to their fellows on the right side. The appearance posteriorly was due to the dragging well to the right of the soft palate and the sloping edge of the bones, and the right posterior choana thus coming into view.

NOTES OF A CASE OF ULCERATION OF THE SOFT PALATE.

Shown by Mr. PARKER. A. G—, male, æt. 32. Last Easter his throat became very sore—was said to be ulcerated. After ten weeks' treatment it got quite well, and remained so till a few days ago. He has always been a strong healthy man, and denies all history of syphilis. He had gonorrhœa thirteen years ago. He is married and has three healthy children, but he states that his wife has had two or three miscarriages.

On examination the soft palate and uvula are found to be covered with a ragged, straggling ulceration of a superficial character; between the patches of ulceration there is a peculiar nodular appearance, and there is a small areola of redness round the diseased parts.

The diagnosis lies between tertiary syphilis and tuberculosis. The former seems to be more probable.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *December 2nd*, 1898.

F. DE HAVILLAND HALL, M.D., Vice-President, in the Chair.

HERBERT TILLEY, M.D.,
WILLIAM HILL, M.D., } Secretaries.

Present—37 members and 10 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentleman was nominated for election at the next meeting:

H. St.George Reid, 25, Old Burlington Street, W.

REPORT OF THE MORBID GROWTHS COMMITTEE.

Slide L.S.L. 16.—Section of growth removed from a female patient of Dr. Barclay Baron's, shown at meeting November 4th, 1898. The Committee report that the specimen submitted to them contains a mass of large polyhedral embryonic cells, which some would term an alveolar sarcoma, others spheroidal-celled carcinoma. Some of these cells are in an active stage of proliferation. The arrangement of the cells tends to show some trace of alveolation, and it is noticeable that there is an intra-cellular fibrous structure. In deeper portions of the section there are evidences of inflammatory change, some recent and some of longer standing. Blood spaces are seen without definite walls. In our opinion the growth belongs to a class which behaves in many respects like sarcoma, but showing slight and local malignancy.

Slide L.S.L. 17.—Sections of glands under sterno-mastoid to-

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gether with portion of internal jugular vein, removed from patient shown by Dr. Bond May 13th, 1896, p. 86; November 11th, 1896, p. 4. Report on section January 13th, 1897, p. 40. Case "Sarcoma of Nose."

The Committee regret that owing to some mistake in the constitution of the fluid in which the growth was originally placed, the mass had almost decomposed before they received it, and only one small portion was at all suitable for sections. This portion was undoubtedly of malignant nature, but whether it was a spheroidal-celled carcinoma or an alveolar sarcoma the condition of the section rendered it impossible to decide.

Wall Charts for Teaching Signs of Suppuration in the Nasal Sinuses.

Shown by Dr. Dundas Grant. These charts were drawn up by Dr. Grant to illustrate his lectures in June, 1898, and were founded mainly, but with various modifications, on the classifications of signs as *presumptive, probable,* and *certain,* given by Lermoyez in his work on the treatment of diseases of the nose and sinuses of the face.

Section of Cyst removed from the Naso-pharynx.

Shown by Mr. Arthur Cheatle. A man æt. 19 came to the Royal Ear Hospital complaining of nasal obstruction. Besides some turbinal hypertrophy and a spur in the nose, a smooth pink mass, the size of half a walnut, was seen in the naso-pharynx immediately behind the septum and stretching from one Rosenmüller's fossa to the other. Under chloroform it felt tense, and was ruptured with the finger-nail before removal. A microscopical section through the mass showed a large and a small cyst, each lined with columnar ciliated epithelium, with a slight amount of adenoid tissue outside on the cut surface.

Preparations of Hypertrophied Tonsils.

Mr. Wyatt Wingrave exhibited sections of enlarged tonsils for inspection by the naked eye. They illustrated the conditions of simple hypertrophy unattended with any inflammatory changes.

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The points of chief interest were the scantiness of the connective-tissue elements, the depth of the lacunæ, which reached to the "bed" of the tonsil, and the fact that one aperture was common to several lacunæ.

The tonsils before cutting had been soaked in collodion, which method binds the tissues together and prevents the lymph follicles falling out.

Sections of Lupus of Larynx.

Shown by Mr. Wyatt Wingrave. The sections were stained by the Ehrlich triple Biondi process, a method which had the great advantage of differentiating the three most prominent histological elements, viz. the small-cell tissue, the epithelial cells, and the sclerotic bands. Neither in this nor in other instances had he been able to demonstrate a specific bacillus.

Apart from the question of the bacillus, he considered that histological differences between tubercle and lupus were to be explained by the respective rates of inflammatory changes.

Microscopic Sections of Papilloma of the Larynx.

Shown by Mr. Wyatt Wingrave. From a case of Dr. Dundas Grant's. It was of the simple stratified squamous variety.

Microscopic Sections of Rhino-scleroma.

Shown by Mr. Wyatt Wingrave. From a case of Dr. Dundas Grant's.

Specimen of Pachydermia Laryngis.

Shown by Mr. Lake. The larynx shown was removed from a patient æt. 34, who had been hoarse, or, as the patient had described it, "had had a man's voice since the age of four years." His family history was good. He had suffered with phthisis for one year, but his larynx showed no traces of this.

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In reply to Dr. Grant, Mr. Lake said the hoarseness antedated the phthisis by about thirty years.

Tubercular Larynx from a Child aged 6 years.

Shown by Mr. Lake. This was shown on account of the comparative rarity of this disease in childhood. When first seen the child had laryngeal stenosis due to subglottic swelling; later destructive ulceration set in, and he died nine weeks later.

Report on a Specimen of Membrane (Epiglottis) from a case of Membranous Laryngitis shown at the last meeting (November) by Mr. Lake.

Three organisms were shown to be present in the cultivations, viz.:

(1) *Staphylococcus pyogenes albus.*

(2) A small diplococcus (morphologically identical with the gonococcus, but staining by Gram's method).

(3) A small-celled torula.

Walter D. Severn.

Recurrent Nasal Tumour from Female aged 23.

Shown by Mr. Lake.

Empyema of Antrum cured by Repeated Irrigations by means of Lichtwitz's Trocar and Cannula.

Shown by Dr. Dundas Grant. Mrs. M— was seen on July 21st, 1898. There was dulness on transillumination, and a free exit of fœtid pus following the use of Lichtwitz's trocar and cannula.

For nine years the patient had been subject to "colds in the head," chiefly affecting the right nostril, but the history of a fœtid discharge only dates about four weeks before her application for relief. Possibly the chronic recurring discharges were due to attacks of suppurative inflammation in the right frontal sinus from which the antrum was secondarily "charged." Transillumination of the right frontal sinus shows less translucency than that on the left side. The signs of antral empyema, which were typical, entirely disappeared after eleven irrigations with Lichtwitz's instrument. The teeth were sound, and

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hence the intra-nasal treatment was adopted in place of any of the buccal methods.

CHRONIC EMPYEMA OF THE ANTRUM CURED BY INTRA-NASAL TREATMENT (ANTERIOR TURBINECTOMY—KRAUSE'S TROCAR).

Shown by Dr. DUNDAS GRANT. M. A. L—, æt. 31, schoolmaster, seen April 22nd, 1898, complaining of offensive purulent nasal discharge which had lasted continuously for six months. Antral empyema was diagnosed by means of Lichtwitz's trocar and cannula. Three carious teeth were removed, and the discharge did not return for two days. Temporary relief followed irrigation by the latter instrument. Alveolar puncture and irrigation were then instituted, and the latter carried out till June 18th, at the first with temporary success, but with pain in the process and no actual cessation of discharge. The alveolar puncture was allowed to close.

Anterior turbinectomy was then performed, and under cocaine Krause's trocar and cannula introduced; through the latter the antrum was washed out and then insufflated with iodoform and finally iodol. Twenty-eight irrigations through the alveolus had been unsuccessful, but after twelve through the intra-nasal cannula the discharge and smell had entirely ceased.

The patient is now quite free from any symptoms of his antral disease, there is no pus on irrigation, and the dulness on transillumination has diminished.

Dr. HERBERT TILLEY thought that the great disadvantage of this treatment was that in the majority of cases the irrigation had to be done by the surgeon rather than by the patient himself—a matter of very considerable importance. The alveolar method, which was without this disadvantage, made it most suitable for the general run of cases as the first line of treatment; for once the patient had been provided with a suitable plug and had been shown how to use the syringe, he could carry on the treatment for himself.

In reply to Dr. Spicer, Dr. Tilley said that he did not for a moment wish to underrate the value of the more radical operations in protracted cases, and cases where it was probable antral polypi were keeping up the discharge. He had himself found them invaluable. His contention was, that in ordinary cases associated with carious teeth the treatment should commence by removal of the latter and insertion of a plug, removable for constant irrigation; that the lotion should be constantly changed, and not until these methods were found to fail should more radical operations be performed,—one great

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disadvantage of which was that patients could not carry out the treatment themselves. He was surprised that Dr. Spicer had met with so few cases cured by the alveolar method.

Dr. Pegler thought the operation of anterior turbinectomy, as performed by Dr. Grant in this case, would become a more general accessory procedure in the treatment of antral disease where a Krause opening was to be made. He had noticed that the inferior turbinal tended to become chronically inflamed and swollen in the presence of much purulent discharge, and in its turn aggravated matters by hindering drainage and keeping up sepsis, besides rendering the Krause's opening more difficult of access. Subsequent treatment by irrigation with a catheter through this opening was also much facilitated by an anterior turbinectomy.

In reply to Dr. Tilley, Dr. Pegler said he could show cases in which the habitual passage of a vulcanite catheter through the Krause opening, during home treatment by the patient, had been carried out, after a little practice, without any great difficulty.

Dr. Scanes Spicer felt it his duty to join issue with Dr. Tilley on two points. Firstly, as to the assumed difficulty of patients washing out the antrum per nares through the operative artificial ostium maxillare. With a proper bent tube, and one or two demonstrations, the patient found no difficulty in doing this within a few days of the operation. He had recently sent a case out of hospital fourteen days after radical operation, and as she was going to Bristol for a month he asked her to present herself at Dr. Watson Williams' clinic, and the speaker believed that that gentleman would say there was not the slightest difficulty. In fact, since he had adopted entire nasal irrigation after operation, he had found that patients had far less difficulty and discomfort than with the tooth-socket tube irrigation. Secondly, he protested against the routine use of tooth-socket tubes and a plate for "two months" in well-proved cases of *chronic* empyema. This doctrine was retrograde, and directly in opposition to all recent English, Continental, and American advances, and should be discountenanced by a society of specialists. Cases of cure of *chronic* empyema by tooth-socket tubes were most rare, while he had come across several cases of supposed "cures" who had gone on wearing their tubes for ten, fifteen and more years, and were still doing so, and using irrigations one, two, or three times a day for the suppuration and smell. It therefore appeared to him better to adopt at once a radical method which was safe, rapid, and practically certain, instead of wasting time and money on a method which almost never succeeded.

Dr. StClair Thomson suggested that in the matter under discussion the feelings of the patient might be slightly considered, and that in his experience when the facts of the case were put before a patient, the larger majority preferred to have the alveolar opening only whenever there was a suitable empty tooth-socket on the same side. A long history of suppuration does not necessarily mean an intractable case, for in his case, referred to by Dr. Scanes Spicer, the patient had had symptoms for seven years and the empyema had been definitely diagnosed two years before operation was decided upon.

Dr. Watson Williams had had a case under his care which

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showed the ease with which a patient could syringe out her own antrum.

Dr. GRANT, in reply, quite agreed that the convenience of the alveolar operation was such that it could never be altogether done away with. At the same time he had seen cases in which it had done no good, and improvement only began when the alveolar opening began to close and other methods of treatment were initiated. On principle he contended that an opening between the mouth and nose was bad physiologically, and still worse bacteriologically. He had therefore tried what could be done by intra-nasal treatment. He showed an instrument for enlarging the opening made with Krause's trocar, and cited a case in which such an opening had persisted. Anterior turbinectomy had at the same time been performed, and the patient could pass a Eustachian catheter into the opening.

X-RAY PHOTOGRAPH OF FOREIGN BODY (SILVER TUBE) IN THE ANTRUM OF HIGHMORE.

Shown by Mr. CHEATLE. The patient was wearing a tube through the canine fossa for chronic antral suppuration; the top broke off, and the patient continued to wear it. One morning on waking it had disappeared. In order to see if it was inside the antrum, Mr. Low took the photograph, which clearly showed it lying across the cavity.

Dr. DUNDAS GRANT had in one case of opening the antrum through the canine fossa found a vulcanite tube which had broken off from its plate. This had been adopted after the alveolar operation, and was supposed by the patient to have dropped out.

Dr. WATSON WILLIAMS cited a case where a peg similarly got lost in the antrum, but passed out into the nose through the ostium maxillare without operative interference.

Dr. WILLIAM HILL recorded another case where the loss of a tube in the antrum was fortunate for the patient, as it necessitated opening the front wall of the sinus, which was found to be diseased, and a radical cure was made of the case.

SPREADING ULCER OF THE NOSE.

Shown by Mr. WYATT WINGRAVE. Charles T—, æt. 50, labourer, seen on Nov. 14th, 1898, complaining of pain over nose and stinking discharge of six weeks' duration. On examination, nostrils were full of fœtid crusts, which on removal showed perforation of vomerine region of nasal septum with granulation tissue in all directions.

He gave a history of syphilitic sore thirty years ago, with falling of

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hair, but no other signs. Married twenty years; wife had two miscarriages, at the second and fourth pregnancies. He had usually enjoyed good health. Two months later a red patch appeared on the outside of each ala at junction of bone and cartilage; this rapidly broke down and the ulceration spread to cheeks and upper lip, the tip of nose remaining free. He suffered considerable pain, and the discharge was profuse and fœtid. He was treated with pot. iodide and bromide, also inunctions of mercury, with negative results.

Cultivations were taken, but no special micro-organism was found, and injections of mallein and tuberculin gave no response. He has not lost flesh to any very great extent. The temperature has sometimes been as high as 103°, but for last six weeks has kept about normal. At the present moment the disease is not spreading as fast as it was, and the pain is but slight. He continues to take biniodide of mercury, which he has been under for the last three months. The ulceration is now much more superficial than it was, and shows a tendency to heal.

He thought that the case possessed interest from its resemblance to one which was presented to the Society by Dr. McBride in 1896, and seen by Sir Felix Semon and Dr. Milligan, who were all in doubt as to its nature.

The cases were alike in their resistance to mercury and iodides, their negative evidence of glanders, and their clinical history. He thought at first that it might be an unusually rapid case of lupus, since the history of syphilis was decidedly equivocal, and scrapings afforded no evidence of tubercle bacilli.

Mr. Spencer considered the case one of malignant ulceration, including under that term rodent ulcer. He would employ thorough erasion and the cautery, and later on cover healthy granulations with epidermal grafts.

Dr. Logan Turner said that he had had the opportunity of constantly observing Dr. McBride's case of destruction of the nose and face, which had been referred to by Mr. Wingrave. The microscope, bacteriological investigation, and specific treatment had failed to establish any diagnosis. In spite of operative interference the ulceration had extended and death followed. Post-mortem examination revealed nothing of a definite nature. It differed from Mr. Wingrave's case in the deeper and more complete destruction both of the soft parts and of the bones. In his (Dr. Turner's) opinion the patient now shown presented rather the appearance of a case of lupus.

Mr. Bowlby suggested that it might well be a form of rodent

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ulcer, in which case the term epithelioma should not be applied, as they were not identical diseases.

In reply, Mr. WYATT WINGRAVE said that the fragments examined afforded no evidence of epithelioma or tubercle, and that no surgical treatment had been attempted. There was no response to the active mercurial treatment, which was thorough.

CASE OF SYRINGOMYELIA, WITH PARALYSIS OF THE RIGHT SIDE OF THE PALATE AND PHARYNX, AND OF THE RIGHT VOCAL CORD.

Shown by Dr. HERBERT TILLEY. The exhibitor expressed his great indebtedness to Dr. Risien Russell for the help he had given him in the examination of the patient's nervous system.

[Dr. Russell, at the invitation of the President, described the chief nervous symptoms of the case.]

C. S—, æt. 15 years, applied to the Golden Square Hospital, complaining of "hoarseness and inability to use her hands properly."

Patient's mother had "chorea" when seventeen years of age, and her mother's grandfather was the subject of fits, and died in an asylum. She was born at full term; labour difficult, and instrumental delivery with injury to the head resulted. Has always enjoyed fairly good health, but has always been subject to eczema of hands since quite young. Menses not established. Weakness of hands noticed first about two years ago, when she found she was unable to open her hands properly. Hoarseness seems to have existed before the latter trouble was noticed.

About two months ago she received a large burn on the hypothenar eminence of left hand, and knew nothing of it till the blister accidentally broke. She experienced no pain as the result of the burn.

Present state (*November* 28th, 1898).—Patient is a pale, well-nourished girl, with noisy breathing and a hoarse voice. Nystagmical jerks of both eyes are observed on lateral and upward movements; they are more marked when the eyes are directed to the right than when turned to the left, and the movements of the globus being lateral, with a certain degree of rotation added.

There is complete paralysis of the right half of the palate, pharynx, and right vocal cord, as opposed to a normal movement of the same on the left side.

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All the neck muscles act well, and show no evidence of atrophy. The scapular and shoulder muscles, also those of upper arm, are intact, and all movements of the shoulder-joint and elbow are well executed. There is moderate wasting of the extensors and flexors of the forearms, with weakness of extension and flexion at the wrist—the defect being more marked in the extensors.

The fingers of both hands are in the "main en griffe" position, and there is marked atrophy of the small muscles of the hands on both sides, but more advanced in those of the left. The wasting of the thenar eminence and first interosseal space is more pronounced than elsewhere. The hand grasps are very feeble; separation and adduction of fingers feeble; inability to extend the second and third phalanges. Adduction of thumb possible, but feeble on both sides. Opposing power of thumb almost *nil*.

All muscles of forearm respond to faradism, but need a stronger current to evoke contraction than do those of the upper arm. No response of palmar muscles to faradism; dorsal interossei respond slightly. On right side, in addition to the response from the dorsal interossei there is very slight contraction of the palmar muscles. Markedly diminished reaction to galvanism is noted in the small muscles of the hands; no response in the palmar muscles (with the strength of current available, viz. one producing powerful response from normal muscles), including those of the thenar eminence on both sides. Dorsal interossei respond K.C.C. > A.C.C.

The trunk and back muscles are practically normal, but there is a pronounced lateral curvature of the spinal column, involving the whole of the thoracic vertebræ, and with its convexity to the right.

The lower extremities, both in nutrition and function, are normal.

Tactile sensibility is everywhere preserved, but there is blunting of painful impressions on both superior extremities; the analgesia, however, is not pronounced. There is complete loss of appreciation of thermal impressions all over both superior extremities, and there also appears to be a similar defect on the back of neck and trunk.

Thermal impressions seem to be normally perceived on the face, but there appears to be some slight defect on the neck and trunk down to the third rib on right side, and again from costal margin to about the level of the umbilicus; on the left side the defect appears to be more definite, and extends all the way down the neck and trunk to about the level of Poupart's ligament.

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Knee-jerks are exaggerated, but no ankle-clonus can now be elicited as was possible a week ago.

Recent trophic disturbances are seen, and scars, the result of similar past affections in connection with skin of fingers; also some sores about the elbows, looking as if they were abrasion. Sphincters, thoracic and abdominal organs, present no clinical evidences of disease.

The PRESIDENT thought the case very interesting, as hitherto he had been unable to find any records of syringomyelia associated with laryngeal paralysis.

Mr. SPENCER pointed out that the nuclei in the lower third of the bulb giving rise to pharyngeal and laryngeal fibres were in this case affected, whilst the fibres arising from the upper part of the spinal cord, going to the sternomastoid and trapezius, were untouched. Doubtless in other cases both groups were affected. But the possibility of one group being alone attacked confirmed the view of a distinct origin.

HYPEROSTOSIS OF MAXILLARY AND OTHER BONES CAUSING NASAL STENOSIS.

Shown by Mr. BOWLBY. E. P—, æt. 43. She has noticed difficulty in nasal breathing and pain about eighteen months. She has been deaf to some extent for nineteen years, but has not got worse lately. Now complains chiefly of the frontal pain and difficulty of nasal respiration.

Present condition.—There is exophthalmos, especially on the left side. The left temporal fossa is occupied by a bony growth which is continuous with an enlargement of the left malar and superior maxillary bones. The left supra-orbital ridge is thickened. Both maxillary bones show overgrowth of their nasal processes, but the nasal bones themselves are not enlarged. There is a bony growth in the floor of each nostril, covered by smooth mucous membrane, and as large as a large almond. The turbinate bones also appear enlarged; the palate bones and the alveolar processes of the maxillæ are normal; the lower jaw is normal. Pulse 130. No tremors; occasional palpitations. Thyroid apparently normal. No definite evidence of syphilis, but has "had bad health" since marriage, has lost five out of six children, and had an "eruption on the face."

Mr. SPENCER asked Mr. Bowlby if he would try treatment by

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thyroid extract on purely experimental grounds; it might do some good, and probably no harm.

A Case of Paresis of Left Side of Larynx.

Shown by Dr. Willcocks. J. T—, male, æt. 37, came under observation about the middle of November. The alteration in his voice began last April, accompanied by dyspnœa and noisy inspiration. For the last six weeks the voice has been worse. Patient had a penile sore followed by a rash about six years ago, and has also been a good deal exposed to vicissitudes of weather in his occupation.

The view of the interior of the larynx is much obscured by the epiglottis, which is very pendulous and almost immobile. The left arytænoid is much restricted in its movements on phonation, while the right side moves freely. There is no definite evidence of intra-thoracic pressure, such as aneurysm of the aorta, and there is no local evidence of disease in the larynx itself. The questions raised as to the nature of the condition were whether the partial paralysis on the left side was due to pressure on the left recurrent within the thorax (of which there is at present no definite evidence), or whether the restricted movement of the left arytænoid depended on some local mischief, such as adhesion, anchylosis, &c.

The Vice-President remarked on the difficulty that such cases as these presented as to whether the immobility was due to mechanical fixation or paralysis.

Dr. Lack had examined the case very carefully, and considered the appearances were those of recurrent paralysis and not of mechanical fixation.

Varix or Nævus of the Posterior Faucial Pillar.

Mr. Ernest Waggett showed a young man who had for a few weeks complained of pain and difficulty in swallowing.

A knot of dilated veins were to be seen under the mucous membrane of the left posterior faucial pillar, connected above with a small nævoid patch occupying the surface of the upper part of the corresponding tonsil. Attention had recently been drawn to the throat by frequent examination for throat lesions, necessitated on account of the occurrence of a suspicious sore on the penis. The symptoms

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complained of dated from the occasion on which the patient for the first time became acquainted with the abnormality described, and his nervous demeanour warranted the symptoms being regarded as constituting a mere mental obsession. Presumably the abnormality was of congenital origin, or at all events one of very long standing, and, until recently, not noticed. No surgical procedure seemed called for.

Mr. WAGGETT, in answer to the Chairman, said that he was unaware that any lesion could be described as "a typical varix of the posterior pillar." He had shown the case as an unusual curiosity, and considered the condition to be very unimportant intrinsically, and one merely forming the basis of a pharyngeal obsession in a nervous patient.

A CASE OF FUNCTIONAL HOARSENESS IN A WOMAN AGED 37.

Shown by Dr. HECTOR MACKENZIE. The patient had been under observation for over six months. About the end of May she was sent up from the country to Brompton Hospital, supposed to be suffering from pulmonary and laryngeal tuberculosis. She had then been hoarse or aphonic for some months. She said her throat was painful, and that she had difficulty in swallowing. The history was strongly suggestive of tubercle. In June, 1897, she was said to have brought up a large quantity of blood. Her father died of phthisis when she was seven years old, and her mother died of asthma and lung disease. One was quite prepared, therefore, to find both pulmonary and laryngeal disease. On examining the larynx, however, one noticed the extreme tolerance the patient showed to examination, so that there was not the slightest difficulty in at once getting a thorough and complete view. This contrasted strongly with the great irritability usually exhibited in tuberculous cases. The movements of the larynx were irregular, and on attempted phonation the cords did not come together, while the ventricular bands tended to overlap them. In adduction the left arytænoid persistently occupied a position slightly posterior to the right. The mucous membrane was lax, but there was no sign of swelling or ulceration, and the cords were of a normal colour. No abnormal signs were found on examination of the chest.

From the appearances the conclusion was arrived at that the

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laryngeal condition was functional. The faradic current was applied to the hands, with the result that the voice became at once quite normal. The voice remained normal for some weeks. The patient was greatly relieved in her mind by the restoration of the voice, and improved considerably in general health, putting on nine pounds in weight in six weeks. There has been a tendency for the hoarseness and aphonia to recur, but the voice has always been easily restored to a normal condition by the application of the battery. Unfortunately the patient lives at a considerable distance from London, so that treatment has been carried out at some disadvantage.

Dr. StClair Thomson was of opinion that the laryngitis was entirely functional. If the patient was put through certain vocal exercises with the laryngeal mirror in position, it was seen that the vocal cords were perfectly healthy and mobile, and that the ventricular bands were much hypertrophied. The patient, in fact, had developed what the Germans call "taschenbandsprache," and he thought that with suitable exercises she might be induced to desist from speaking with her ventricular bands, and return to the natural use of her vocal cords.

Dr. Grant suggested that she should constantly practise inspiratory phonation, which he had found useful in a similar case.

Papilloma of Tonsil.

Shown by Mr. de Santi. The patient, a girl æt. 19, suffered occasionally from enlarged tonsils. No other trouble. When examined a papillomatous growth was discovered on left tonsil. The tonsil and growth were removed together.

Malignant Disease of Nose in an Old Man.

Dr. Bond showed a case on whom radical operation on the nose and two operations for removal of glands had been performed, the patient having twice previously been shown to the Society and reports made on microscopic sections of tissues removed.

In May, 1898, the nose was clear of disease, but there was a large mass of glands in left side of neck the size of a hen's egg. This was cut down upon and removed with all adherent structures, viz. much of the sternomastoid fasciæ, the internal jugular vein, and the spinal

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accessory nerve. The patient is now apparently free from malignant disease and in good health.

The case is of interest since—1st, the left side of palate and left cord have become paretic; 2nd, the remnant of left sternomastoid and trapezius have wasted; 3rd, the general condition of the patient is good, after suffering from undoubted malignant disease for some six years.

In reply to the Vice-President, Dr. Bond thought that the paralysis of the cord might be explained by the fact that the vagus was considerably pulled about during the operation, and of course it was possible that pressure was being exercised upon it by a deeper set of glands.

Recurrent Papilloma of Larynx in Girl of 18.

Shown by Dr. Bond. This patient came to Golden Square about eight years ago with papilloma of larynx, which she seems to have had all her life. When first seen, in 1892, she had not, and was said never to have had, any voice. She was thought to be dumb, was said to have no laugh, and had considerable dyspnœa. Both cords were covered with papillomatous growth on the upper surfaces and edges, and there was a considerable amount below cords in front. The growths have been cleared away every few months during the last eight years. The patient has now a fair voice and the cords are almost clear, though it is some four months since the last operation. The case is of interest owing (1) to the great length of time during which the growths have persisted; (2) to the fact that the growths are recurring with less and less vigour as the patient gets older; (3) the fact that a child of ten could be thought to be dumb owing to the presence of these growths seems a novelty in laryngology.

In reply to a question by the Vice-President as to whether Dr. Bond had used any local applications, the latter said that perchloride of iron grs. vij ad ℥j had been used.

Dr. Grant suggested the use of a 5 per cent. solution of salicylic acid and absolute alcohol.

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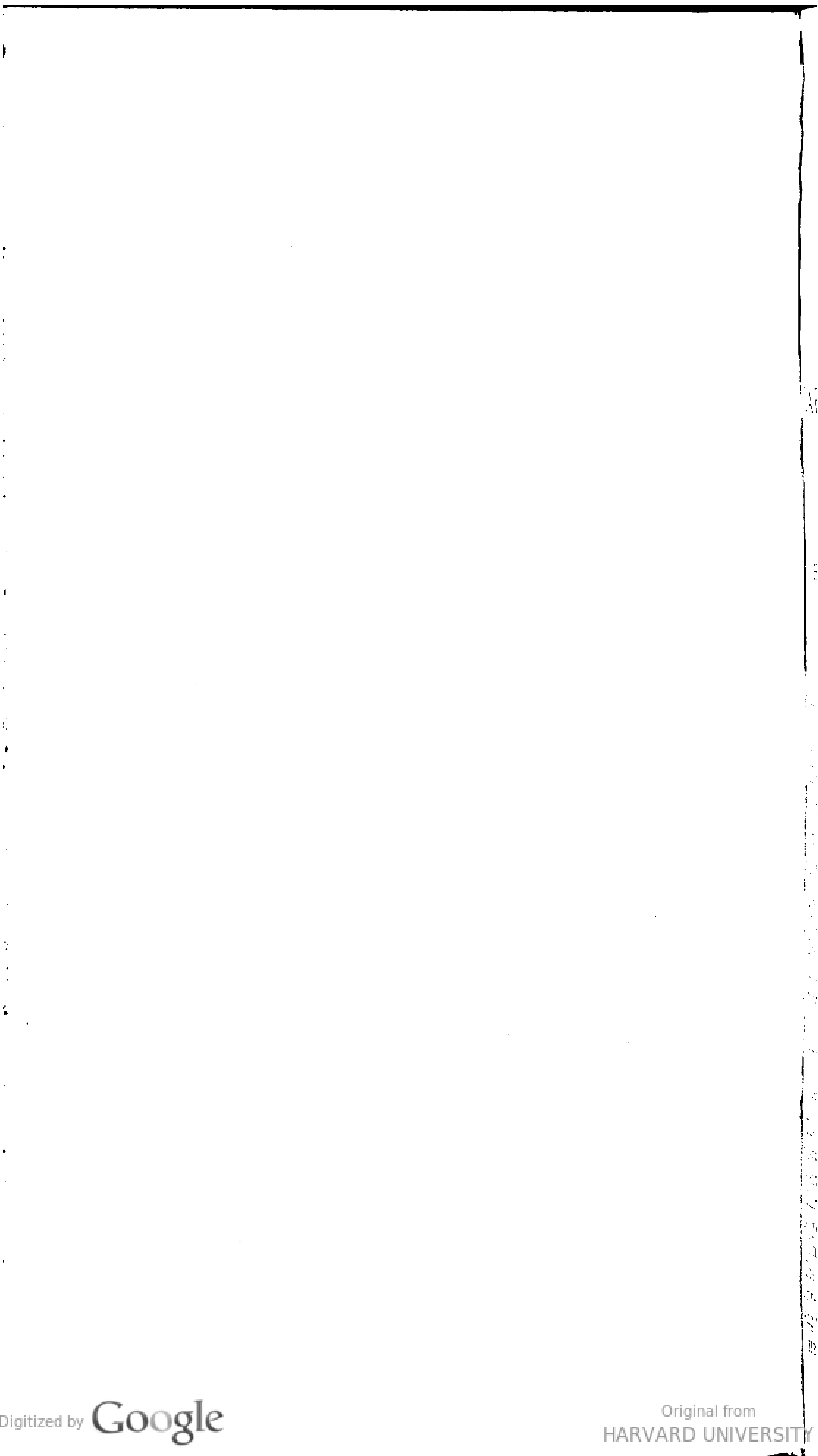

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ANNUAL GENERAL MEETING, *January 6th*, 1899.

HENRY T. BUTLIN, Esq., F.R.C.S., President, in the Chair.

HERBERT TILLEY, M.D., } Secretaries.
WILLIAM HILL, M.D., }

Present—45 members and 3 visitors.

The minutes of the Sixth Annual Meeting were read and confirmed.

Mr. Wyatt Wingrave and Mr. Milsom Rees were appointed Scrutineers of the ballot for the election of Officers and Council for the ensuing year; they reported the result of the ballot as follows:

President.—F. de Havilland Hall, M.D.
Vice-Presidents.—A. Bronner, M.D.; W. H. Stewart, F.R.C.S.Ed.
Treasurer.—Clifford Beale, M.D.
Librarian.—J. Dundas Grant, M.D.
Secretaries.—William Hill, M.D.; Lambert Lack, M.D.
Council.—Edward Law, M.D.; Walter Spencer, M.S.; F. W. Milligan, M.D.; A. Bowlby, F.R.C.S.; Herbert Tilley, F.R.C.S.

The following Report of Council was then read and adopted:

The Council are pleased to report the continued prosperity of the Society, as evinced by the increase in the number of its members and the enthusiasm thrown into the work of the ordinary meetings.

Thirteen gentlemen have been elected ordinary members during the past year, which including the nine honorary members brings the total membership of the Society to 135.

The meetings of the Society have been well attended, the average of thirty-five attendances for the ordinary meetings during the past year being the highest hitherto recorded.

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A special meeting of the Society was held July 13th, 1898, to discuss—1. Whether it was desirable to limit the membership of the Society. It was decided to add the words "and as proficient in laryngology" to the present declaration on the nomination paper, and also that the name of each candidate for election should be brought before the Council before being submitted to the ordinary meeting for election.

2. Whether, in deference to the opinions expressed by certain provincial members, it was desirable to alter the day of the ordinary meetings. A letter was sent to each member of the Society asking his opinion in the matter, and in accordance with the wishes expressed by the majority of those who replied, it was decided to hold the ordinary meetings on the first Friday of the month in place of the second Wednesday as heretofore.

Bye-laws were passed giving effect to these alterations in the Rules, subject to confirmation at the next Annual Meeting (January 6th, 1899).

During the past year two gentlemen have resigned their connection with the Society, and we have to regret the loss through death of Mr. John Fallows, L.R.C.S.Ed., who perished in the wreck of the Mohegan.

The Society especially deplores the early death of Professor A. A. Kanthack, lately of Cambridge University. Professor Kanthack was one of our original members, and made many valuable contributions to our Proceedings. Before he determined to devote himself to pathology he turned his attention to laryngology, and, while in Berlin, studied with success some interesting points in the anatomy and pathology of the larynx. The results of his researches were published in 'Virchow's Archiv.' After he had given up clinical medicine and surgery he still continued his interest in matters connected with laryngology, to the good fortune of our Society, which loses in him one of its most active and able members.

The Treasurer's Annual Statement was then presented as follows:

The actual receipts for the year are £152 5*s*. This amount includes six subscriptions for 1899 and one for 1900.

There are still fifteen subscriptions (£18 18*s*.) outstanding for 1898, the majority of which are good.

The seven outstanding subscriptions for 1897 (£7 7*s*.) mentioned in last year's report have been paid during the current year.

The actual expenditure is £111 10*s*. 6*d*., which leaves a balance for the year of £40 14*s*. 6*d*. This, added to the balance from 1897 (£170 0*s*. 5*d*.), leaves in the Treasurer's hands a total balance of **£210 14*s*. 11*d*.**

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BALANCE-SHEET, 1898.

INCOME.

	£	s.	d.
Balance from 1897	170	0	5
111 Subscriptions at £1 1s. .	116	11	0
12 „ at £2 2s. .	25	4	0
1 Compounding Fee at £10 10s.	10	10	0
Total . .	£322	5	5

The income for the year is . . . £152 5 0

EXPENDITURE.

		£	s.	d.
Rent and Electric Light (20, Hanover Square)		31	10	0
Adlard for Printing and Postage, May, 1897, to August, 1898		71	18	3
Strangeways (Photo-engravings)		1	0	0
Professor Kanthack (refunded for hire of microscopes)		1	10	0
Indexing volume, 1898 (Clarke)		1	1	0
Mathew (porter), 3 meetings (1897), 8 meetings (1898) .		1	18	6
Petty Cash—				
Rogers (Carbolic Acid and Spirit) . .	£0 10 6			
Receipt books (Creswick)	0 6 6			
Bank Charges . .	0 0 6			
Baker (hire of microscopes)	0 12 0			
Dr. Tilley (secretarial expenses)	0 11 3			
Hon. Treasurer's expenses (postage, &c.)	0 12 0			
		2	12	9
Balance in Treasurer's hands		210	14	11
Total . .		£322	5	5

The expenditure for the year is . . £111 10 6

Audited and found correct, *January* 6, 1899. { PHILIP R. W. DE SANTI. L. HEMINGTON PEGLER.

The following embodies the Librarian's Report, which was then read:

I beg to report that since the last Annual Meeting I have received the following periodicals, and shall endeavour to have them bound in time for the next meeting:

Revue Internationale de Rhinologie, Laryngologie, et Otologie (Natier).
Revue hebdomadaire de Laryngologie, d'Otologie, et de Rhinologie (Moure).
Archivi Italiani di Laringologia (Massei).
Belletino delle Malattie, &c. (Grazzi).
Archiv für Laryngologie (Frankel).
Journal of Laryngology (D. Grant).
Laryngoscope (StClair Thomson).
Annales des Maladies de l'Oreille, du Larynx, du Nez, et du Pharynx (Gougenheim).
Monatsschrift für Ohrenheilkunde (Gruber).
The Brooklyn Medical Journal (Vol. XII. from June).

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Moure, Dr. E. J. De la Tracheo-thyrotomie dans le Cancer du Larynx (Travail de la Clinique de Moure).
Moure, Dr. E. J. Sur les Traitement des Sinusites (Travail de la Clinique de Moure).
Moure, Dr. E. J. Traitement de l'Ozène (1897).
Catalogus van de Boekerij der Nederlandsche Keel-, Neuw-, en Oorheelkundige Vereenigung, 1897 and 1898.
Brighton and Sussex Medico-Chirurgical Society Proceedings and Annual Report, 1897–8.
Gesellschaft der Ungarischen Ohren- und Kehlkopfärzte Jahrbücher, Band III.
Niederlandische Gesellschaft für Hals, &c., 1897–8.
Laryngologische Gesellschaft zu Berlin Verhandlungen, Band VIII.
American Laryn. Assoc. Transactions of the 19th Annual Meeting.
Eighteen Monographs in reprint from Professor Gradenigo.
Five Monographs in reprint from Professor Grazzi.
Several microscopical specimens have been added to the Society's collection, including Lupus of the Larynx (Professor Massei).
Volumes bound as completed.

The following bye-laws (*vide* Council Report) and suggestions from the Council were then discussed, and it was agreed that they should henceforth be regarded as rules of the Society :

(*a*) That the words "and as proficient in laryngology" be added to the nomination papers for future candidates. (Special meeting, July 13th, and Council meeting, October 7th.)

(*b*) That the names of candidates for the membership of the Society shall be submitted to the Council before being placed before the ordinary meeting for ballot. (Council meeting, October 7th.)

(*c*) That the ordinary meetings of the Society be held on the first Friday (instead of the second Wednesday as heretofore) in each month, from November to June inclusive (see Rule 19). (Council meeting, October 7th.)

(*d*) That in Rule 3 the reference to provincial members be expunged. (Council meeting, December 2nd.)

The Forty-sixth Ordinary Meeting of the Society was subsequently held, the President being in the Chair.

Chronic Nodular Laryngitis in a Boy aged Fifteen.

Shown by Dr. StClair Thomson. This case was shown as illustrative of the nodular laryngitis of children described by Moure of Bordeaux. This latter observer, however, had attributed the condition to the straining of the voice, especially in children with treble voices who were compelled to sing seconds. In the present case there was no such history of voice abuse. He was brought with a history of a few months' hoarseness, but

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on further inquiry it appeared that he had been more or less hoarse since an attack of croup at the age of three or four. On examination it would be seen that there was a rounded thickening at the junction of the middle and anterior thirds of both vocal cords—the usual site of singers' nodules,—but in the present instance, instead of being situated on the free margin, the nodules were on the upper surfaces.

The cords were generally injected. Some adenoids had been removed in October last without relief, and since then he had been treated with insufflations of alum, sprays of iron, lactic acid, &c., without relief. Rest to the voice has been prescribed.

Dr. de Havilland Hall thought that at the present time Dr. StClair Thomson would probably feel inclined to alter the nomenclature of the case, as the appearances were those of a chronic laryngitis, the nodules not being distinct. The case, in Dr. Hall's opinion, resembled a chronic laryngitis due to nasal obstruction.

Two Cases of Chronic Laryngitis, entirely limited to the Right Vocal Cord, and probably Tubercular in Character.

Shown by Dr. StClair Thomson. One case was that of a young woman who had been hoarse for more than a year; the other was that of a man who had been hoarse for the last nine months. He had at one time lost flesh, but had latterly put on weight. In neither case were there any definite physical signs in the lungs, and there was no expectoration to examine. The temperature was not raised. In each case there was a red fleshy condition of the right vocal cord, and it was interesting to note, as confirmatory of Dr. Jobson Horne's pathological researches on this subject, that the free edge of the cord was but slightly affected, while the granulations on the cord appear to originate from the mouth of the ventricle of Morgagni. The diagnosis was arrived at by a process of exclusion. Both cases were decidedly improving under general treatment, although they lived in London.

Dr. Hall thought that the evidence in favour of a tuberculous laryngitis was not decisive in Dr. StClair Thomson's second case.

Dr. Clifford Beale observed that the limitation of the affection to one or the other side of the larynx must always be a strong point in diagnosis in cases of doubtful tubercular infiltration where evidence of other specific diseases was wanting.

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Dr. HERBERT TILLEY agreed with Dr. Thomson in looking upon these cases as tubercular. The speaker had shown at a former meeting a man who had tubercular ulceration of the tip of the epiglottis which had been almost completely cured by lactic acid applications and curetting. He had had him under observation nearly twelve months, and when he saw him two days ago he noted a marked granular congestion of the left vocal cord and vocal process, the rest of the larynx being normal. There was well-marked tubercular mischief in both pulmonary apices.

Dr. STCLAIR THOMSON in reply said he had been led to the diagnosis of tuberculosis in these cases by the one-sidedness of the affection, the absence of symptoms of new growth or syphilis, the chronic nature of the complaint, and the situation and appearance of the fleshy granulations. It was hardly likely that a simple chronic catarrh would remain limited to one vocal cord for a whole year, and that it would not disappear completely under vocal rest, such as these patients had tried. Recovery—and these two cases were improving—was not necessarily opposed to this view, for tuberculosis of the larynx, as of other parts, got well, and in some instances even without treatment.

Sir FELIX SEMON said that whilst fully recognising the diagnostic importance of isolated congestion of one vocal cord—a point, in fact, which he had always emphasised himself—he should not go so far as to make a definite diagnosis from this appearance alone. In his opinion the discovery of such an isolated congestion ought to draw the observer's attention to the possibilities of tuberculosis, malignant disease, and syphilis, and no doubt in the majority of cases one of these affections would be found later to develop in the congested part; on the other hand, however, he looked back personally upon a small but definite number in which such an isolated congestion was not followed by any further untoward developments. He should not, therefore, pin his faith upon the discovery of the appearance named alone, but simply look upon it as a valuable warning signal.

CASE OF CURE OF CHRONIC EMPYEMA OF MAXILLARY ANTRUM BY RADICAL OPERATION.

Dr. SCANES SPICER showed this patient, operated on by him six weeks ago.

A. B—, æt. 23, eight years ago had attacks of pain and recurrent abscesses for two years over region of left upper first molar. Six years ago this tooth was removed, and there has remained a fistulous track high up on anterior wall of gum, discharging fœtid pus on and off ever since. In October, 1898, increase of swelling, pain, and fœtor in left nostril. No loose bone could be detected with a probe. Patient, actively engaged

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in business, pressed for an immediate cure. Exploration was advised under an anæsthetic, and permission obtained to remove any sequestrum, or to deal with the antrum as might be deemed necessary.

On November 29th this was done. A large gap was found in the anterior bony wall of superior maxilla of irregular shape, and in the membranous structure filling this gap were small, loose, thin, bare scales of bone. The probe and finger easily passed into the antral cavity, which was filled with thick inspissated pus, cheesy débris, also polypi and granulation tissue, with indescribable fœtor. The cavity was thoroughly cleaned out, and the naso-antral bony wall found to be similarly absorbed; the finger passed into the antrum with the slightest pressure met the finger passed into the corresponding nasal fossa, breaking through the membranous portion in the inferior meatus region. The opening was enlarged with finger and curette so as to admit a large drainage-tube, which was cut off near the nostril, and the tube secured by silk threads tied behind each ear. The muco-antral opening was sutured (apparently not sufficiently so, as this incision has not yet healed).

The patient's doctor carried out all subsequent irrigation and drainage by this nasal tube, and after its removal in five days through the naso-antral opening.

Patient reports there has been no pus or fœtor since the end of the third week.

The case is interesting for the following reasons:

(1) It exemplifies the polypoid proliferation and caseation of retained pus, so usually found in chronic antral empyema.

(2) There was a co-existence of a rarefying osteitis of superior maxilla with necrosis of small scales of bone, rendering use of trephines, gouges, or Krause's trocar unnecessary to open and drain the antrum.

(3) The cure of fœtor and suppuration of eight years' standing was rapid, and performed well within the time allowed the patient by his governing board.

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Specimen of Dead Bone, Polypi, and Débris removed from a Case of Chronic Empyema of Antrum cured by Radical Operation in Eight Weeks.

Dr. Scanes Spicer showed this specimen. The patient from whom it came, E. P—, female, æt. 18, had complained of unilateral nasal stench and evacuation of foul crusts for nearly eighteen months. This stench was relieved by the evacuation of a crust, and then gradually increased for two or three days, until another crust was discharged. All teeth were present and apparently sound. Diagnosis confirmed by transillumination. Patient's parents had brought her from the north of England for cure, and were staying in London for that purpose. Radical operation as in last case was advised and performed. The patient returned after eight weeks with no fœtor or suppuration, and several reports up to Christmas, 1898, state there is no recurrence of fœtor or pus as before.

The presence of the sequestrum (suspended in the bottle by a silk thread), and the polypi, &c., which filled the bottle at time of operation, indicate the extreme improbability of cure being effected by tooth socket tube.

Dr. Scanes Spicer also showed the temperature chart of another patient on whom he had performed the radical operation in St. Mary's Hospital for cure of chronic empyema of antrum, to illustrate that the modern form of operation was by no means the severe and dangerous procedure which had been stated. On no day had the temperature subsequent to operation exceeded the normal by a degree. The patient will attend at a subsequent meeting.

Further Report of Case of Sarcoma of the Nose shown at November Meeting.

Dr. Barclay Baron (Bristol) reported that he had sent a piece of growth removed from his case of sarcoma of the nose shown at the November meeting to the Morbid Growths Committee. They reported it to be an alveolar sarcoma, and showed sections of it at the December meeting. The growth rapidly increased

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both within the nose and externally, displacing the eye outwards. At Dr. Baron's request, Mr. Charters Symonds kindly undertook its removal, full view of the growth being obtained by enlarging the opening in the superior maxilla made by the disease. The dura mater was found to be exposed in one place, the bone covering it having been destroyed, and it would, therefore, have been a dangerous procedure to attempt to curette the interior of the nose without seeing what was being done.

The patient made a quick recovery, and there is very little disfigurement.

Mr. SYMONDS, in describing the operation, said that when he first saw the case in the wards at Guy's Hospital it seemed to him to presently clinically the ordinary appearance of a sarcoma of the nasal fossa. The elastic projection at the inner corner of the eye which had been noticed in November had projected and displaced the eye both upwards and outwards. In respect to the various opinions expressed as to the nature of this swelling, he carefully exposed it and found it to be composed chiefly of soft growth. It was limited by the stretched periosteum, and between the two was some thick nasal mucus, an arrangement which would account for the sense of fluctuation. The incision was carried down to the ala of the nose and another outwards below the orbit, then with a keyhole saw a part of the nasal process of the superior maxilla, and of the floor of the orbit and anterior wall of the maxilla, were removed. The aperture thus obtained, together with that made by the growth, which had destroyed the lachrymal bone and a part of the ethmoid, gave a large opening into the upper part of the nasal cavity. Through this the entire growth was removed. A sterilised pad was plugged into the posterior naris. On removing the growth the dura mater, as Dr. Baron had mentioned, was exposed; this was not due to the forcible removal of bone, for the growth itself lay in contact with this membrane. That it was dura mater was clear from its bluish-white colour and its density; thus it was obvious that a large part of the ethmoid had been destroyed, and that the starting-point of the new growth was somewhere in the mucous membrane covering this bone. The mucous membrane round the area was cut away with scissors, including the middle turbinal, and the edges of bone around the site were also removed by cutting forceps. The maxillary sinus, which had been slightly opened, was freely laid bare by removing the inner wall. The wound was sutured, and the patient went home in a week. The eye returned nearly to the normal position, and the movements were unaffected and there was no diplopia. The microscopic examination which was made by the surgical registrar at Guy's Hospital, Mr. Fagge, confirmed the report of the Morbid Growths Committee that it was alveolar sarcoma. The structure was identical in all parts of the tumour: it may be added that the growth extended from the nostril to the pharynx, but did not occupy the antrum.

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In his report Mr. Fagge stated that the microscopic appearances were those not uncommon in neoplasms of the nasal fossæ.

Mr. Symonds added that he usually, in operations upon the upper jaw, preferred, instead of the set procedure usually recommended, to use a keyhole saw, and surround the growth, leaving any portion that appeared to be quite healthy, for in this way more or less of the palate in some cases might be preserved.

Specimen of Peg removed from Maxillary Antrum through Ostium Maxillare.

Shown by Dr. Watson Williams.

Lupus of Nose.

Shown by Mr. Wyatt Wingrave. Female æt. 30 complained of nasal obstruction with discharge of five years' duration. Four months ago the floors of both nasal fossæ were found occupied by granulations, which extended as high as the middle turbinals. Large quantities were removed by sinus forceps and curette, only to be followed by rapid recurrence. They are much less numerous now, but have involved the turbinals. The cartilaginous septum is perforated, and there is some evidence of old pathological changes in the soft palate. The larynx is normal.

Owing to the large amount of granulation tissue, the existence of severe pain, and evidence of caries on probing, syphilis was suspected, but no history could be obtained, and she did not respond to specific treatment. The tissue on examination gave no evidence of tubercle bacilli, but presented the usual features of lupus.

She has lost one brother and one sister from consumption, and suffers from lung trouble herself.

Mr. Cresswell Baber and Dr. Thomson thought the appearances and fœtor resembled syphilis.

Dr. Watson Williams suggested that in the discussion of such cases the terms lupus and tubercle should be used synonymously, as they were essentially identical diseases, and differing only in their chronicity and mode of growth.

Dr. de Havilland Hall upheld this restriction of nomenclature.

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Tubercular Laryngitis in a Dwarf.

Shown by Dr. Herbert Tilley. Patient is a female æt. 45, height 3 feet 2 inches. In February, 1898, she had an attack of influenza and bronchitis, since when she has had a chronic cough and hoarseness.

The larynx is very small, the vocal cords being only about 15 mm. long; both of them were ulcerated, also the right vocal process.

Tubercle bacilli had been found in the expectoration.

Two Cases of Epithelioma and One of Sarcoma of the Larynx treated by Thyrotomy, and keeping well two and a half years, one and a half years, and six months respectively after operation.

Shown by Sir Felix Semon. Case I (already described by the patient himself, Mr. C. Fleming, L.R.C.P., &c., in the 'Lancet' of October 16th, 1897).—Medical man, æt. 47, noticed in June, 1895, slight huskiness, which steadily increased. In November a whitish, pointed, sessile thickening was seen in the middle of left vocal cord. The cord itself congested, its movements free. In May, 1896, voice much worse, no other symptoms. Posterior part of left vocal cord generally thickened, slightly œdematous, no distinct growth visible, movements of cord still free. Two months later conditions unchanged. Proposal of exploratory thyrotomy supported by Mr. Butlin. Operation on July 21st, 1896. Left vocal cord was found to be tumefied in its entire length, and was removed with an area of healthy tissue around it. Mr. Shattock pronounced the growth as a typical squamous-celled carcinoma in the early stage, with little horny transformation. Convalescence took place without any complications, and the patient resumed his practice within a month from the performance of the operation. Since then perfectly well. Voice very good. On laryngoscopic examination a marked cicatricial ridge is seen in the position of the former left vocal cord.

Case II.—Naval officer, æt. 57, sent by Dr. Clay of Plymouth on March 30th, 1897, on account of increasing hoarseness. Both

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vocal cords very irregular, considerably thickened and congested, particularly in their anterior two thirds. Their movements free. Differential diagnosis between chronic laryngitis and malignant disease doubtful. The latter suspected on account of the unusual amount of thickening, and expectoration on one occasion of slightly blood-tinged sputum. Two months later hardly any change. Consultation with Mr. Butlin, who shared my suspicion of malignancy. Intra-laryngeal removal of some small projecting pieces of the general thickening for microscopic examination. Mr. Shattock's report on the largest of these ran as follows:—"I took the greatest pains to cut the section of the small flat piece of tissue at right angles to its slightly uneven and granulated surface. The result was wholly successful, and then I saw at once that the growth is a squamous-celled carcinoma. It is so marked that there can be no two opinions about it. The growth has a slight tendency to be horny, *i.e.* less malignant than other forms." Operation on May 31st, 1897. Thorough removal of both vocal cords, scraping of bases. Uninterrupted convalescence. Two months afterwards granulation tumour in anterior commissure, which was removed intralaryngeally. Patient has enjoyed good health since operation, but the voice of course has been reduced to a whisper, as *both* vocal cords had to be removed, and as the cicatricial ridges which have been formed do not compensate for their loss.

CASE III.—Private gentleman, æt. 69½, sent by Dr. Branfoot, of Brighton, on July 15th, 1897, on account of gradually increasing hoarseness, which had already lasted several months. A reddish, irregular, mammillated, broad-based growth occupied the greater part of the much congested right vocal cord, beneath which it seemed to pass into the subglottic cavity. Mobility of cord, if at all, certainly not much impaired. Differential diagnosis doubtful between fibroma and malignant new growth. Microscopic examination (Mr. Shattock) of intra-laryngeally removed fragment showed the tumour to be a sarcoma, nowhere undergoing fibrous transformation, but in part the seat of leucocytic infiltration, and altogether apparently of a highly malignant type. Thyrotomy on July 21st, 1898. The thyroid cartilage was completely ossified, and had to be divided by sawing. The larynx having been opened, it was seen that the growth was

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partly pedunculated, but in part infiltrated the anterior part of the right vocal cord. The growth and the anterior half of the right vocal cord were removed and the basis scraped. The posterior part of the right vocal cord was stitched to the right ventricular band. The whole wound was immediately closed after operation, and only a small drainage-tube left in its lowest part. This, too, was removed on the second day after operation. The temperature rose in the evening of the first day to nearly 101°, and came only very gradually down until the normal was reached on the sixth day. In all other respects uninterrupted progress. The patient returned home a fortnight after operation, and ever since has been perfectly well. His voice has an almost normal character, and is still improving in strength.

Mr. SPENCER asked for information on three points: (1) What antiseptics were used. (2) Whether the thyroid cartilage was always sutured. (3) Whether the muscles of the neck were sutured together before closing the skin wound.

Sir FELIX SEMON (in replying to Mr. Spencer) said that his methods of operation had been described in the 'Lancet' of 1894, and in the 'Archiv für Laryngologie' for 1897; that he always rubbed iodoform into all the tissues before closing the wound; that he sutured the thyroid cartilage by means of catgut or silver ligatures; that he now closed the wound in its entire length, withdrawing the sponge cannula immediately after the operation, and only left in its lowest part a drainage-tube; that he was not quite certain whether this modification represented a real improvement, as he thought he had observed that the temperature kept up longer than when the lower third of the wound, as previously, was left open for three or four days, and that he might possibly revert to the latter method. He had only once had to suture the *muscles*, and this was in a case of *tubercular* disease of the larynx, in which the wound had become infected. He added that the appearance of a tumour in the anterior commissure of the vocal cords was—to conclude from his own experiences—rather suggestive of the formation of a granuloma than of a recurrence of the malignant growth; and secondly, that a recent communication of Professor Chiari's in the 'Archiv für Laryngologie' had shown him that the idea of painting the laryngeal mucous membrane with a 20 per cent. cocaine solution to diminish bleeding and reflex irritation had not originated with him, as he had thought, but that he had been forestalled with regard to this by the late Professor Billroth.

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SPECIMENS.

Dr. MILLIGAN showed the following specimens:
1. Lymphangioma of Vocal Cord.
2. Laryngeal Papilloma.
3. Naso-pharyngeal Fibro-sarcoma.
4. Large Exostosis removed from Maxillary Antrum.

MULTIPLE AND DIFFUSE PAPILLOMATA OF THE LARYNX.

Dr. JOBSON HORNE showed a case of multiple papillomata occurring in the larynx of a woman æt. 22. Change of voice had been noticed by the patient's friends for upwards of eighteen months, gradual in onset,—at first only a roughness of voice, which had developed into complete hoarseness. Difficulty in respiration had been experienced after physical exertion, especially after going up and down stairs, and after prolonged talking. Latterly the patient has been distressed by nocturnal attacks of dyspnœa on first lying down, but had not been disturbed by them in the course of the night. It was on account of these attacks that the patient first sought advice.

Laryngoscopic examination showed a subcordal mass of papillomata attached in the neighbourhood of the anterior commissure, which when driven upwards during phonation occupied more than half the glottis. Diffuse papillomata also covered both cords.

The subcordal mass was removed, and the attacks of dyspnœa had ceased, and some improvement had taken place in the voice.

The growth under the microscope was found to be a simple papilloma.

TUBULAR EPITHELIOMA OF THE NOSE.

Dr. BRONNER (Bradford) showed a microscopic specimen of a tubular epithelioma of the nose. The growth was of the size of a large pea, and had been removed from the nasal mucous membrane just above the anterior part of the lower turbinated bone of a man of forty-seven nearly ten years ago.

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There was a history of slight nasal obstruction and frequent slight hæmorrhage from the nostril. The growth had been removed by scissors, and the base then thoroughly burnt with the galvano-cautery. There has been no recurrence. The report of the Clinical Research Association was :—"The growth is malignant, of an epithelial type; it may be classed with the tubular epithelioma. At the periphery beneath the mucous membrane tubules with a definite lumen can be seen.

Mr. Butlin thought it would be very difficult to decide whether it was an adenoma or carcinoma, and suggested that sections should be made by the Morbid Growths Committee.

Case of Right Recurrent Paralysis with Paresis of Trapezium, Sterno-mastoid, and Palate, with Slight Ptosis and Facial Paralysis, all on the same Side.

Shown by Mr. R. Lake. This patient, an intelligent man æt. 36, was sent to me for an affection of the larynx. The following history was obtained. Eleven years ago he was stabbed over right eye, and had subsequently Jacksonian (?) epilepsy, the last attack twelve months ago. No history of syphilis. He has had a cough since August, 1898, and loss of voice for three weeks, dysphagia, and food going the wrong way for two months. His right shoulder is lower than the left; wasting and want of power are noticed in the trapezium and sterno-mastoid, some paresis of palate; reflex present on both sides, the same with pharynx. Left pupil large, and only reacts slightly to accommodation, but not to light. Slight right ptosis and loss of power in the right labial muscles. No Romberg's symptoms. The patient has been taking 90 grains of iodide of potash daily, and had mercurial inunctions every other day for the past six weeks. The dysphagia is getting worse; the voice is now, and has been for the last week, nearly normal.

Growth of Left Vocal Cord in a Man aged Thirty-two.

Shown by Mr. C. A. Parker. *History.*—Voice began to be slightly husky about the middle of August last. The huskiness varied at first, but has been getting gradually worse during the

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last eight weeks. The patient is a tea inspector, and he is constantly inhaling tea dust. There is no loss of flesh and no history of syphilis.

When first seen on October 14th there was a large growth of left vocal cord, especially affecting the anterior half of the cord, where there appeared to be a superficial slough. From its appearance it seemed to be a simple papilloma. The cord was then moving freely.

On October 28th the anterior portion of the growth was removed and examined microscopically by Dr. Hewlett, who reported it to be a papilloma. Since then the growth has recurred to a great extent, and now looks more an infiltration of the cord than a growth attached to the cord; meanwhile the movement of the cord has become impaired.

The case is before the Society for suggestions on the diagnosis and treatment. It seems at present to be something more than a simple papilloma, and in spite of his age (thirty-two years) one is inclined to think it may be a case of early malignant disease.

He has taken 10 grains of iodide of potassium three times a day for six weeks without the slightest improvement.

Sir Felix Semon thought it looked very like malignant disease, and advised thyrotomy.

Mr. de Santi expressed similar views.

After History of a Case of Recurrent Paralysis of Vocal Cord.

Dr. Willcocks, who showed the patient at the December meeting, reported that he had since had pneumonia, and died suddenly of intra-thoracic hæmorrhage, pointing with little doubt to aneurism which during life had presented no physical signs.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *February 3rd*, 1899.

F. DE HAVILLAND HALL, M.D., President, in the Chair.

WILLIAM HILL, M.D., } Secretaries.
LAMBERT LACK, M.D., }

Present—31 members and 3 visitors.

The minutes of the previous meeting were read and confirmed.

The PRESIDENT briefly thanked the members of the Society for the honour they had conferred on him in electing him to preside at their meetings. He promised that he would spare neither time nor energy in furthering the interests of the Society, and in endeavouring to maintain the high standard of his distinguished predecessors in the chair.

The President announced that at the Council meeting just held it had been decided, owing to the large number of clinical cases shown, to increase the number of the electric lamps. To facilitate the reporting and enhance the value of the proceedings a shorthand writer would attend at the next meeting. It was decided further that one meeting, viz. May 5th, should be entirely devoted to a discussion on "Asthma and its relation to diseases of the upper air-passages."

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The following gentlemen, their names having been previously submitted to the Council, were nominated for election at the next meeting:

H. Fitzgerald Powell, M.D.(St.And.), F.R.C.S.Edin. Practice, Laryngology and its branches.
Mark Purcell Mayo Collier, M.S., F.R.C.S. Practice, Laryngology and Surgery.
St. George Caulfield Reid, M.R.C.S. Practice, General and Special.

Dr. Lack was elected a member of the Morbid Growths Committee in place of the late Dr. Kanthack.

The following cases and specimens were shown.

Slight Defective Abduction of the Right Vocal Cord.

Shown by Mr. H. Betham Robinson. F. E—, æt. 37, came on December 22nd, complaining of increasing weakness of his voice in singing for some three months, with some pain on the right side of his neck. There was no sore throat and no cough, but occasionally he had night sweats.

His occupation is that of clerk, but he sings a good deal. No history of syphilis.

His father had disease of the knee-joint after an injury ten years before; for this it was excised and subsequently amputated, from which operation he succumbed.

On examination there was slight impaired abduction of the right cord with some injection of both cords; there was no other intra-laryngeal lesion. On the right side of the neck, below the posterior part of the right ala of the thyroid cartilage, was some fulness and slight tenderness on pressure. There was no evidence of any nerve lesion. The treatment was iodide of potassium and benzoin inhalations.

On January 19th his condition seemed decidedly better as far as the external fulness was concerned, and he remained in the same state when shown.

The lesion was regarded as an extra-laryngeal infiltration mechanically interfering with the action of the right cord through

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involvement of muscle or hindrance of proper movement at crico-arytænoid articulation. This, in spite of its subsidence under iodide of potassium, was regarded as probably tuberculous.

Dr. Dundas Grant considered that the defective movement of the right cord was due to mechanical fixation.

Mr. Milsom Rees thought that the appearance of defective abduction arose from a distortion of the larynx, the epiglottis being twisted.

The President remarked the right cord showed evidence of inflammatory changes; and

Mr. Robinson, in reply, said that both cords were congested when the case first came under observation.

Tumour of Right Vocal Cord. Case after Removal.

Shown by Mr. H. Betham Robinson. F. G—, æt. 48, was exhibited at the meeting on June 8th, 1898, with a small sessile swelling on the right cord at the junction of its anterior third with the posterior two thirds. It was convex, of a whitish colour, and compressible. Its removal was advised. This was accordingly done effectively with Grant's forceps under cocaine about ten days later. The tumour was very soft, and smashed up in the forceps, exuding a mucous fluid; thus no microscopical examination could be made. Its nature was either a cyst containing mucus or a myxoma.

The patient had now complete absence of symptoms, and on examination his right cord would be pronounced normal.

The President congratulated Mr. Robinson on the excellent result.

Paralysis (? Complete) of Left Cord.

Shown by Dr. Furniss Potter. The patient, a man æt. 48 years, came under observation on the 3rd of January last, complaining of hoarseness, which had come on gradually seven weeks previously. History of a "sore" twenty years ago, but none of rash, sore throat, or other sign indicating constitutional infection. Always had good health.

On examination the left cord was seen to be fixed and practically immoveable in a position rather external to a line midway

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between the extremes of adduction and abduction. The left side of the soft palate was markedly paretic, there was some diminution of sensation, chiefly along the lower border; the tongue when protruded deviated to the left side; no affection of trapezius, sterno-mastoid, or orbicularis oris. There were slight lateral nystagmoid movements of the eyes; the knee-jerks appeared to respond rather too readily. Examination of the chest gave negative result. Patient had been taking ten-grain doses of iodide of potassium for the last month, but with no appreciable effect.

Sir FELIX SEMON asked why Dr. Potter hesitated to call the case complete recurrent paralysis. He regarded it as a perfect case, the left cord being in the typical cadaveric position.

Dr. HERBERT TILLEY thought that such cases as these tended to uphold clinically what had been experimentally proved by Horsley and Beevor, viz. that the nerve-supply of the palate, contractors of the pharynx, and probably the muscles of the larynx, was the spinal accessory. This was the fourth case of the kind the speaker had seen within two months, and he thought it was very doubtful if the facial nerve innervated the palate at all, as had until recently been taught in our schools.

CASE OF ULCER OF NASAL SEPTUM.

Shown by Mr. BOWLBY. Female æt. 32, married, and with several healthy children. No history of tubercle or syphilis, and no evidence of either. Had some swelling of the septum nasi about a year ago. This remained covered by normal mucous membrane for six or eight months, and recently has become ulcerated. There is now an ulcer about the size of a large pea at the upper part of the cartilage of the septum. It is not painful. There is no bare bone and no other disease of the nose. The ulceration progresses very slowly in depth, and not at all in extent. No tubercle bacilli have been found.

Dr. DUNDAS GRANT considered the perforation more irregular in outline than the typical perforating ulcer, and more suggestive of tubercle or lupus. This idea was confirmed by the patient's tint and the injurious influence of cold weather.

Dr. STCLAIR THOMSON agreed that the ulceration was situated too far in the nose to be a simple traumatic perforation from the irritation of dust or nose-picking. He thought that against the suggestion of syphilis was to be placed the consideration that the disease had lasted

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a considerable time without the progress which is to be found in specific affections. The characteristic odour of nasal syphilis was also absent. He thought the indolent thickened margin and the situation both suggestive of tuberculosis. He had shown a similar case at the Clinical Society, where in portions of the removed granulations he had discovered typical giant-cells. In his case it had been objected that tubercle bacilli were not found in the sections, although carefully sought for. But as his patient had been treated with tuberculin and reacted strongly, he thought his diagnosis fully confirmed. Tuberculin might be used in the present case both for diagnostic and curative purposes.

Mr. WAGGETT said that the history of previous bilateral swelling and the presence of the much thickened and inflamed edges differentiated the ulcer in Mr. Bowlby's case from what was generally known as the perforating ulcer. The latter was characterised throughout its course by an atrophic process.

Dr. SCANES SPICER thought that the ulceration was probably syphilitic in nature, in spite of the absence of a characteristic stench.

The PRESIDENT said it was certainly not a case of ordinary atrophic ulceration. He had observed such cases from the commencement, and in one case had been able to predict a perforating ulcer. There was never previous thickening of the mucous membrane, but always atrophy.

SPECIMEN OF ABSCESS OF THE LARYNX.

Shown by Dr. DE HAVILLAND HALL. The larynx shown was removed from a female æt. 17. The patient was admitted into the Westminster Hospital on December 17th, with acute Bright's disease and lobar pneumonia of septic origin. Shortly after admission she became hoarse, and suffered from dysphagia. A satisfactory laryngoscopic view was impossible on account of the patient's condition. She died December 24th. At the necropsy about an ounce of dark green fœtid pus escaped from around the larynx, the cartilages of which were quite necrosed; the abscess had recently perforated the larynx through a small aperture. Both lungs were pneumonic. There were old thin pericardial adhesions. The cardiac valves were normal with the exception of the mitral, round which was a ring of large coarse vegetations. In the right lobe of the liver was a hydatid cyst, the size of an orange, containing hydatid membrane and thick olive-greenish viscid pus. The rest of the liver was febrile. The spleen and kidneys showed the ordinary changes of toxæmia.

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Infant exhibiting a Peculiar Grunting Inspiratory Sound.

Shown by Dr. William Hill. The noise was practically continuous, being just as well marked during sleep as at other times, but there was an occasional intermission during one or two respirations. The grunt was not affected by retracting the palate, and was, he believed, produced in some part of the larynx and not in the trachea. He had not passed a Schroetter's tube into the larynx, but such a measure would serve to differentiate between a tracheal and laryngeal sound. He thought the case belonged to the group described by Dr. Gee and Dr. Lees, and more recently by Dr. Lack, and he accepted the latter's explanation (which was an amplification of Dr. Lees' theory of the influence of the epiglottis) that the vestibular structures were here exceptionally lax, and collapsed during inspiration. This could be seen by the aid of the mirror. The sound was unlike those produced in the glottic region, and there was no reason to suspect stenosis from paralysis, or from any intra-laryngeal swelling.

The President did not consider the case agreed in all particulars with those described by Dr. Gee as cases of respiratory croaking in infants.

Sir Felix Semon thought that in this case the stridor was produced in the trachea, or at any rate below the larynx. He alluded to some recent papers pointing to enlargement of the thymus gland as the possible ætiological factor in such cases. He thought intubation would certainly settle the point as to whether the stridor arose in the larynx.

Mr. Milsom Rees remarked that the stridor ceased when the child cried, and asked if it continued in sleep.

Dr. Lack looked on the case as one of the milder forms of the affection commonly known as congenital laryngeal obstruction, and due, as in all such cases, to collapse of the vestibule aided by curling of the epiglottis. Where there was very marked obstruction the inspiratory sound was "like a chicken crowing," and occasionally associated with slight expiratory stridor. In less marked cases like Dr. Hill's the stridor was of a "purring," "grunting" character, with no expiratory sound. In all cases of tracheal obstruction due to pressure of an enlarged thymus *expiratory* stridor only was present, or at any rate much more marked than *inspiratory*.

Dr. Hill said the stridor continued during sleep. He would give the child chloroform and ascertain if the stridor continued then, and intubate with a long tube so as to exclude a laryngeal origin for the sound. Personally he thought it appeared to arise from the parts above rather than below the larynx.

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Case of Papillomata of Larynx.

Shown by Mr. Richard Lake. Patient has been hoarse for five years, but worse since an attack of typhoid fever last year. There is now a large papilloma in the anterior commissure springing from the right vocal cord, and also one of moderate size on the left vocal process.

Man æt. 51, shown at the November Meeting as a Case of Hypertrophic Laryngitis of Doubtful Nature, which is now seen to be Tuberculous.

Shown by Dr. StClair Thomson. The history of this case is described in the 'Proceedings' for November, 1898, p. 2. At that period the patient presented no evidence of pulmonary tuberculosis, and some suspicions were expressed that the case was malignant, and it was advised that a portion of the growth should be removed for microscopic examination. This was done, but with a negative result. The patient was put upon large doses of iodide of potassium. An ulcer, very suspicious of tuberculosis, appeared on the epiglottis, and the patient rapidly wasted. Further examination showed commencing phthisis, and the expectoration, which had previously been absent, revealed numerous tubercle bacilli. The case was now evidently one of tuberculosis, and was shown as illustrative of the difficulties which this affection in the larynx might present. From this point of view the case was similar to the one shown by Mr. Stephen Paget at one of the meetings last year.

Dr. Clifford Beale asked if the œdema occurred suddenly in this patient, remarking that he had commonly observed its rapid onset in similar cases where iodide of potassium was prescribed. Once present, however, it remained, and thus differed from acute œdema.

The President suggested that the iodide could be used like tuberculin, as a diagnostic test for tubercle.

In reply, Dr. StClair Thomson said the development of œdema of the arytænoids was as Dr. Clifford Beale suggested; it occurred quite suddenly in one week.

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Large Naso-pharyngeal Polypus.

Shown by Dr. Herbert Tilley. The polypus was removed from a woman æt. 45. The post-nasal space was filled by the growth, and it extended by a nipple-like process below the level of the uvula, producing, especially at night, a feeling of suffocation. It was removed with Löwenberg's forceps, and the resulting hæmorrhage was slight.

Sir Felix Semon inquired if the polypus had undergone cystic degeneration. In his experience, almost all nasal polypi which protruded into the post-nasal space contained larger or smaller cysts, whilst such were not nearly so frequently found in the myxomatous polypi situated in the nose itself.

Dr. Hill thought this was, properly speaking, a case of nasal, and not post-nasal polypus, the growth apparently arising from the interior of the nose. Further, he objected to the term myxoma being applied to nasal polypi.

Sir Felix Semon said he had used the term inadvertently from old custom.

Dr. Lack said he had quite recently removed a nasal polypus protruding both from anterior and posterior nares, and very firm, with no cystic degeneration. The specimen was very similar to Dr. Tilley's in shape and size.

Dr. Spicer agreed that nearly all polypi springing from both anterior and posterior ends of the middle turbinate contain cysts, often eight to ten small ones. He suggested that large cysts are often dilated ethmoidal cells.

Mr. Waggett wished to corroborate Sir Felix Semon's statement that cysts were generally evident in polypi removed from this position. Moreover small glandular cysts were to be found in the large majority of all nasal polypi.

In reply, Dr. Tilley said that he removed the polypus with Löwenberg's forceps passed into the post-nasal space. He had used the term naso-pharyngeal in an anatomical sense, and not as indicative of the pathological nature of the new growth. The polypus contained one or two large cysts, and measured five inches in its longest and three and a half inches in its shortest diameter.

Epitheliomatous Ulceration of Naso-pharynx.

Shown by Dr. Herbert Tilley. Patient is a man æt. 55. He complains of difficulty in breathing through the nose, and an unpleasant discharge into the mouth, also general weakness.

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The palate is seen to be immobile and almost vertical in direction, obviously due to something in the post-nasal space. Its free borders are so thickened and congested that only a small aperture just sufficient to admit the index finger to the naso-pharynx is present. On introducing the finger the ulceration is very evident, and the discharge peculiarly offensive, reminding one of that which is so characteristic of advanced epitheliomatous disease of the tongue. There is an enlarged gland under the upper part of the left sterno-mastoid. A mixture of iodide of potash and mercury perchloride during the last week has had no visible effect on the disease.

Dr. StClair Thomson had had a similar case in a patient æt. 34. He had considered it a case of late adenoids, although the growth appeared rather congested. Operation was attended with profuse hæmorrhage. Patient was seen a few months later with recurrence of growth and enlarged glands in neck. He died shortly after, and the diagnosis of epithelioma of Luschka's tonsil was confirmed by necropsy and microscopical examination.

Mr. Milsom Rees had recently had a similar case.

Case of Empyema of the Antrum cured by Alveolar Irrigation after Failure of Intra-nasal Treatment.

Shown by Dr. Dundas Grant. In this case an endeavour had been made to treat the condition by irrigations by means of cannulas introduced into the antrum through the inferior meatus according to Lichtwitz's method, but without bringing about any continuous cessation of the discharge. The condition obviously arose from disease of several teeth, the stumps of which were thoroughly removed. The alveolar puncture was then resorted to, and the patient irrigated her antrum night and morning without difficulty, with the result that extremely rapid improvement took place, and there was every prospect that eventually a cure would be effected. Dr. Grant brought forward this case to show that his advocacy of intra-nasal methods did not prevent him from recognising the value and unequalled convenience of the alveolar puncture in suitable cases.

Sir Felix Semon thought the Society should be very grateful to Dr. Grant for bringing this case forward, as a contrast to the one

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shown at the last meeting. Sometimes one method, sometimes another, was to be preferred; tnere was no royal road to success.

Dr. HILL and the PRESIDENT suggested this case was of dental origin, and therefore alveolar puncture was successful when intra-nasal failed.

In reply, Dr. GRANT stated that he had in that Society formulated the proposition that antral empyemata of dental origin should be treated through the alveolus, those of other origin through the nose.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

48TH ORDINARY MEETING, *March 3rd,* 1899.

F. DE HAVILLAND HALL, M.D., President, in the Chair.

WILLIAM HILL, M.D., } Secretaries.
LAMBERT LACK, M.D., }

Present—27 members and 1 visitor.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were unanimously elected members of the Society:

Mark Purcell Mayo Collier.
St. George Caulfield Reid.
H. Fitzgerald Powell.

The following gentlemen were nominated for election at the next meeting:

Henry J. Davis, M.B.Camb., M.R.C.P.London.
Peter Abercrombie, M.D.Glasgow.
Alfred B. Lazarus, M.B., C.M.Edinburgh.

The following cases were shown:

CASE OF LARYNGEAL PARALYSIS SECONDARY TO STRICTURE OF THE ŒSOPHAGUS.

Shown by Mr. BOWLBY. Man æt. 50. Suffers from difficulty in swallowing and loss of voice. His symptoms began

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twelve months ago, when he had a very slight difficulty and pain at about the middle of the sternum on swallowing. Six months ago he suddenly lost his voice, and has had partial aphonia ever since. Swallowing has gradually become more difficult, and for three months he has been unable to take anything more solid than soaked bread.

Present condition.—On the left side of the neck there is some fulness, and a mass of hard, matted lymphatic glands can be felt reaching from the clavicle upwards to the level of the cricoid cartilage. On passing an œsophageal bougie a stricture can be felt at a distance of seven inches from the teeth. Laryngoscopical examination shows that the larynx is natural, except that the left vocal cord is fixed in a position midway between abduction and adduction. In front of the processus vocalis the free edge of the left cord is concave. Nothing abnormal in the chest. Pulses equal. Pupils equal.

I have seen paralysis of the vocal cords in cases of œsophageal stricture on several occasions, the left cord being more often involved. I think it may be compressed either by the original growth or by enlarged and infiltrated glands. In the present case the concavity of the cord is very marked, a condition probably due to paralysis of the internal tensor.

Dr. Clifford Beale described a case he had just seen which was almost similar, but at a somewhat more advanced stage. The patient had been for some time under observation, the first evidence of mischief being obstruction of the larynx. On the left side of the trachea there was a swelling which was acutely tender. Under large doses of iodide of potassium the swelling had considerably diminished, and the pain absolutely disappeared. The larynx showed complete abductor paralysis, the cords lying in the cadaveric position. When first seen she spoke with a clear voice. As the patient was subject to adductor spasm, tracheotomy had to be performed. It was now possible to examine freely, and all down the neck on the left side of the œsophagus a hard infiltration could be felt. Under chloroform the top of the growth could be made out with the finger. There was no evidence to indicate how long the paralysis of the cords had lasted, as the voice had not been affected, and up to the time he had first seen her there had been sufficient breathing space.

Sir Felix Semon would not undertake to say off-hand whether, in his experience of œsophageal stenosis, the right or the left vocal cord was more frequently affected, but he could recall several cases of œsophageal obstruction in which the right vocal cord had been paralysed. It was possible that the latter cases made a greater impression

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on their minds, since in cases of left-sided paralysis an aneurism was more often the cause than œsophageal mischief. With reference to the flaccid and excavated appearance of the left vocal cord, and the question whether that was due to participation on the part of the superior laryngeal nerve, or whether implication of the recurrent was alone sufficient to explain it, he believed that the latter fully sufficed, because, if the internal tensor became paralysed, the result, in his experience, was the excavated and flaccid appearance of the vocal cord exhibited by Mr. Bowlby's patient. It has been recently stated that if the recurrent laryngeal nerve was completely paralysed, the crico-thyroid muscle would, being no longer opposed by any antagonistic muscle, from mere inactivity undergo degeneration and atrophy. This statement, he was convinced, was purely theoretical. He need only point to cases of abductor paralysis in tabes, such as shown in this Society, in which the affection had lasted for ten or more years, and yet the patient had been able not only to speak with a perfectly normal voice, but even to sing. If that period was not sufficient to produce paralysis of the crico-thyroid from inactivity, he wondered what time was required for the purpose. Besides, Dr. Friedrich, of Leipzig, and Dr. Herzfeld, of Berlin, had found on post-mortem examination the crico-thyroid perfectly normal in cases of complete and long-standing recurrent paralysis. He would suggest that every opportunity be seized in such cases of making a post-mortem examination and instituting a thorough macro- and microscopic examination of the crico-thyroid, and publishing the results of the observation.

Dr. de Havilland Hall could see no anatomical reason why, in cases of malignant disease of the œsophagus, one vocal cord should be more frequently affected than the other. He thought he had himself seen more cases of right than of left-sided paralysis, but, as Sir Felix Semon had remarked, right-sided paralysis probably made more impression on their minds than left-sided, which was so comparatively common that they were not surprised to find it, whereas a case of right-sided paralysis put them on the *qui vive* to ascertain its cause. As for the place of involvement of the nerve, he found that on pressing the enlarged gland of the neck the man had a distinct attack of spasm of the glottis, and there was marked stridor. This, he thought, the left cord being paralysed, must have been through the afferent fibres and down the vagus on the right side.

Case of Lupus of Nose.

Shown by Dr. Edward Law. Female, æt. 33, came to the hospital three years ago suffering from lupus of the skin of the left ala nasi, with a few granulations inside the nasal orifice. Perfect cicatrisation took place after scraping, &c., and no recurrence was noticed for eighteen months, when granulations appeared on the floor of the left nasal fossa and extended up to

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the middle turbinal, with nodules on the posterior margin of the septum. Curetting, and applications of lactic acid brought about a satisfactory result, and the patient was discharged apparently cured. A few weeks ago, a posterior rhinoscopic examination revealed a small swelling in the soft palate, immediately behind the posterior margin of the septum.

CASE OF NASAL POLYPI COMPLICATED BY WELL-MARKED BILATERAL SEPTAL OBSTRUCTION.

Shown by Dr. EDWARD LAW. Patient, æt. 31, came under observation at the end of last year on account of difficulty in nasal respiration, one or other side being constantly blocked. There is a history of the nose having been broken whilst playing football sixteen years ago, and of a similar accident five years ago, "when there was some difficulty in keeping the three pieces in their proper position."

Examination showed an irregularly deflected septum, with well-marked bilateral prominences at the lower margin of the nasal bones, and an unusually large, long, and thick spur running parallel to, and in union with, the inferior turbinate on the left side. The whole septum is much thickened, and there are polypi in each nasal cavity behind the obstructions. At first it was impossible to obtain a posterior rhinoscopic image on account of the great irritability which accompanied the naso-pharyngeal catarrh. This disappeared after the discontinuance of tobacco, malt liquors, and attention to diet, &c. The posterior extremities of both inferior turbinals are somewhat hypertrophied. The case is interesting, and the opinion of members is requested as to the methods and extent of operative interference.

A discussion ensued on operative interference in cases of stenosis of the nose in general.

Sir FELIX SEMON said he had recently had a series of cases in which the tendency to adhesion, which was so marked a peculiarity after operations in the nose, had been even more prominent than usual. In one case in which he had removed, by sawing and cutting, a projecting part of the turbinate bones and the septum, every means

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he had tried to keep the passage open had failed. The patient had been unable to bear plugging with gauze or wadding; neither could she stand gutta percha, celluloid, or silver. Ivory was the only thing she could bear. He had tried every astringent and sedative he knew of, and had employed cocaine so as to contract the mucous membrane. Nothing availed; everything irritated and gave pain; and each time the plugging was left off adhesions formed. He had sent the patient to her home, and there the parts grew together again, so that he had anew to operate. She was now wearing an ivory plug. When it was taken out she breathed as freely through one nostril as the other, but, although there was a distance of 2 mm. between them, the opposite surfaces touched and united when the plug was left out for six hours. He would like to know if anyone could suggest what to do in such a case. At present he was merely applying pure paroleine, and there was no pain now.

Dr. WILLIAM HILL said that within the last few months he had operated on a case seven times. First he had cut away a piece of the turbinal and a small bit of septum. On removal of the plug, a clot or a scab would form and a bridge appear. In this case he had cut with scissors the turbinal on the outer side, and destroyed the bridge quite six times. He had used the soft rubber plug, which he believed was least irritating, though not very aseptic, and it had been borne well. He believed that if they simply went on persistently with a suitable plug, healing must in course of time occur.

Dr. WAGGETT said he had had a similar case that gave great trouble. He had come to the conclusion that the prolonged use of plugs after operation was disadvantageous, in that it caused a local anæmia of the injured parts and prevented healing. The parts could be kept asunder without pressure by inserting a sheet (not a plug) of celluloid, which took up little room and left quite enough space for the escape of discharge from the surfaces of the ulcers. The celluloid should be removed daily, and the nose syringed.

Mr. SPENCER said it was the continuance of the local treatment that was the difficulty, owing to the pain caused, especially in the hyperæsthetic cases. In Dr. Law's case there were two very thick ridges of half cartilage, half bone, close down upon the floor of the nose. To treat such a case by Bosworth's saw on either side would be exceedingly difficult, the nose was so narrow. Every case should be treated, if possible, under cocaine, but there was a more complete method of treatment, namely, to remove, under an anæsthetic, the whole of the inferior turbinal, either by knife or scissors, and at the same time, if the nose were excessively narrow, to dilate it till it was thoroughly free Dr. Hall had sent a young man to him in whom there was marked hyperæsthesia. The anterior part of the inferior turbinal had been removed by a practitioner, but an adhesion to the septum had formed. A plug had been put in, but the pain prevented its retention. Under a general anæsthetic, the whole inferior turbinal bone was removed, the nose was plugged for a day, then douched, and under this treatment had healed, leaving a free passage.

Dr. SCANES SPICER said he felt sure Dr. Law's case was one of those in which, having obtained permission to remove whatever was necessary

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to radically clear the nasal obstruction, a general anæsthetic should be given and the thing done thoroughly. It might be necessary to remove the spurs on both sides and to tackle the middle (for the case was complicated with polypi and purulent sinusitis) as well as the inferior turbinates. That, of course, would mean ten days or a fortnight's confinement to hospital; but such a case as this was best and quickest treated in this radical fashion. Referring to Sir F. Semon's case, of late years he had had no troublesome adhesions after nasal operations until last December, when, through not continuing long enough personal attention to the nose, he had seen two. One patient, having been in London for ten days, was allowed to return home too soon after operation; a "cold" supervened, a bridge formed, and she had to return to London, and it took over a fortnight to conquer the bridge. In the second case exactly the same thing happened. He had worked at this case for two months, and the patient was not yet out of the wood. In obstinate and irritable cases he believed the proper plan was to give the patient a complete rest and allow the bridge to consolidate, simply lubricate with soothing unguents, and get all inflammation down; then, later, attack the non-inflamed bridge. In such a case as Sir Felix Semon had described, a temporary policy of masterly inactivity, such as recommended, would in the end prove most efficient and shortest. It was possible that in these cases freer removal of adjacent parts should have been done, and would have prevented this bridging. For his own part the speaker felt his errors had been invariably in the direction of removing too little rather than too much.

Dr. DE HAVILLAND HALL said that nothing short of the heroic measures taken in the case instanced by Mr. Spencer would have succeeded, the condition being one of long adhesion in narrow nostrils. The result was exceedingly satisfactory.

Dr. DONELAN said he had had much trouble with an adhesion associated with a good deal of hyperæsthesia. There was eczema of the auditory meatus, for which he was using Burow's solution of acetate of lead and alum. He at last tried this in the nose, separating the adherent surfaces with lint soaked in it. The hyperæsthesia was at once relieved, and the adhesion was soon overcome. He further referred to the occasional ill effects of turbinectomy, and mentioned a case in which necrosis of the upper jaw and facial paralysis had followed that operation.

Dr. DUNDAS GRANT said that he had performed inferior turbinectomy for the purpose of getting rid of an adhesion with satisfactory result; but in one case, where there was no previous adhesion, plugging after complete removal of the inferior turbinate body was followed by such inflammatory reaction that an adhesion formed. In one case of adhesion between the left turbinate and the septum in a medical man he had removed the anterior extremity of the turbinate; but that did not prove sufficient. The patient then asked him simply to remove the band, and he would try to keep it open by means of a nasal bougie made of the silk-wove material used in urethral bougies. This the patient cut short, and went about with it *in situ* all day. He was now cured. It was sometimes a question whether adhesions required to be

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interfered with. In a case in which the nasal obstruction was so marked that he could only remove the polypi at the posterior part after sawing away a spur on the septum, an adhesion formed which seemed to cause no discomfort, and the relief from the partial operation was so great that he was exercising a "masterly inactivity." Use of cocaine had two effects, anæsthetisation and contraction. But a spray of 4 per cent. of antipyrin would bring about contraction of longer duration. It was, however, rather irritating, and he preceded it by a spray of 5 per cent. eucaine. With that combination an enormous amount of comfort was afforded without risk. In reply to a remark by Mr. Atwood Thorne, that bridges did not seem to him to form unless both terminal and spur were operated on at one time, and his suggestion that they should be dealt with at different times, Dr. Grant replied that there had been cases of adhesion which had arisen without any operative interference at all.

Dr. Edward Law, in replying to the discussion, said that unless the adhesion mentioned by Sir Felix Semon was a very broad one, he should certainly let it heal, and not tamper with it for six or twelve months. One had occasionally to break down adhesions in order to pass the Eustachian catheter, and he had been surprised at the ease with which the surfaces could be kept apart compared with the adhesive tendency manifested after any operations in the nose. This freedom from adhesion in the case of the division of bridges of long duration was probably accounted for by the adjacent mucous membrane being in a more or less normal condition.

Case of Complete Adhesion of the Soft Palate to the Posterior Wall of the Pharynx.

Shown by Dr. de Havilland Hall. The patient, a married woman of 33, was quite unaware of her condition until informed of it, but she noticed that she could not blow her nose like other people. She has never suffered from sore throat or skin affection. The left central incisor, upper jaw, is notched and pegged. Eyes not affected. Patient had one child 12 years ago, and has had no miscarriage. She is an only child, and states that her mother had miscarriages. The case is clearly one of inherited syphilis.

Foreign Body impacted in the Naso-pharynx for Four Years.

Shown by Dr. D. R. Paterson. This was a metal regulator for rubber tubing frequently used with infants' feeding bottles.

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It was removed from a child aged six years, who came with the history of otorrhœa of the left side and fœtid discharge from the left nostril. There was inability to breathe freely through the nostrils, and something could be distinguished in the posterior nares on looking through the left nostril. Under an anæsthetic a hard mass was felt above the soft palate, fixed immediately behind the posterior choanæ, and on removal was found to be the foreign body thickly coated with phosphates. A history was obtained that when the child was fifteen months old, and was playing with a regulator, it suddenly showed difficulty of breathing, which was relieved by suspending with head downwards, though from that time the nasal breathing became obstructed and the child suffered in health. At various times bougies were passed by different medical men into the œsophagus with a view of disabusing the parents of the notion that there was a foreign body in the throat, and it was for relief of the aural and nasal trouble that advice was lately sought.

Mr. PARKER related what might be called a surgical freak. A boy had come to him complaining of obstruction of the nose. By the aid of the posterior mirror he saw a large grey mass in the posterior nasal space, but, unable to determine what it was by inspection, he had put his finger up. This did not reveal the nature of the body; but just then the boy gave a great heave, and from the back of his nose came a piece of drainage-tube about two inches long and half an inch in diameter. The boy had had an abscess in his neck two years previously, in connection with which the drainage-tube had been used.

CASE OF LARYNGEAL VERTIGO.

Mr. ATWOOD THORNE showed a man, æt. 51, who came to Dr. William Hill at St. Mary's Hospital, on January 5th, 1899, complaining that "whenever he had a fit of coughing he felt giddy and lurched towards his right front." He has been subject to paroxysms of coughing on and off for two years, but the condition has been getting worse lately. He has never fallen, but has to catch hold of something to prevent his doing so.

He is slightly deaf, and for the past two months has had noises "like heavy traffic" in his head.

He has polypoid hypertrophy of both middle turbinates, some lymphoid hypertrophy at the base of the tongue, and some

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slight swelling in the interarytænoid space. There is some pulmonary emphysema. No other cause for vertigo being ascertained, the case is brought forward as one of laryngeal vertigo.

Fifteen minims of dilute hydrobromic acid have been given three times a day, and the man describes himself as rather better.

While at the hospital the man has never had an attack, forced coughing not having affected him in any way.

Dr. LAW thought it was possibly a case of *aural* vertigo. The patient complained of deafness and tinnitus; the tympanic membranes were retracted. He thought that catheterisation would reveal the Eustachian tubes to be over patent. The man had probably for some time given his ear repeated concussions either by coughing or blowing his nose. He should be recommended not to blow his nose violently, and some remedies should be given to relieve his cough.

Dr. HILL said the man had been under him for aural treatment. He at first had assumed the case to be one of aural vertigo, but finding the patient had signs of exhaustion sinusitis before one of the attacks, he then was inclined to think it was a case of *nasal* vertigo. Afterwards it was found that the attack *always* came on in connection with some laryngeal irritation and cough, and narrowed down in that way; he believed it was really an instance of laryngeal vertigo.

Dr. DUNDAS GRANT said although the theory of aural vertigo had been propounded by some authors, he was indisposed to accept it, if only because of the extreme rarity with which vertigo followed inflation of the middle ear, a result he himself had never seen. In a case of very definite laryngeal vertigo, or rather syncope, as it was better called, there was a strong gouty tendency, after treatment for which he believed the vertigo disappeared.

Dr. STCLAIR THOMSON suggested that it might be *cardiac* syncope. The patient's pulse was very small and quick, and slightly irregular. The man himself said that when he bent forward to lace his boots he felt inclined to fall on his nose.

CASE OF TUBERCULOUS INTERARYTÆNOID GROWTH.

Shown by Mr. J. S. LUCAS for Mr. Lake.

The patient, a female æt. 33, has been hoarse for four months. For the last eight weeks she has been under treatment, and the throat has been painted with formalin in 3 per cent. solution. She has improved greatly, but still complains of pain if the throat is not painted daily. The swellings in the interarytænoid region are rather unusual, being very irregular.

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Two Cases of Extra-laryngeal Cyst.

Mr. Waggett showed two young men exhibiting cystic formations in the thyro-hyoid region.

In the one case a cyst the size of a hazel-nut was found lying upon the thryo-hyoid membrane on the left side. In the second case a tumour, partly cystic, and about the size of a walnut, was present on the left side over the thyro-hyoid membrane and extending down over the corresponding ala of the thyroid cartilage. This was probably a cyst developed from the pyramidal lobe of the thyroid gland.

Mr. de Santi thought the first case a bursal cyst, extra-laryngeal and unconnected with the thyroid. It might be necessary to make a deep dissection, but he thought Dr. Waggett could cut down and remove it. He could not get "blowing out."

Dr. StClair Thomson asked whether the possibility of so-called pneumatocele had been considered, as the tumour could be distended by blowing with closed lips.

Mr. Waggett had at first considered the second case to be one of pneumatocele. He had, however, convinced himself that the slight enlargement which occurred on coughing was due to venous engorgement. On external pressure a slight prominence occurred in the region of the left aryepiglottic fold, but it was quite impossible to cause any diminution in the size of the tumour by prolonged manipulation. He felt certain that the cyst in no way communicated with the lumen of the air-passages. Mr. Waggett agreed with Mr. de Santi in thinking the first case to be one of bursal cyst. As it caused no inconvenience he did not propose to operate.

Case of Multiple Laryngeal Papillomata in a Child æt. 3½ Years, completely removed in three sittings by Endo-laryngeal Method under combined General Anæsthesia and Local Cocainisation, and without Tracheotomy. Result: Full Restoration of Voice and Normal Breathing.

Dr. Scanes Spicer showed this case. Boy, æt. 3½, lost his voice after a cold at the age of seven months, and has always spoken since in a breathy whisper; there is no sound in his laugh or cough, and his breathing is noisy, especially at night. He is highly intelligent, but shy, and can say anything

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in his peculiar whisper. His tonsils are enlarged, and there is post-nasal adenoid hyperplasia. Laryngoscopic examination not practicable without anæsthetic.

February 1st.—Dr. Fred. Hewitt administered gas, ether, and chloroform, and patient was placed in intubation position in nurse's lap. The condition was:—Large median, cauliflower mass, whole length of glottis, flapping freely in air current, and attached somewhere on right side; right cord embedded in multiple, pale, warty growths; left cord perfectly healthy and mobile. The median mass only was removed by antero-posterior cutting forceps, as the larynx was irritable, and preparations had not been made to tackle the growths on that occasion.

8th.—No return of voice, but breathing much quieter, especially at night. Anæsthetic was given again as before, and the larynx was sponged with a few drops of 20 per cent. cocaine solution, and well mopped out. This was done two or three times until the larynx was tolerant of the probe and forceps. Eight or ten large clusters of growths were then removed, blood being mopped away at times. After this the tonsils and adenoids were removed.

16th.—The patient still speaks in a whisper, but there is sound in the cough and laugh. Anæsthetic given again and cocainisation as before. Small growth removed and larynx seen to be absolutely free. Recovering from anæsthetic a curious croupy inspiration was observed, which was especially marked when anyone was in the room, but subsided when patient was left alone. The sound of voice did not return for some days, and only gradually. Apparently determined effort was requisite to produce the voice, and it had a raucous, monotonous character devoid of inflexion.

This case is interesting as a further proof of the practicability of removing laryngeal growths in young children by the method described by the writer some years ago. He then had had four such cases, later one more, and, until the present one, no case of the kind for five years. This case has been far more rapid than any of the others, and the operator has been much indebted to Dr. Hewitt for many suggestions in connection with the anæsthetic and position. It is also a point of much interest that the

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voice did not return at once, though there was no mechanical impediment to adduction. This might have been due to slight bruising during operation, or it might have been a result of the threefold co-ordination of breath, articulation, and adduction never having been established at the time when the child lost its power of adduction.

Sir FELIX SEMON thought the result most satisfactory, and one upon which Dr. Spicer ought to be congratulated. He had himself seen the child before the operation. It was then in a very bad condition, perfectly aphonic, and with loud laryngeal stridor, and a suggestion of tracheotomy had been made.

Dr. WILLIAM HILL said Dr. Spicer's results put the question of treatment of papillomata in children of three or four years of age on quite a new basis. Instead of putting off operation till the patient was seven or eight, Dr. Spicer cleared out the larynx at any age. He had himself seen two cases in which the finger nail was used at his suggestion to remove some of the growths.

Dr. SCANES SPICER said the growths were removed under the guidance of the mirror. The longest time occupied at a sitting in his earlier cases was two hours. There was a good deal of trouble in connection with the chloroform. Very little cocaine solution was used. He followed up the spray immediately with a dry cotton-wool mop, giving it a brisk turn round so that no cocaine was swallowed, and a local anæsthetisation was thus procured, which supplemented the chloroform and allowed the field to be operated on without exciting reflex contraction and closure. In the present case Dr. Frederic Hewitt had given the chloroform, and had much facilitated the operations.

CASE OF PACHYDERMIA OF THE LARYNX, PROBABLY DUE TO CHRONIC RHINITIS.

Shown by Dr. DUNDAS GRANT. Man, æt. 21, was first seen by Dr. Grant on the 25th February, when he complained of huskiness of the voice which had persisted for two months subsequent to a cold, also frequent coughing and hawking. He attributed the condition to an attack of diphtheria nine years before. It appeared that on at least two occasions such hoarseness had followed colds and had lasted for several months. On examination of the larynx there was found a dry congestive condition of the vocal cords, with a pale irregular fringe on both vocal processes. The thickness on the vocal processes was

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irregular, and the processes appeared on phonation to dovetail into each other.

In the nose there was hypertrophy of the inferior turbinated bodies and increased muco-purulent secretion. There was no history of specific disease nor of excessive use of the voice. The patient is otherwise in excellent health, and the condition, if not absolutely typical of pachydermia, seems to approximate to it extremely closely. The treatment proposed is the removal of the hypertrophied portions of the inferior turbinated body and application of the alcoholic solution of salicylic acid to the larynx.

Dr. de Havilland Hall doubted whether the case could be called one of pachydermia. It did not extend far enough along the processus vocalis. He had seen pachydermia in alcoholics who were also voice users. Sir Felix Semon having remarked that he had seen it most frequently in clergymen, Dr. de Havilland Hall further remarked that one of his cases was that of a clergyman in whom lipomata on the nape of the neck had led him to suspect alcoholism.

Dr. Dundas Grant thought his case approximated closely to pachydermia, though not of the typical shirt-button type, and was a hyperplasia of the epithelial tissue.

Case of Papilloma of the Larynx previously shown in an Elderly Man. Complete Removal.

Shown by Dr. Dundas Grant. Man, æt. 60, came under my care on the 28th October on account of hoarseness and loss of voice of a year's duration. The growth in this case was removed by means of Grant's forceps, and on microscopical examination presented the characteristics of a soft papilloma. The stump underwent some regrowth, but the alcoholic solution of salicylic acid was applied and the forceps again used, leaving only a slight roughness on the site of the growth. This was treated with local application of salicylic acid two or three times a week, and at present the voice has reached its normal condition; the edge of the cord is nearly smooth, though its colour is still abnormally red.

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Case of Multiple Papillomata.

Shown by Dr. Dundas Grant. A woman æt. 59 came under my care on February 23rd on account of hoarseness and loss of voice of two years' duration. On the edge and upper surface of the right vocal cord was a sessile mass of a soft, warty appearance, which was, from its mobility, apparently of soft consistency, the papillation of the surface being particularly marked. This extended to the anterior commissure, where there was a roundish outgrowth. The left vocal cord was reddish and irregular at its edges, but was partially concealed by the growth from the other side. The movement of both sides of the larynx appeared to be normal, the voice was almost lost, and was more whispering than hoarse. By means of Grant's forceps a large portion of the growth was at once removed, but no particular effect on the voice was produced. Three days later, further removal was effected by means of the same instrument, but the growth at the anterior commissure could not be reached, probably on account of the length of the beak of the forceps employed. This was, however, removed completely by means of MacNeill Whistler's forceps. On the 1st of March the larynx was free from any large mass of growth. There still remained a slight fringe on the right cord, and there was seen below the middle of the left one a pale smooth sessile growth of very small dimensions. A 5 per cent. solution of salicylic acid was then applied between the cords. At this date the voice seemed as toneless as ever, but with a little insistence the patient was induced to utter hoarse but fairly loud sounds. It seemed as if the habit of whispering had become established, and that even after removal of the new growth in the larynx this would have to be overcome by practice.

Case of Large Gumma in Posterior Pharyngeal Wall.

Shown by Mr. Arthur Cheatle. A woman, æt. 37, came to the Royal Ear Hospital ten days ago, complaining of difficulty of swallowing, and "a lump" in her throat. A smooth swelling,

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an inch and a half in breadth, situated slightly to the left of the middle line, reached from high up in the naso-pharynx downwards to the level of the top of the larynx. It was soft and fluctuating in the centre, hard at the edges, where it faded into surrounding parts. There was a history of numerous miscarriages and some stillbirths. Resolution was taking place under iodide of potassium and perchloride of mercury.

Case of Fixation of Left Vocal Cord with Fibrillar Movements.

Shown by Mr. W. G. Spencer. The patient, æt. 62, served in the navy, but having suffered from repeated attacks of rheumatism, he was invalided. His voice has not been good for years, and he has had attacks of aphonia. During the last four months he has been very hoarse or completely aphonic. The left vocal cord is fixed as regards voluntary movements. The arytænoid cartilage is fixed and drawn forwards, forming a ridge. The cord itself is unaltered, but continually exhibits fibrillar movements. Some congestion of the larynx has become less under treatment.

Dr. Herbert Tilley suggested that the curious appearance presented was due to tilting and fixation of the arytænoid cartilage, and that there might be some trouble (possibly rheumatic) in the crico-arytænoid joint. The twitching movements of the tissues covering the fixed arytænoid reminded him of a similar condition seen in a case of syringomyelia, with palatal and left abductor laryngeal paralysis, shown to the Society by Dr. Horne (June 9th, 1897).

Sir Felix Semon referred to a former paper of his on the subject, which described a case in which there was also complete tilting of the arytænoid cartilage, with fixation of the cord and the formation of a ridge in consequence of the drawing of the parts. In that case there appeared to be congenital anchylosis and luxation of the crico-arytænoid joint.

Case of Recurrent Papillomata of Larynx.

Shown by Mr. C. A. Parker. The patient, a man æt. 25, was first seen three years ago, when he had been hoarse for four months. The larynx was then found to be almost entirely filled

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with papillomatous growths. The growths were removed, with great improvement to the voice. At intervals of a few months the patient has returned with recurrence of the growths, which have been removed on about twelve occasions. The patient has not been seen until now for fourteen months. The voice is impaired, and he has pricking pain on swallowing. The whole of the anterior part of the larynx seems to be filled up with growths, the posterior wall alone is free.

A Skiagram of Foreign Body in the Œsophagus.

Mr. de Santi showed a skiagram of a halfpenny tightly wedged in the œsophagus, opposite the level of the top of the sternum.

The patient was a child of 2 years 11 months, who had swallowed a halfpenny eleven days before Mr. de Santi saw him.

The mother of the child stated she had carefully examined the stools passed, but had seen no halfpenny. Beyond having occasional attacks of vomiting there had been no symptoms.

When brought to Mr. de Santi the mother stated the child complained of pain in the right iliac fossa. On examination the child cried on that locality being pressed.

Mr. de Santi ordered the air-passages to be skiagraphed. The halfpenny was then clearly seen in the œsophagus. Under chloroform the top of the coin was with difficulty felt with the tip of the index finger. It was extracted by means of the coin-catcher, although tightly wedged.

The child made an uninterrupted recovery. The interest of the case lay: (1) in the length of time the coin had remained impacted in the œsophagus, *i. e.* twelve days; (2) the absence of any localising symptoms, such as pain, dysphagia, or dyspnœa; (3) the presence of pain around cæcum, suggesting lodgment of the coin in that neighbourhood; (4) the absence of any inflammation or ulceration in the neck where the coin was wedged.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

50TH ORDINARY MEETING, *May 5th*, 1899.

F. DE HAVILLAND HALL, M.D., President, in the Chair.

WILLIAM HILL, M.D., } Secretaries.
LAMBERT LACK, M.D., }

Present—33 members and 9 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentleman was nominated for election at the next meeting:

Charles Heath, F.R.C.S., 3, Cavendish Place.

DISCUSSION ON ASTHMA IN ITS RELATION TO DISEASES OF THE UPPER AIR-PASSAGES.

The PRESIDENT in a few introductory remarks said that it had been decided to devote this meeting to a discussion upon "Asthma in its relation to Diseases of the Upper Air-passages." This subject in many respects was a purely medical one, and illustrated the importance of the laryngologist being not only a surgeon but an able physician. He was glad to announce that Dr. Percy Kidd had consented to open the discussion with the medical aspect of the case, and that Dr. P. McBride would follow, and treat the subject from the point of view of those who practised more especially in the diseases of the upper respiratory tract.

Dr. PERCY KIDD said: In accepting the invitation of the Council to

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assist in opening the present discussion, I felt more than the traditional hesitation professed on such occasions from the conviction that there must be many members of the Society who have had a larger experience of the subject in certain of its aspects. But hearing that my task was to be shared with Dr. McBride I took courage, for I had the assurance that any deficiency on my part would be more than made good in his address. In order to promote discussion and not to occupy too much time I shall endeavour to make my remarks as short as possible, avoiding any attempt to discuss the literature of the question, and dealing mainly with matters of which I have had personal experience. According to the generally prevailing view, asthma is essentially a neurosis, in which the respiratory system is predominantly engaged, though reflex relations with other organs are often manifested. In speaking of asthma I refer only to what is commonly described as bronchial asthma, no mention being made of cardiac or renal asthma. It is well known that nasal symptoms, sneezing, hypersecretion, and obstruction of the nares, are not uncommonly met with in connection with asthma, and great attention has been devoted to this relation since Voltolini succeeded in curing a case of asthma by removing nasal polypi. The pathology of the asthmatic seizure is still somewhat uncertain, the theories most in favour ascribing the dyspnœa either to spasm of the bronchial muscles, or to vasomotor dilatation of the blood-vessels of the bronchi. A considerable advance in our knowledge was undoubtedly made when the close relations of bronchial and hay asthma became recognised, for a strong side-light was thereby thrown on the pathology of the asthmatic paroxysm. In view of the phenomena of hay fever one can hardly doubt that vascular dilatation plays a very important part in the production of asthma, whatever the influence of spasm may be, and the tenacious pearly sputum of asthma with its peculiar spiral threads is quite as easily explained according to this view as by the assumption of a special form of bronchiolitis.

To return to the subject of the relation of nasal disease to asthma. It appears to me that the frequency of this association has been much exaggerated, particularly by Bosworth, who says, to quote his own words, that "a large majority, if not all cases of asthma are dependent upon some obstructive lesion in the nasal cavity." It is assumed by this writer and others that nasal symptoms in asthma are invariably the result of some definite local lesion, and that asthma is a reflex result of the morbid condition of the nose. It cannot be denied that nasal symptoms may precede, accompany, or alternate with attacks of asthma, but the evidence forthcoming in support of the view that the two groups of phenomena necessarily stand in the relation of cause and effect is not altogether convincing. It cannot be said that there is anything characteristic in the nasal changes found in asthmatic subjects polypi, periodical swelling of the mucous membrane of the inferior turbinal and other parts, hypertrophic rhinitis, œdematous swelling over the cartilaginous septum, and various obstructive deformities, such as spurs and deviations of the septum. These conditions are common enough, and yet it is quite the exception to find them associated with asthma. According to my experience, the state

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of the nasal cavity in asthmatic persons is generally substantially sound. The strongest proof of the influence of nasal disease upon asthma consists in the relief to the paroxysms of dyspnœa that sometimes follows surgical treatment of the nose.

In some cases (I should say, a very few) the amelioration is so marked as to suggest that the asthma was a reflex result of the nasal disorder. But in most instances any improvement that ensues is temporary and incomplete. If we remember what marked mitigation of the asthmatic seizures may follow an unimportant modification of drugs, a change of residence, or some powerful emotion, we shall be loth to credit any slight improvement to surgical operations on the nose. One of the worst cases of asthma I have seen obtained more relief from a course of compressed air-baths than from any other measure, including hypodermic injections of morphia. It is hard to resist the suspicion that the success of the compressed air-bath was largely due to psychical influences, and some of the apparent triumphs of nasal surgery are perhaps susceptible of a similar explanation.

To sum up my own experience. I have seen two or three cases of asthma associated with polypi, and in two of these removal of polypi was followed by manifest relief to the asthmatic condition. Unfortunately the patients were lost sight of, and their subsequent history is unknown to me. A moderate degree of swelling of the inferior turbinal, more particularly of its posterior extremity, was met with in a few asthmatic subjects. But in only one instance was there any noteworthy obstruction to nasal respiration, and except in the case of this patient, I have not felt justified in proposing cauterisation or removal of the swollen tissues. The patient referred to remains under observation and has been recommended to undergo appropriate local treatment, the uncertainty of the result *quâ* asthma having been explained to him. Periodical swelling of the inferior turbinal may have existed in some cases from the history of passing nasal obstruction given by the patients, but I have had no opportunity of verifying this surmise. I do not remember to have seen any instance of gelatinous swelling of the anterior septal region, or of any marked development of spurs, in this connection. No cases of asthma with adenoid vegetations in the naso-pharynx have come under my observation. Of localised areas of hyperæsthesia in the nasal cavity I have no experience to offer. It may seem that this account reads very like a confession of inexperience. But it must be borne in mind that the cases to which I refer presented themselves on account of asthma primarily, whereas asthmatics that apply for relief to specialists in the domain of laryngology and rhinology, are likely to comprise an unduly large proportion of cases of pronounced nasal disease. The clinical history of cases in which sneezing and other symptoms of hay fever alternate with, or are succeeded by, spasmodic dyspnœa may be regarded as supporting the reflex nasal origin of asthma; and the same view may be taken of asthma induced by the smell of the cat, horse, dog, powdered ipecacuanha, violets, roses, &c. But, as Semon and Watson Williams point out, where the attacks ensue on the inhalation of irritant particles like pollen and ipecacuanha, it is not impossible that asthma may be the result of a bronchial

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rather than a nasal reflex, some of the fine powder reaching the lower air-passages as well as the nose. It is generally admitted that for the production of hay fever at least two factors are required, viz. an external irritant and a morbidly sensitive nervous system. Some writers consider that a further element, a pathological condition of the nasal mucous membrane, is also necessarily present, a statement which I cannot accept as correct for all cases. I am inclined to believe that too much is now-a-days expected of the nose, and the result is that the happy individuals that would be certified as possessing an ideally healthy nose are comparatively few. If rhinological examination is conducted according to this counsel of perfection, we need not be surprised that most if not all patients with nasal symptoms are found wanting.

The following conclusions appear to be justified. In some cases asthma is relieved by the removal of polypi, though the explanation of this effect is still very obscure. Hay asthma may sometimes be benefited by treatment of morbid conditions of the nose and naso-pharynx, an experience of which, at present, I can claim no personal knowledge. The prospects of improvement in such circumstances as in the case of polypi seem to be very uncertain, but in the presence of definite nasal stenosis local treatment is not only warranted but advisable. In the ordinary form of asthma uncomplicated by hay fever or polypi, nasal symptoms are not uncommon, but the nose is generally healthy and requires no local treatment, though a spray of cocaine is said to give relief in some cases. Here the nasal symptoms may be regarded as merely part of a general vaso-motor neurosis of the respiratory tract. The history of some instances of hay asthma, in which spasmodic attacks persist in the winter although the nasal symptoms are then in abeyance, shows how important is the neurosal element, quite apart from the existence of peripheral irritation of the nares.

Dr. McBride said: In addressing an audience of specialists it would be out of place—it would almost be an impertinence—to consider the relation of asthma to the upper air-passages from an historical point of view. The names of Voltolini, Hack, B. Fränkel, and many others will at once occur to you all as pioneers whose teachings have been of great value in calling attention to a connection which is admitted by all thoughtful physicians and specialists of to-day. Again, it would be equally out of place to ask you to follow me through the immense mass of literature which relates to reflex neuroses, of which asthma is probably the most important. This literature is in its main facts, no doubt, familiar to all here. As you are aware, it is abnormal conditions of the nose which have been most generally found to cause asthma, and it has seemed to me, therefore, best to begin my remarks with the heading—

Nasal Asthma.

The most generally known form is undoubtedly the variety which occurs in the course of hay fever and allied conditions. You are all familiar with the chain of events in these cases—the symptoms of coryza induced by the pollen of grasses and flowers, dust, and the like,

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or more rarely by emanations from animals, chemicals, and a variety of other causes, followed in certain persons by asthma which differs in no respect from the affection as commonly described in our medical text-books. In this chain of events we have an illustration of nasal asthma in its most familiar form, and it is generally admitted that hay fever requires for its development a neurasthenic, or at least a neurotic condition which acts as a predisposing cause. Of course you are all aware that in a proportion of cases we find more or less marked abnormalities in the nasal passages, but I am quite sure that in a very large number of instances these parts are, excepting during the attacks, for all practical purposes normal.

I take it that the course of events is as follows: the specific irritant touches the mucous membrane, which, in order that the other phenomena may result, must be hyperæsthetic; erectile swelling then occurs followed by hypersecretion. In certain persons a reflex asthma is set up by the nasal irritation. It is well known that hay fever is to some extent dependent upon race, thus Anglo-Saxons are more prone to be affected than persons of other nationalities. It seems also to be influenced very materially by social position, for I presume that most of us have observed it either chiefly or entirely among the better or, shall I say, wealthier classes. Speaking for myself I have seen numerous cases, but with one or two exceptions they have always occurred in private patients.

A less common but still a relatively common form of nasal asthma is that which seems to depend upon the presence of nasal polypi. In these cases the nostrils are usually not completely occluded, so that the presence of the growths may escape observation unless attention be directed to this point. I have now seen a considerable number of people who suffered from asthma, and in whom nasal polypi existed. Where this combination occurs I consider that we may very reasonably expect to benefit the former by removal of the latter. It is somewhat difficult to explain why small polypi should be more liable to cause asthma than large growths, but probably the former being more mobile are for this reason more likely to irritate the mucous membrane.

In certain cases of hypertrophic catarrh and deviations, or outgrowths from the septum, we also meet with asthma which may be benefited by local treatment. Sometimes the pathological condition is obvious and so marked as to interfere with nasal respiration, and thus give rise to local discomfort. In such cases there can be no great difficulty in determining upon the proper line of treatment. In other instances, however, deviations from the normal are slight—so slight that perhaps we should not be justified in calling them pathological. Gentlemen, I know I am treading on thin ice when I say that we have as yet no satisfactory definition of a normal nose. We know very well what the anatomically correct organ should look like—the nasal septum should be straight and have no outgrowth, the middle and inferior turbinated bodies should be of a certain size, shape, and colour. This is the ideal, but we rarely find it, just as it is uncommon to find perfection elsewhere in this world. I have introduced this matter in order to lead up to the fact that we are often called upon to

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make rhinoscopic examinations of asthmatics, and frequently find nothing, which if discovered in another person we should be justified in stigmatising as pathological. I think I may say without offence that rhinologists all over the world are divided into two classes. One holds that it is most desirable for a man's nose to be symmetrical, not only externally, which we all admit, but also internally. Gentlemen of this persuasion make it their business to straighten every septum which is not mathematically straight, to remove any excrescences which they find disagreeable to the examining eye, and finally to reduce the turbinated bodies to such size as seems proper to them. Those who belong to the opposite camp tend to limit treatment to cases in which the condition of the nose is such as to produce nasal symptoms appreciable as nasal by the patient. I fancy that most of us here hold with the second class, and I need hardly say that my own views are decidedly conservative with regard to nasal surgery. At the same time if these conservative views in their entirety be brought to bear upon nasal asthma they may prove misleading, and, moreover, if your patient falls into the hands of a nasal specialist who believes no nose normal, he may effect a cure where you have failed.

I do not wish to say that I have met with nasal asthma in an absolutely normal nose, but it appears to me that in some asthmatics nasal treatment is permissible and even desirable, where the conditions are such that on other grounds operative measures would certainly not be indicated. Thus, if the bronchial attack be preceded by sneezing and nasal hypersecretion, the application of the electric cautery may be beneficial, just as it is in some cases of hay fever, even if at the time of application the parts are fairly normal. I take it that in some of these cases this treatment is beneficial by destroying nerve-endings through which reflex vasomotor changes are produced, while in others good results are obtained by the formation of cicatrices, which bind down the erectile tissue and thus prevent swelling. I do not think, however, that in all cases the paroxysm is preceded by nasal symptoms, even where nasal treatment may do good. I have, however, found that in a considerable proportion of asthmatics there can be detected on the nasal mucosa spots which, when touched with a probe, produce cough. My experience has been that in almost every patient who shows this phenomenon, the application of the electric cautery to these sensitive areas will produce marked amelioration, amounting, in some instances, to a practical cure. These cough spots may be met with in any part of the mucous membrane, but are most commonly situated on the inferior turbinated body, while occasionally the reflex area may be encountered while passing a probe between a projection from the septum and the outer wall. I have said that I consider the presence of this reflex cough as an indication in favour of intra-nasal treatment, but I have not found that when it is absent such treatment is always useless, although in the one case we are entitled to express a conviction in favour of the probability of benefit, while in the other operative measures must be looked upon as more or less experimental so far as the asthma is concerned. I cannot help thinking that the clinical value of this symptom has been overlooked, although I have repeatedly

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called attention to it for many years. In this connection a very interesting question confronts us, may it not be possible to benefit asthma in certain cases by applying the cautery to a normal nostril? The fact that we speak of a nasal reflex asthma implies that we admit something like the following chain of events: a stimulus travels from the periphery to a centre, and there sets up molecular changes, which result in a paroxysm of asthma. Observe we admit that an irritant applied to the nasal mucosa may effect molecular changes in a centre which is responsible for asthma. It almost follows as a carollary that we can influence this centre from the nose, and I very much question whether many asthmatics—even those with normal noses—might not be benefited by the use of the electric cautery, not as a destroyer of tissue, but as a counter-irritant.

It may, perhaps, not be amiss to glance for a moment at the prognosis of nasal asthma. I do not think it is ever safe to promise the patient a cure, because every thinking rhinologist will admit that the nose is rarely, if ever, the only cause of asthma. In cases of polypi, however, we can usually do much good by removal of the growths, and when we have the introduction of a probe into the nostrils followed by cough, the probability of benefit is much increased. In ordinary hypertrophic catarrh, and in the case of spines or deviations, the last-named symptom becomes of even more significance.

Asthma caused by other Parts of the Upper Respiratory Tract.

While nasal asthma is comparatively common, it is in my experience rare to have this neurosis produced by other parts of the upper respiratory tract. I am aware that cures have been reported after removal of enlarged tonsils and after destroying granulations upon the posterior pharyngeal wall, but I do not remember to have met with such cases myself. On one occasion only have I found asthma apparently cured by removing adenoids from a young boy. I have thought it well, thus, at the risk of appearing egotistical, to confine my remarks to an expression of personal experience and views. To discuss the subject by any other method would have occupied much time without any commensurate advantage.

In conclusion, I would venture once more to express my conviction that while the upper air-passages may be the exciting causes of asthma, its occurrence depends upon some individual predisposition. We can therefore hardly speak of cures by local treatment of the nose and throat without modifying the expression, and we must not forget to use such general remedies and modifications of regimen as have been found useful by physicians generally.

Dr. J. C. Thorowgood expressed his thanks to the Society for allowing him to be present as a visitor, and to be able to listen to such interesting papers, whose wisdom he admired. He thought with the last speaker that it was quite right not to promise the patient cure from asthma, and he remembered a case in which he had been consulted where, by following this plan, he had been able to prevent troublesome consequences. Speaking from his own experience, he

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could not agree with Dr. McBride that asthma was not very often associated with adenoid growths; he had come across cases where the removal of adenoid growths had much mitigated the attacks of asthma, and in one case the patient had been almost free from asthma owing to the removal of these growths. He was quite convinced that there are certain areas in the air-passages which, when touched, give rise to paroxysms of asthma—this had occurred on the removal of polypi; one had to be particularly careful not to excite these centres in highly neurotic patients. In alluding to the effect of asthma on the circulation, he mentioned a case in which, other remedies having failed, chloral gave marked relief. Being a dilator of the vessels, theoretically chloral ought to answer if, as he believed, the asthma was due not to vaso-motor dilatation so much as to violent spasmodic contraction of the vessels.

Mr. WAGGETT believed that it was very seldom that a causal relationship between true spasmodic asthma and nasal disease could be established on a strictly logical basis. Although he had many opportunities of meeting with these cases he could remember but one instance in which the nasal origin of the trouble was proved with any real certainty. The case in question was that of a man of forty, who complained of distressing attacks of asthmatic character which had persisted for twelve years in spite of medical treatment. The attacks occurred at all times of the day but more particularly after lunch, and lasted about an hour or so. To quote the patient's own report: "They commenced with tightness amounting to severe pressure across the bridge of the nose; suffocating feeling about the throat, and apparent inward pressure from the ears. There was distinct tightness of the chest—very little wheeze—but difficult breathing with much effort to clear the throat; generally, too, there was dryness of the throat, and, on the whole, the feeling was that one would fall down." On examination a very large septal spur was found pressing tightly against the right inferior turbinate in its middle part, the nose, in other respects, being unusually patent. The spur was removed and the attacks immediately ceased. Eight months later the patient returned, stating that the attacks gradually recommenced about two months after the operation and were again very distressing. A large bony bridge was discovered stretching between the inferior turbinate and the site of operation. This was removed and the attacks at once ceased. Five weeks ago the patient reappeared, stating that the attacks recommenced about four months after his previous visit. A narrow bony bridge was again found in the former situation. This was removed and the patient reported himself as being, for a third time, relieved of his attacks. The general conditions of the patient as to occupation and place of residence had remained unaltered throughout the course of the case. On no occasion could an attack be induced by experimental irritation of the nasal fossæ. The interest of the case, which was one of diffuse neurosis embracing the symptoms of true spasmodic asthma, lay in the sequence of events, the cardinal point being the disappearance of the special symptoms on three occasions as a sequel to three almost identical intra-nasal operations. Even in this case a causal relationship between the neurosis and the

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nasal lesion could not be absolutely established, as no evidence was forthcoming that the reappearance of symptoms coincided in point of time with the bridge formation. The speaker was compelled to believe that true nasal asthma was a rare disease, and inasmuch as it was often spoken of as an everyday occurrence, he thought it would be valuable if members would take this opportunity of furnishing statistical data.

Dr. MacIntyre (Glasgow) said, while he could fully understand the desire to obtain exact statistics we had to remember one difficulty. The patients who came back to us were very often those in whom the treatment had been unsuccessful, judged from the standpoint of being cured, whilst those that got relief were not so easily traced. Judged from every standpoint, however, he thought that from his own experience he could recall a few cases of which it would be justifiable to use the term cured. These were a very small minority, and, like others, his experience had been such as to induce him to speak of relief rather than cure where success was claimed for treatment. He thanked both gentlemen for the manner in which they had introduced the subject, knowing the difficulties in opening such a debate. On the one hand, while there might be over-enthusiasm and too great a tendency to surgical procedure, nevertheless the openers of such a discussion had a certain responsibility in presenting their views, because it was possible to throw such an amount of doubt upon the matter as to damp the enthusiasm and ardour of those who are inclined to investigate this difficult and as yet experimental branch of surgery. Further, it was exceedingly difficult before beginning the treatment of a case to give an exact prognosis, notwithstanding the fact that in a certain number of cases, as a matter of experience which could scarcely be conveyed in language, the surgeon felt more hopeful than in others. Asthma might be induced from an irritation of the nasal membrane, but other causes might exist in the same patient. He gave instances of the difficulty of arriving at a prognosis by quoting two cases in which patients had been sent for surgical treatment in the nostrils, and in one of which it was ultimately found that the irritation was due to a sarcoma at the base of the skull, and a second was ultimately traced to a neoplasm in the mediastinum. There was one point which had not been spoken of as yet, and that was the information which might be got from a study of the action of the diaphragm, which was not always the same in cases of asthma, but which could now be observed. At present he was engaged in a series of investigations not yet published bearing upon this, and it was not at all impossible that, in some cases at least, light would be thrown upon the subject by the differential diagnosis which might be got by means of the X rays.

Dr. Herbert Tilley said that his experience was very similar to Mr. Waggett's, and he thought that only a minority of cases of asthma would be found amenable to surgical treatment of the nose. Cases of inherited asthma had received no benefit from intra-nasal treatment at his hands, and his experience in these cases was, perhaps, larger than is usual, because both in his own and his wife's family asthma was an unfortunate constitutional legacy. He had recently operated on a young sister-in-law who had commenced her asthmatic

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career the paroxysms coming on at night or even in the daytime after violent exercise, *e. g.* cycling uphill or horse-riding. He removed a post-nasal growth, and later on the anterior ends of both inferior turbinates because they were producing marked nasal obstruction, and the patient was always suffering from sneezing fits and severe colds. Here was a case which seemed to be an excellent test case for intra-nasal treatment. It was now nearly two months since the treatment was carried out, the patient expresses herself as delighted with the comfort of free nasal respiration, but the asthma attacks are "about the same, if anything a little better, but the medicine (Potassium Iodide, stramonium and arsenic) keeps the attacks off as long as it is taken." He thought that such would be the experience of others in inherited cases, as also in gouty asthma; at the same time he would not deny that occasionally cases might be immensely relieved by intra-nasal treatment, on the same principle that epileptic attacks had been completely cured by removal of nasal polypi, but such cases would be a minority. The speaker described his own personal experience of asthma, which was typical of "place asthma," *i. e.* in certain parts of England he was almost sure to get an attack about 2 o'clock in the morning, the attacks lasting some two hours and then completely passing off. In London he was always free, and if returning from the country with an attack upon him, nothing produced such splendid relief as a journey by the underground railway. Recently going down the Channel he had had two severe attacks whilst in his cabin below deck, the attacks passing off immediately he went on deck. He considered his case was probably gouty asthma, as his father was a martyr to the latter disease. His asthma attacks were not preceded by any nasal irritation or catarrh, and in spite of the suggestion of his friends he scarcely thought it worth while at present to undergo nasal treatment. With reference to destroying the sensitive areas in the nasal mucous membrane referred to by Dr. McBride, he had almost discarded the galvano-cautery for this purpose, because trichloracetic or even glacial acetic acid seemed to possess more penetrative and permanent properties. The only cases in which he could consider he had *cured* asthma by surgical treatment were those in children where the disease was associated with large tonsils, post-nasal growths, and accompanying bronchial and nasal catarrh with much secretion—these were very favourable cases, but he could not say the same for cases of genuine spasmodic asthma in the adult.

In reply to Dr. MacIntyre Dr. Herbert Tilley said that he thought it was scarcely scientific in a test case to give iodide of potassium whilst surgically treating the nose, because they all knew what relief that drug alone would give.

Dr. Scanes Spicer considered that Dr. McBride had very judicially reviewed the question under discussion. On the present occasion he would desire to remark on two points mentioned in Dr. McBride's opening, *i. e.* (1) the word "experiment" as applied to a surgical measure; (2) the term "a normal nose." As to the word "experiment," the public is apt to be misled by ambiguous terms. The word experiment is ambiguous. Most persons regard it, used surgically, as equivalent to a vivisection or laboratory research, and as implying

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something rash and risky—a kind of "kill or cure" procedure. This idea is widespread. The consequence is that a critic who describes a suggested procedure as "an experiment" tends to excite a prejudice against it and to prevent dispassionate consideration, whereas all the critic is justified in predicating is, that the procedure is not certain to "cure radically" every case—which, indeed, is true of all therapeutic measures. Unless, indeed, he desires to be understood as meaning by the word a procedure of which the result is sure and unvarying, as in a chemical or physical experiment. Since, then, the idea that any given surgical procedure is not an infallible cure for every case can be expressed in unambiguous English terms, and those not calculated to excite prejudice, the speaker thought that the use of the word experiment in clinical therapeutics was inappropriate and unwise, and should be discouraged. He regretted that it had, in this connection, crept into Dr. McBride's excellent book. With reference to "a normal nose" no definition had yet been agreed upon. Could any nose be called normal in which the patient was conscious of suffering or discomfort? Thus, although no spur, polypus, or other gross lesion might be found on examination, the nose may regularly be obstructed at night and cause insomnia, restlessness, &c., as a consequence of the nasal discomfort; that is to say, a nose which may appear normal during the day when patient is erect, becomes insufficient at night when he is horizontal. And here a protest should be entered against a widespread notion that spurs should be operated on *quâ* spurs and as deviations from a theoretical symmetrical ideal. Such a procedure should be strongly discountenanced. The correct indications for attacking a spur are: (1) that it acts as an impediment to the due physiological intake of air, with consequent alteration of normal air tension on the nasal mucosa and in the pneumatic accessory spaces; (2) that it is in abnormal contact with other intra-nasal structures, either permanently, or periodically on mucosa turgescence, and leads to irritative and reflex disturbances. Hence, a large spur may often be ignored if in a cavity otherwise roomy, whereas a small one in other relations and situations demands attention. It is this insufficiency of passage and presence of abnormal contacts which form the true criteria of interference. Hence, a nose which presents no obvious pathological changes, and may so be regarded in one sense as normal, is abnormal, if from arrested evolution its channels are inadequate to admit the air demanded by the organism of which it is a part. His own experience had convinced him of the positive and great benefits derived in many cases of "asthma" from thorough nasal treatment, which was not to be expressed in terms of polypi and galvano-cautery. A few patients were prepared to maintain they were cured, while the majority obtained great relief; but the speaker's cases were not, with very few exceptions, drawn from the class of fossil asthmatics which would gravitate to the chest physicians, and were in nearly all instances less confirmed cases of spasmodic dyspnœa, in which other troubles—usually nasal—were as prominent as the asthmatic condition.

Dr. P. Watson Williams (Bristol) reported one case in which intra-nasal treatment, in conjunction with general treatment, had

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apparently resulted in practically a complete cure, as for three years the patient had been free from asthma. The patient came to him five years ago with constant asthma, which had persisted more or less for eighteen years. She was having at least two paroxysms every twenty-four hours, as they came on both day and night. The mucous membrane of the nose was very hyperæsthetic, but there were no particular spots of special irritability, nor did sneezing, cough, or asthma occur on probing. The mucosa over the septum and turbinals was œdematous, and to such a degree overlaid the middle turbinals as to be polypoid. The polypi were snared and the bases and surrounding sodden area cauterised. Violent attacks of paroxysmal sneezing alternated with the attacks of asthma, and the patient experienced marked temporary relief from the use of a cocaine spray. There was therefore good reason to believe that the intra-nasal irritation had a close connection with the asthma in this case.

We do not know for certain what is the actual condition of the bronchi in asthma, but it seemed to him that there is sufficient ground for believing that the paroxysm is due to excessive contraction of the bronchial muscular coat and of the bronchial arteries. He was unable to accept the view that it is due to vascular dilatation. Radcliffe Hall, cited by Walshe, considered the use of the bronchial muscular coat was by its "tonus" to counteract the effect of coughing. But is it not possible that it, like the alæ nasi and vocal cords, may rhythmically dilate and contract with deep inspiration and expiration, and that in asthma the normal "tonus" is heightened, and while imperfect *dilatation* occurs during inspiration, the *contraction* phase is excessive during expiration? There is expiratory, not inspiratory dyspnœa; consequently the air in asthma, and in bronchitis too, distends the chest. It is difficult otherwise to understand why dyspnœa is expiratory and the chest gets distended. If there be such a closely associated physiological action between the movements of the upper and lower respiratory tracts, we can readily comprehend how in some cases there seems such close interdependence in their *morbid* relationship.

When we come to discuss this relationship between intra-nasal disease and asthma, we are confronted at the outset by the difficulty in deciding what constitutes a morbid condition of the nasal passages. He had no manner of doubt that in a very large percentage of asthmatic patients the nasal passages present conditions which cannot be regarded as ideal, and when we have excluded all septal deflections and spurs, turbinal hypertrophies, polypi, general hyperæmias, &c., there will be only very few cases left to participate in the other very numerous intra-nasal defects which civilised humanity is heir to. Moreover, we have ample testimony that *removal* of these defects—especially, in my experience, removal of polypi and cauterisation of markedly hypertrophic turbinal bodies—will be followed in a very large proportion of cases by more or less prolonged amelioration, or even cessation, of asthmatic attacks. But it was very difficult to decide how far the nasal affection is the cause of the asthma, even in those cases in which intra-nasal treatment has proved successful in relieving the asthma.

When one bears in mind the association of asthma with various

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neuroses and with gout and renal disease, the very *frequency* with which nasal disease is associated with asthma should make one suspicious that there was something more than simple cause and effect in their relationship. Dr. Watson Williams thought that most frequently the intra-nasal affections, such as hypertrophic rhinitis, waterlogged mucous membranes, and perhaps even sometimes œdematous polypi (he took but little notice of minor septal deformities), are the *consequence* and not the cause of the asthma, and sometimes there may be no evidence whatever of their existence until after the asthmatic paroxysms have recurred for years. Yet such experience as he had had made him very unwilling to leave untreated any obvious intra-nasal defects in an asthmatic patient which could really be a cause of irritation or an embarrassment to nasal respiration; since the removal of any contributory factors towards the occurrence of the paroxysms, although they might not be the essential cause, will often materially aid our efforts in other directions to combat the disease, whilst occasionally the happy results that follow the intra-nasal treatment seem conclusive proof that therein lay the essential cause of the malady.

Dr. Theodore Williams could recall one case of asthma cured by the removal of nasal polypi, but from the discussion which had taken place he gathered that the Society was not in favour of operating on the nasal cavities in order to cure asthmatic attacks, a conclusion of some comfort to himself, as he doubted whether he had recommended operations as often as he might have done. For the medicinal treatment of genuine spasmodic bronchial asthma generally, he found iodide of potassium in eight to ten grain doses three times a day combined with stramonium, henbane, or belladonna of great advantage, and if these failed, compressed air baths, such as were used at the Brompton Hospital, gave great relief.

Dr. W. Permewan thought the distinction between "great relief" and "cure" was an extremely narrow one; cure was a large word, and not very properly used in a question of this kind. In the majority of cases relief was very great, and unmistakably the result of treatment was to give relief.

Sir Felix Semon: How long lasting?

Dr. Permewan: Until necessity arose for further intra-nasal treatment. Of the variety of nasal diseases polypi were by far the most important, and he agreed with those who deprecated the indiscriminate use of the cautery. He thought that a normal nose, considered from a surgical point of view, was one which offered no point of attack to the surgeon. He believed that asthma was the result of a nasal condition, and that he was perfectly justified in healing the nose though he could find objectively nothing to attack. He emphasised the importance of respiration through the nose; if a patient's nose was blocked up with polypi, and he is unable to breathe through it; that is the factor which starts asthmatic paroxysms, and not a reflex centre. The speaker thought one was justified in promising the patient more than one could accurately say was the whole truth; this was an important element in dealing with neurotic patients; but of course this practice might be abused. There were two sides to this question—

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the "practical" and the "scientific," and while the exact sequence of cause and effect might be open to criticism from the scientific side, from the practical side there could be no doubt as to the propriety of nasal treatment in cases of asthma.

Dr. Dundas Grant thought that Dr. Theodore Williams ought to have been more impressed by the result of the first case he mentioned, where nasal treatment had been of such great service and might with advantage have been carried out at a much earlier stage. Dr. Grant thought the discussion was too pessimistic on the one hand and too sanguine on the other, and that the truth was far from these extremes. He then related the history of a case in his early practice in east London. The patient was a chronic sufferer from bronchial asthma, and a very remunerative client. He urged the removal of nasal polypi importunately; finally the man consented and was practically cured. He had seen the mere act of treating the nose for asthma make the condition for the moment worse though ultimately curing it. He had had a fair proportion of cases in which bronchial asthma had totally disappeared after nasal treatment. This was natural enough when one considered the class of cases likely to come into the hands of the nasal specialist. It was the duty of a physician, if treatment by drugs failed, to submit the case to the observation of someone accustomed to explore the nose, and capable of giving a reliable report as to whether or not an operation on the nose should be carried out. There should be a judicious combination of the medical and surgical treatments so as to give the patient a double chance of cure. Dr. Grant found the gouty diathesis well marked in a number of the cases which had been referred to him, an opinion confirmed by the beneficial effect of the administration of salicylate of soda, a drug which he thought might with advantage be more frequently employed in the treatment of asthma. The galvano-cautery in some cases acted beneficially by pinning down the turgescent mucous membrane, but its beneficial effect was often no doubt due to its action as a counter-irritant. After the application of the galvano-cautery he was in the habit of applying deliquescent trichloracetic acid, which appeared to him to diminish the inflammatory reaction. Antipyrin in a 4 per cent. spray reduced the swelling, but it was irritating and it ought therefore to be preceded by the application of eucain which acted, so far as anæsthesia was concerned, like cocain, and was in other respects freer from objection. Glycerine extract of supra-renal capsule applied in the form of a spray was often valuable as a vaso-constrictor.

Dr. Clifford Beale, in speaking of continued nasal treatment for asthma, described a case recently observed in which several operations had been performed from time to time until most of the interior of the nose had been removed. The attacks of asthma, relieved for a time after each operation, had regularly recurred. There was no evidence to show that the attacks arose from any sensitive point in the upper air-passages, whereas there were abundant morbid changes in the lower air-passages, which might equally well be assumed to be the starting point of a reflex spasm. In the heart, also, one might look for such causes. Some years ago he had a run of such cases. Four boys, all occupied in work that involved considerable heart strain, and all

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about fourteen years of age, suffered from what appeared to be genuine asthmatic attacks, which were relieved by antispasmodic inhalations and rest. In these there was no reason to suspect any nasal reflex, but the attacks were far more likely to have found their origin in the over-strain of the immature heart. He quoted the observation of Dr. Moritz Schmidt to the effect that the nasal cavity if carefully searched with a probe might sometimes be found to present sensitive points, the irritation of which set up respiratory spasm. He thought that unless some definite evidence could be obtained that the source of irritation was in the nose, any operation except for the relief of obstruction was hardly justified.

Dr. William Hill could not agree with the last speaker that it was "unjustifiable" to apply intra-nasal treatment unless a cough reflex was obtained; we had a plain duty to do the best we could for our patient, who rightly expected us to try not only every medical means, but also every surgical procedure which held out a reasonable chance of affording relief. A cure, in the strict sense of the word, could not, of course, be promised, nor often even expected, but a fair measure of relief, amounting in some instances to a practical cure, might, in his experience, be looked for in considerably more than half the cases where asthmatic symptoms were associated with obvious disease in the nose. If practitioners neglected intra-nasal treatment because they could not promise their patients an absolute cure, they not only ran the risk of being scored off by more enterprising neighbours, but, what was more serious, they laid themselves open to the charge of not having done their duty and their utmost for their patient. It was necessary to speak thus strongly because he feared that visitors at this debate, especially physicians who did not practice rhinology, would take away a very wrong impression of the attitude and experience of those who had dealt with a considerable number of cases of asthma with associated nasal disease. Not only was it necessary that a thorough examination of the nose should be made, in order that nothing abnormal might escape observation, but if intra-nasal treatment appeared to be indicated it was essential that this should be carried out in a very thorough way. Half measures were worse than useless, as they not only either failed to relieve at all, or led to early relapse, but unfortuately brought undeserved discredit on what was often a valuable remedial measure. He could not agree with Dr. Kidd's conclusions, but it was easy to understand difference of opinion here, as that physician, whose experience of asthma in general was large, frankly admitted that he had seen and treated very few cases indeed where there was a co-existing nasal factor. He desired to associate himself with the views of Dr. McBride, who had admirably summarised the scientific and clinical aspects of the subject, and whose practical suggestions on treatment all would do well to follow. Dr. Hill had not himself tried intra-nasal cauterisation where there was no obvious morbid condition in the nose, but he had made a note of what the opener of the discussion had said on that subject. In conclusion he thought he was considerably below the mark in asserting that marked relief might be expected in 50 per cent. of cases of asthma *plus* nasal disease, provided the nasal treatment was carried out with requisite

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thoroughness; overlooking a small morbid area might make all the difference. He had no doubt it was our duty to advise our patients to submit to these surgical procedures, which were, after all, not formidable ones.

Sir FELIX SEMON, in a short historical retrospect, referred to the publication by the late Prof. Hack in 1884, entitled "Radical Cure of Hay Fever, Asthma, &c.," in which that author endeavoured to establish the existence of an intimate connection between affections of the nose and asthma. Long before that time, however, cases had been noted by good observers, such as Voltolini, Bernhard, Fraenkel and others, in which the mere removal of nasal polypi, not undertaken with any view to cure co-existing asthma, had been followed by that result, *i.e.* the asthma attacks—which had formerly been very troublesome, either entirely disappeared, or became less intense after the removal of the polypi - returned or became intensified with the recurrence of the polypi, and improved again after renewed removal. This was a very clear proof that asthma may be positively produced from the nose, and it was certainly a grave fault to altogether deny such a possibility. Nor were nasal polypi, although in the speaker's experience by far the most obvious, the only cause of nasal asthma; other forms of nasal obstruction could produce this effect, such as great tumefaction of the nasal mucous membrane, considerable deviation or excrescences from the septum, &c. In no class of cases, however, was the connection more clearly established than in cases of nasal polypi. In the speaker's experience, relief might be given by nasal treatment in such cases,—occasionally even when the asthma had been in existence for a long time, although the number of cases of the last-named category in which he had obtained satisfactory results was extremely small. Altogether the number of cases in which a short-lived success had been obtained was in his own experience infinitely greater than the number of those in which a long-lasting relief had been afforded. He himself had never been able to produce an asthmatic attack from the nose by exploring that cavity with the probe. In one single instance only had he been able to produce very violent paroxysmal cough by that method of investigation. With such experiences, he asked himself, what was one to tell a patient in whom asthma existed together with nasal disease? They had heard that afternoon diametrically opposed opinions in reply to that question. He invited them, however, to consider the enormous number of cases of asthma that had been treated since Hack's publication by intra-nasal interference. How small in proportion to these had been the number of those cases in which a real cure or, at any rate, a long-lasting improvement had been seen even by the warmest advocates of that treatment! In view of that fact, was one justified in promising any definite success to a patient? And what had struck him most in this discussion was that no mention had been made of those, in his experience most frequent cases, where *no results had been obtained at all!* Personally he divided these patients into three classes: (*a*) Lasting success obtained, exceedingly small percentage; (*b*) Temporary benefit, comparatively large percentage; (*c*) No success at all, very large percentage. Now considering that he had

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to frankly confess that he was himself unable to make out beforehand, by any method of examination whatever to which of these three classes the individual patient would ultimately belong, what was the treatment in such cases but an "experimental" one? He stuck to this word most emphatically. He was in the habit of telling those patients suffering from asthma, in whom considerable nasal abnormalities existed: "Undoubtedly in a number of cases such as yours, in which the nose is treated, relief has been obtained; whether in your own case relief will be permanent or temporary, or whether there will be no relief at all, I cannot tell you beforehand. If your suffering are great, and if you should like to undergo this treatment, I consider your case a legitimate one for it, but you must understand that it is purely experimental." He had not found that his patients misunderstood so simple a statement.

Dr. StClair Thompson suggested the addition of a fourth class to Sir Felix Semon's classification, viz. those who were considerably damaged by the intra-nasal treatment. He had met these cases, who had suffered from a too forward policy of the nose and throat, at foreign health resorts, trying to get back their lost mucous membrane. He thought that in some cases of asthma the nasal conduction may be causal, but in many cases it was consequential.

Dr. Lambert Lack thought the undoubtedly frequent relation of asthma to nasal disease was not a simple reflex. He was very surprised to hear Dr. McBride's statement, on which he laid particular emphasis, that an irritant applied to the nasal mucosa may effect molecular changes in a centre which is responsible for asthma. In his experience he had never met with a single case in which irritation of the nose, as by probing, had produced an asthmatic attack, and he would much like to know if any other member had met with such a case. Dr. Thorowgood and others who supported this theory quoted instances in which cough had been produced. This Dr. Lack thought a not very uncommon result of nasal irritation, but he could not admit that a true asthmatic attack could be experimentally excited in such a way. He could add one case to those which had been cited, in which asthma was closely related to adenoid growths. The patient was a child, the subject of inherited asthma and gout. Removal of the adenoids was followed by complete freedom from asthmatic attacks; eighteen months later the asthma returned, and on examination there was found to be recurrence of the adenoids with nasal obstruction. Operation for the relief of the nasal obstruction was again followed by complete cessation of the asthma.

The President said they might be reasonably satisfied with the result of this discussion, which was of great interest; to a certain extent, the atmosphere was clarified. They had heard extreme views from both sides—those who thought no good was to be obtained, and those who believed that most benefit is derived from the adoption of intra-nasal treatment. Personally, he took the middle course, and he was quite certain that he had seen in a very fair proportion of the cases considerable and permanent relief; he mentioned the case of a lady whose polypi had been removed, and who had spent the winter in the Riviera, who had severe asthma, from which she had been

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practically free for the last year. He thought they would all agree with the remark made by Goodhart that the "chronic asthmatic was almost as hard to cope with as the chronic epileptic," and they must not expect to work miracles or they would be disappointed. They should look to getting hold of the cases at an earlier stage, when relief is more easily given, especially in the case of adenoids.

Dr. PERCY KIDD said that his remarks had been misunderstood in some respects. He said that if there was obvious disease of the nose, local treatment was advisable, though the uncertainty of the result as regards the asthma should be clearly explained to the patient.

Dr. McBRIDE said that owing to the kind reception his remarks had received, there was little left for him to reply to. With regard to the question of adenoids and asthma, he said that he had often seen cases where the patients were said to be asthmatic, but on inquiry it was generally found that the difficulty in breathing was due to the local causes. He had, however, on one occasion, as mentioned, immensely relieved a truly asthmatic child by removing adenoids. Questions had been asked as to the cure of asthma, but he considered that asthma, like epilepsy, could hardly be considered cured so long as the patient lived. He mentioned several cases illustrating the fact that asthma can be much benefited by local treatment of the nose, both in polypi and hypertrophic conditions. With regard to Dr. Beale's remarks, he begged to observe that he had never seen asthmatic paroxysms produced by touching the mucous membrane, but he would again refer to the great importance to be attached to the presence of a cough reflex in cases of suspected nasal asthma. With regard to Dr. Theodore Williams' remarks, Dr. McBride thought that they showed that laryngologists must be singularly devoid of the power of expressing their meaning clearly—it would not, of course, be proper to suggest another alternative. He failed altogether to see how Dr. Williams could have arrived at the conclusion that most of the speakers thought local treatment useless in asthma, and it would be a thousand pities that his remarks should be published as a serious contribution to the debate. Dr. McBride had no doubt that his words were spoken in jest, but every reader of the report might not be aware of this. With regard to Dr. Lambert Lack's criticism, he would refer him (1) to the fact that reflex nasal asthma was generally admitted to exist; (2) to the experiments of Lazarus which had been confirmed by Sandmann. It has thus been shown that irritation of the nasal mucous membrane can produce spasm of the bronchi and that such spasm ceases after section of the vagi.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

51ST ORDINARY MEETING, *June 2nd*, 1899.

F. DE HAVILLAND HALL, M.D., President, in the Chair.

WILLIAM HILL, M.D., } Secretaries.
LAMBERT LACK, M.D., }

Present—32 members and 5 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentleman was unanimously elected a member of the Society:

Charles Heath, F.R.C.S., 3, Cavendish Place.

The following cases and specimens were shown:

CASE OF UNILATERAL PARALYSIS OF PALATE, PHARYNX, LARYNX, &c.

Shown by Dr. HERBERT TILLEY. The patient, a female æt. 29, had been complaining of hoarseness and dryness of throat with difficulty of swallowing for three months. There was an accumulation of saliva in the throat and some difficulty of swallowing solid food, and occasional regurgitation of fluids through the nose. Patient had probably had syphilis. Exami-

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nation showed the left half of the soft palate, left half of the pharynx, and left vocal cord paralysed, the last being in the cadaveric position.

Sensibility was much diminished on the paralysed parts. The upper part of the left trapezius and the left sterno-mastoid showed unmistakable signs of commencing degeneration. There was no paralysis of the tongue or the facial muscles, and no evidence of any other cranial nerves being affected.

The exhibitor remarked that during the past four months he had met with four similar cases, and these tended to prove clinically, what Horsley and Rethi had shown experimentally, that it was the spinal accessory nerve which innervated the muscles of the larynx, the pharynx (partly), and the soft palate.

A Case of Disseminated Sclerosis with Paresis of Left Half of Soft Palate and Larynx, and a Case of General Paralysis with Paresis of Left Half of Larynx.

Shown by Dr. Jobson Horne.

Dr. Permewan asked what was meant by "general paralysis" in these cases. Did it mean "general loss of power"?

Sir Felix Semon would not have used the word "paralysis." A point of great interest in Dr. Horne's case was the nystagmus-like movements of the left vocal cord; abduction was separated into three distinct movements. He thought this a very interesting phenomenon, of which he was unable to give any elucidation; it might be a lesion below the fourth ventricle.

Dr. Jobson Horne said by general paralysis was meant general loss of power.

A Specimen of Larynx blocked by a Mass of Papillomatous Growth from a Boy aged Eleven.

Shown by Dr. Permewan. Six years ago, while the patient was under the care of Mr. Murray at the Liverpool Infirmary for Children, Dr. Permewan had seen him and removed some growths with the intra-laryngeal forceps. The dyspnœa still continuing, Mr. Murray performed thyrotomy, removed the

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growths, and cauterised the base of them thoroughly. This was followed by much relief, but three years later the symptoms had recurred, and the operation was repeated, again with relief. In April of this year he was admitted into the Northern Hospital with evident signs of growths, but with no apparent urgency of symptoms; he was, however, found dead one morning, evidently from asphyxia. On post-mortem examination the larynx was found almost completely blocked by a large mass of papilloma as shown.

Dr. Permewan thought the point to be emphasised here was the fact that two complete thorough operations had failed to cure the case; he doubted whether thyrotomy was any more radical in its effects than the repeated removal by intra-laryngeal methods, difficult though that might be in young children.

The President suggested that a discussion might at some time be devoted to the treatment of these cases.

Dr. Powell asked if tracheotomy was performed on this case.

Dr. Permewan said that tracheotomy was done (before he had seen the patient) six years ago for urgent symptoms. The case showed too clearly the great tendency of these papillomatous growths to recur after complete removal. He thought it was better not to perform indiscriminate thyrotomy.

Specimen of Larynx from a Case of Perichondritis.

Shown by Dr. Permewan. The patient was admitted into the Liverpool Southern Hospital under Dr. Cameron in September, 1898, having been ill six weeks. There was then much cough and dyspnœa, which necessitated tracheotomy. The epiglottis and ary-epiglottic folds were much swollen, and the larynx externally measured 2¾ inches across. There were enlarged and painful glands on both sides of the neck, particularly the right side. The diagnosis lay between malignant disease and perichondritis of the thyroid cartilage; the lungs were healthy, but there was chronic bronchial catarrh. There were no tubercle bacilli in the sputum.

After some time the glands began to soften and break down; an abscess formed on the right side, and was opened, and bare cartilage found at the bottom of it. This was repeated two or

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three times, and a small bit of cartilage came away. The laryngeal symptoms became less marked and more favourable, but six weeks before death he began to complain of pain in the lumbosacral region of spine. This was rapidly followed by angular curvature, followed by paraplegia, paralysis of the rectum, and bleeding, from which he died.

Larynx shows necrosis of thyroid cartilage, but no growth. No examination was made of the spine.

Case of Parathyroid Tumour causing Symptoms of Malignant Disease of the Larynx; Operation and Recovery.

Shown by Mr. de Santi. Patient, male æt. 58, sent to me by Mr. Eliot, who stated that he had been persistently hoarse for ten months, had a brassy cough and some stridor. Dr. Mitchell Bruce could find no chest affection to account for it. There was no pain or dysphagia, no expectoration, and no loss of flesh. Patient denied syphilis.

There was found very impaired mobility of right vocal cord and marked limitation in abduction. The right cord was uniformly red and somewhat swollen; there was no ulceration or neoplasm visible. No glands to be felt in the neck; old scarring of right face and cheek suggestive of old syphilis. Voice very hoarse and feeble. I considered it most probable that the case was one of early malignant disease of the larynx, with an alternative of syphilis or mediastinal tumour pressing on right recurrent laryngeal nerve. I ordered rest of voice, no smoking, and iodide of potassium.

In September, 1895, the patient's voice was almost a whisper. He had gone downhill rapidly, having lost much in weight. The right carotid artery pulsated visibly, and seemed pushed forward by a smallish, indefinite, probably glandular swelling deep in the neck, and about the level of second or third ring of trachea.

In December, 1895, the swelling in the neck was smaller, the voice better, the right vocal cord a little more moveable, and there was a gain in weight.

During 1896 the patient was in very fair health, had gained

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weight; the voice, though hoarse, was stronger, and the swelling in neck moveable, softer, and more defined; the right vocal cord was *in statu quo*.

In February, 1899, patient had an attack of flatulence and dyspepsia; this was shortly followed by difficulty in swallowing solids, and later liquids. He lost flesh rapidly, half a stone between February 6th and March 29th. At the same time a very marked increase in the size of the cervical swelling was noted. There was regurgitation of food, and sensation of blockage at level of cricoid cartilage.

Examination of larynx showed right vocal cord more fixed, but otherwise the same. I passed a No. 18 œsophageal bougie, and met some considerable obstruction about level of upper part of sternum; no blood or pus on withdrawal.

The lump in the neck felt to be the size of a Tangerine orange. It seemed elastic, and not stony hard. I took a grave view of the case, and advised exploratory incision in the neck, as I considered from the whole course of the events that the main trouble was extra-laryngeal.

An incision was made over the anterior border of the right sterno-mastoid down to the level of the sternum and a large tumour exposed, situate in the lower carotid triangle, extending down to and under the upper part of the sternum. By careful dissection this tumour was gradually defined; I found it distinctly encapsuled, the carotid artery and jugular vein were pushed far over to the outer side: the whole tumour was very vascular. I eventually clearly isolated it, the chief difficulty being with the right recurrent nerve, which was attached to the tumour and flattened, and with the inferior thyroid artery; the right innominate and part of the left innominate vein were exposed, as the tumour was partly substernal. The œsophagus was seen to be distinctly compressed by the tumour; the latter had no connection with the thyroid gland, but there was some fibrous infiltration of the œsophagus opposite the seat of pressure.

A cross cut and partial division of the sterno-mastoid had to be made to thoroughly get at the tumour. The right dome of the pleura, the right phrenic nerve, and the right subclavian artery were seen at the time of operation.

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Recovery was uneventful, and swallowing powers improved almost at once.

Microscopic sections show the tumour to be of the nature of parathyroid tissue and essentially innocent. The growth itself is completely encapsuled, and there is a large cyst in the centre.

The case seems to be of great interest. At first everything pointed to early malignant disease of the right vocal cord—the age of the patient, the uniform redness and impaired mobility of the cord, the hoarseness, and later the presence of a lump like a gland externally; on the other hand, time proved the trouble not to be intrinsic carcinoma. Later on, *i.e.* in February, 1899, everything again pointed to malignant disease, though more of the neck than the larynx.

Though the microscopic appearances are those of innocent tumour, I am still inclined to think that the tumour was commencing to become malignant, for the clinical course of sudden and rapid increase in activity in a man of sixty-two, of a tumour anywhere which may have remained dormant even for years, is always very suspicious, and I consider clinical evidence more important in such cases than microscopic evidence.

Case of Complete Paralysis of one Vocal Cord and Impaired Abduction of the other.

Shown by Dr. StClair Thomson. This patient, a boy æt. 17, was said to have been hoarse since his voice changed at the age of fourteen, and it was therefore to be presumed that the laryngeal condition had existed for three years. The condition is sufficiently described by the title of the case. There is nothing in the boy's neck, chest, or nervous system to explain the cause of the paralysis. The exhibitor suggested influenza as a possible cause, and wished to know if others had seen cases at this early age.

Dr. Permewan had had three cases of paralysis of the right vocal cord, of which he was not able to discover the cause; possibly it was due to disease of the top of the pleura. He did not agree with the other part of the title, viz. "impaired abduction of the other cord;" from his own view, it moved quite freely. Dr. StClair Thomson's suggestion of influenza ought to be taken into account. He had a

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patient who suffered from influenza and had recurrent paralysis, which remained for some weeks. The patient then became convalescent and got well again.

Sir FELIX SEMON said he had seen several cases of laryngeal paralysis after influenza, amongst them those of two medical men who both got well in a short time. With regard to Dr. StClair Thomson's question as to the age of these cases, he had seen loss of abductor power in patients of one and a half to five years of age.

The PRESIDENT remembered seeing a case with Sir Felix Semon, which almost completely recovered; he had also reported to the Society a case of double abductor paralysis in a child of six.

Dr. STCLAIR THOMSON said he had shown a case undoubtedly due to influenza, which had cleared up between the announcement and the patient's appearance at the meeting, but in that case the patient had had the paralysis only six months, whereas in the case under notice the disease was of three years' standing.

CASE OF LARYNGEAL ULCERATION WITH CALCIFICATION OF THE FASCIA OF THE NECK.

Shown for Mr. CHARTERS SYMONDS by Mr. STEWARD. The patient, a woman æt. 32, complained of loss of voice and difficulty in breathing, and gave the following history.

When a child she had an abscess on the right side of the neck, and at about the same time she became deaf.

About ten years ago swelling and stiffness of the neck began, and this has gradually increased since that time.

The present attack of hoarseness commenced three months ago. The patient is very deaf, the skin is pallid, the bridge of the nose is broad and flattened. The eyes and teeth are normal. Just behind the angle of the jaw on the right side is a large scar. The whole of the structures in the front of the neck are hard and matted. There is great thickening around the hyoid bone and thyroid and cricoid cartilages, and these structures appear to be united into a dense hard mass.

There are several enlarged glands in the submaxillary region, and lower down in the neck are several very hard nodules, one particularly hard being situated in the right sterno-mastoid muscle. The soft palate and pharynx are much scarred, and are adherent to one another.

The upper opening of the larynx is red and swollen, and there is ulceration on the right ventricular band.

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Sir FELIX SEMON said that he had a strong suspicion that this case was specific. The configuration of the patient's face and the large distance between the eyes pointed to congenital syphilis. With regard to the pharynx, the adhesions are very characteristic of either tertiary or inherited syphilis.

Dr. WILLIAM HILL said that Mr. Symonds was doubtful as to the correctness of the term "calcification." To him it seemed to be an extensive line of scars rather than calcification.

Mr. STEWARD said that the whole thing might be syphilitic. There was considerable swelling on the right side of the larynx, loss of voice, and troublesome dyspnœa, which was steadily getting worse in spite of calomel baths and doses of iodide of potassium for three weeks.

CASE OF SLOUGHING ULCERATION OF THE PHARYNX.

Shown by Mr. STEWARD for Mr. CHARTERS SYMONDS. Male æt. 31, has always been healthy till nine months ago; has no history of syphilis.

At the end of October, 1898, patient had a thick discharge from the nose, with headache and pains in the back. Shortly after this a hard round lump appeared below the left ear, and a similar lump soon appeared on the right side. These were followed by other lumps, which coalesced to form large swellings. Later the tonsils were enlarged, and a large ulcer with yellow surface appeared on the left one, and soon afterwards the right tonsil became similarly affected. The left tonsil healed, but the swellings in the neck steadily increased.

When first seen on December 11th, 1898, there was a large ulcer involving the lower part of the right tonsil, and extending on to the base of the tongue. The ulcer was covered with yellow slough, and the edge was hard, raised, and indurated. There were also large masses of swollen glands on each side of the neck; some of these were soft and fluctuating, others quite hard.

Patient was ordered iodide of potassium in increasing doses, and for a time improved.

On March 9th the ulcerations had considerably increased, as had also the swellings in the neck. Small hard glands were found in the left axilla and right groin. Calomel vapour-baths were ordered in addition to the potassium iodide, and on March

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14th the ulcers were curetted, and then cauterised with nitric acid.

After this considerable improvement took place and the throat nearly healed, but early in May a relapse occurred, and spread of ulceration took place.

On the 9th several softening glands were opened and curetted, and one was removed; the throat was also again curetted.

The softened glands contained a semi-fluid material of yellowish-brown colour. Microscopically the excised gland showed caseating foci and a small-celled infiltration, but no definite evidence of tubercle.

Mr. Cresswell Baber said that in his opinion the case was syphilitic.

Sir Felix Semon thought there was little doubt it was a case of lympho-sarcoma, and advised the administration of arsenic. He had seen three or four such cases in which tumours had formed and disappeared almost entirely; suddenly they would appear again and assume a serious form. He always treated them by increasingly big doses of arsenic.

Mr. Steward said the man had been treated with large doses of iodide and mercury, but had not had arsenic. It might be of interest to mention that the man had several glands in the right axilla and in the left groin. As regards the examination of the stuff from the opening in the neck and gland, the view of lympho-sarcoma was supported. Under the microscope was seen a mass of small round cells, with fair-sized nuclei, and there were caseous foci in the gland itself. No tubercle bacilli were found.

Dr. William Hill thought if the suggested arsenic treatment was of no avail it would be well to try electrolysis.

Tumour of the Nasal Cavity.

Patient and specimen shown by Mr. Cresswell Baber. A female æt. 66 came as out-patient on March 17th last, complaining of right nasal obstruction since the previous summer. She had also had a sore throat and pain in the right ear. No deafness. A large polypus was snared from the right nostril. On April 7th a polypus was felt in the right choana with the finger, and snared from the front. April 14th.—Right side still much obstructed, also much muco-purulent discharge. Posterior rhinoscopy, with the aid of the palate-hook, showed a red

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growth in the right choana; two more pieces of reddish, friable growth snared from the front. May 1st.—On palpation, a small mammillated moveable growth was felt in the right posterior naris. May 2nd.—The growth could be just discerned from the front, and was moveable, but whether it grew from the inferior turbinated body, or from the outer wall of the nasal cavity, could not be ascertained—it was not attached to the septum. Transillumination on April 21st and May 2nd showed both infra-orbital regions light. No enlarged glands.

The growth removed on April 14th was reported on by the Clinical Research Association as "columnar-celled carcinoma arising from the nasal mucous membrane." I decided to take steps to lay the disease freely bare, so that its extent could be more clearly seen, and, if necessary, a radical operation performed. With this object, on May 6th I removed, under general anæsthesia, the growth in the posterior naris with the spoke-shave, and subsequently the inferior turbinated body with the same instrument. The outer wall of the nasal cavity was then freely curetted with a large sharp spoon. Afterwards, on inserting the little finger into the nasal cavity, I could feel that there was an aperture into the antrum, probably the result of the curetting. The growth was soft and irregular. The patient recovered from this well, and has been kept carefully under observation.

Her present condition—more than three weeks after the operation—is as follows:—There is some dirty-looking, fœtid, muco-purulent discharge coming from the right nasal cavity. In consequence of the removal of the inferior turbinated body the nasal cavity can be easily inspected. The only sign of the growth is what looks like small, rather vascular roots of mucous polypi, between the lower margin of the middle turbinated body and the outer wall. No growth seen by posterior rhinoscopy, though there is a red spot on the margin of the right choana at its upper outer part, where the last growth may have sprung from. Still plunging pain in the right ear. Both antra light up on transillumination, but the right seems a shade darker than the left. Possibly some of the discharge may have got into the antrum.

Mr. Baber asked the opinion of members as to the malignancy

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of the growth, and the advisability of further operative measures.

Dr. PEGLER thought that the growth was not malignant; one corner of the slide showed doubtful-looking cells, but not characteristic of carcinoma. He suggested the specimen should be referred to the Morbid Growths Committee.

Dr. WILLIAM HILL asked whether it was ulcerated on the surface, and if there was any hæmorrhage before operation. It was not possible to make a diagnosis, as the sections did not go to the root of the tumour.

Mr. BABER said Mr. Butlin had seen them, and thought the case was one of carcinoma.

Dr. WAGGETT said it would be a valuable section to have in the cabinet for reference in subsequent years.

Mr. BABER said he would do no further operation unless there was a recurrence.

The PRESIDENT moved that the specimen be referred to the Morbid Growths Committee. This was adopted.

SPECIMEN OF EPITHELIOMA OF ŒSOPHAGUS CAUSING BILATERAL PARALYSIS OF VOCAL CORDS.

Shown by Dr. CLIFFORD BEALE. L. H—, æt. 33, female domestic servant, admitted January 13th, 1899, for cough and muco-purulent expectoration of long standing, with some dysphagia and occasional dyspnœa. The patient was a good deal emaciated, and complained of recent acute tenderness of the left side of the thyroid. Some swelling and tenderness was present. On examining the larynx the vocal cords were seen to be normal in appearance, but lay during normal and forced respiration in the cadaveric position. On phonation they were brought together, and a fair volume of sound was produced. While under observation in hospital many attacks of adductor spasm occurred, and the voice gradually got feebler until it was lost altogether. The sensation within the larynx was unimpaired. Tracheotomy became necessary and gave immediate relief. Dysphagia increased especially for solid food, and it was noted that fluids and sometimes solids were occasionally regurgitated through the tracheotomy tube; and hence, after a short period of rectal feeding, gastrostomy was performed, and the patient was fed directly into the stomach for the five weeks pre-

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ceding her death. The constant welling up of muco-pus from the œsophagus, and the occasional regurgitation of the food in the stomach, led by slow degrees to a septic broncho-pneumonia, which was the immediate cause of death on April 12th, 1899.

The specimen showed infiltration of the mucous membrane and submucous tissue of the œsophagus by a cancerous growth. The growth began below the level of the larynx, and extended for about two and a half inches downwards, embracing the whole lumen of the tube. At the anterior part a perforation communicating with the trachea was visible. The œsophagus above and below the growth was healthy though somewhat engorged. The thyroid body was enlarged and thickened in both lobes, being exceedingly tough and fibrous on section. The trunk of the vagus was seen to be compressed, together with the vessels, on one side, while the recurrent laryngeal nerve could be traced into the body of the thickened thyroid gland on the other side. No other cancerous growth was discovered in any part. The growth in the œsophagus was a typical epithelioma.

CASE OF UNUSUAL PHARYNGEAL TUMOUR.

Shown by Sir FELIX SEMON. The patient, a female, was shown at the March, 1898, meeting of the Society, and was now again brought forward to show that the condition remained absolutely *in statu quo*.

Dr. WILLIAM HILL asked Sir Felix Semon to explain why he took such pride in keeping this tumour.

Sir FELIX SEMON had the greatest pleasure in answering that question; he did not feel justified in doing anything because he did not know what the growth was or how far it went. That it was intimately connected with the vagus he suspected because the least pressure caused coughing and retching; meanwhile it caused the patient no inconvenience whatever.

A CASE OF STRICTURE OF THE LARYNX FOLLOWING TRACHEOTOMY FOR DIPHTHERIA SUCCESSFULLY TREATED BY DILATATION.

Shown by Dr. LAMBERT LACK. The patient, a child æt. 6, had

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tracheotomy performed for diphtheria one year ago. Three months later, it being impossible to remove the tube, an exploratory thyrotomy was performed by Mr. Stanley Boyd, and an ulcer of the larnyx with much granulation tissue, almost completely obstructing the lumen, was found just below the vocal cords. The granulation tissue was removed and the wound allowed to heal. Attempts were then made to dilate the stricture of the larynx by intubating with O'Dwyer's tubes; but after a month of intermittent treatment this method was abandoned, its tediousness and painfulness seriously affecting the child's health. It was then resolved to dilate the stricture from below. A metal plug with a shield attached to fit over the tracheotomy tube was made. Under chloroform the tracheotomy wound was enlarged and the stricture forcibly dilated with curved forceps; the plug and the tracheotomy tube were then inserted. The plug was worn continuously for five months without causing any inconvenience; it was then removed, and the tracheotomy tube was corked up. The child being able to breathe freely through the mouth both day and night, after a month the tube was dispensed with. The wound soon healed, and the patient now—a month later—seems cured.

The President congratulated Dr. Lack on his success in this case. Many attempts had been made and much time had been spent in trying to dilate laryngeal strictures, but generally in vain.

Dr. Lack, in replying to a question by Dr. Permewan, said that the dilatation was done through the tracheotomy wound with ordinary dilators and a plug inserted to keep the parts dilated, and worn for about five months continuously. He had treated the case with intubation tubes, but directly they were left out the trouble recurred.

Case of Node in Nasal Process of the Right Inferior Maxilla and Ulcerative Rhinitis in a Tubercular Girl.

Shown by Mr. Atwood Thorne. The patient, a girl æt. 7, came to St. Mary's Hospital complaining that for the last two months the nose had been gradually growing broader, and the nostrils becoming increasingly blocked. The trouble was attributed to a fall on the nose.

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On examination there was found a mass as large as a hazel-nut attached to the nasal process of the right superior maxilla, and there was some swelling in a similar position on the left side. The nostrils were almost completely blocked by pale granular masses, and there was a thin watery discharge.

With the exception of a very small opacity of the left cornea (said to be due to an accident) there was nothing to suggest congenital syphilis, while the patient had been in St. Mary's for the treatment of a tubercular ulcer of the foot, and had had an operation at Golden Square for enlarged cervical glands.

The PRESIDENT asked if the nasal secretion had been examined for tubercle bacilli.

Dr. HILL suggested the case was a mixture of syphilis and tubercle.

CASE OF TUMOUR OF PALATE IN WOMAN ÆT. 34.

Shown by Dr. BOND. The swelling was first noticed twelve years ago shortly after the extraction of three teeth. It slowly increased in size, but lately has grown more rapidly. There is now an elastic, painless, non-tender swelling covering the hard palate, and extending into the alveolus on the right, and also into the soft palate. It is rather more dusky than the normal mucous membrane; in the centre is a paler area. There are no enlarged glands in the neck. The floor of the nose is normal.

The growth was thought by several members to be an adenoma. Dr. Bond proposed to report further on the case after operation.

Mr. DE SANTI took the swelling of the palate to be an adenoma, and considered it would be quite an easy matter to dissect it out.

Dr. WATSON WILLIAMS said that many years ago one of the first cases he saw in a young girl about fourteen was very similar to this. The tumour had existed for some years, and was increasing in size very greatly. It contained numerous small cysts. He had opened the growth and introduced weak chromic acid, with the result that the growth was inflamed for some days and soon after disappeared entirely, and it had not recurred a few years later.

Dr. BOND said he proposed attempting to remove the growth in a few days.

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Female æt. 26, with Large Sarcomatous Tumour of the Naso-pharynx.

Shown by Dr. StClair Thomson. Though not by any means rare in early life, this case was shown as an example of malignant disease in a young adult. The patient had traces of having been operated upon for tuberculous glands in the neck, and it was therefore a little difficult to say whether the glands, which were now evident on each side of the neck, were also tuberculous, or whether they were secondary to the malignant growth. They were sufficiently hard. The growth pushed forward the soft and hard palates without invading them. It completely obstructed the choanæ, and had seriously interfered with swallowing and breathing. The author invited discussion as to whether an attempt should be made to remove the growth, and as to whether the patient should have tracheotomy or gastrostomy or both.

Mr. de Santi looked upon this swelling as probably of a malignant nature; its rapid growth and general appearance were consistent with such a diagnosis. The glands, though originally the patient had had tubercular cervical glands removed, were probably sarcomatous. Though the case might be one of mixed infection, tracheotomy should be done soon, and then an attempt to explore the palatal growth might be made. It would be interesting to know the microscopic appearances.

Dr. Bond thought that tracheotomy ought to be done; then it would be possible to get away some of the mass from the mouth: a large part might be snared off. In any case after tracheotomy, it should be thoroughly examined with the finger. He thought something might be done to relieve the case for a time.

Dr. Tilley asked if the glands were secondary to the particular growth in the palate or independent.

Dr. StClair Thomson was encouraged to follow the advice given. The woman had had tubercular glands in the past, and he thought they were not secondary to this growth.

A Case of Laryngeal Disease for Diagnosis.

Shown by Mr. E. W. Roughton. A man æt. 42, suffering from hoarseness, cough, and dyspnœa of three months' duration.

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There was a swelling involving and fixing the left cord and arytænoid. No evidence of tuberculosis and no history of syphilis. He asked for a diagnosis.

Mr. DE SANTI was of opinion that this was a case of epithelioma. There was marked infiltration of the parts and very impaired mobility. Moreover the redness was quite unilateral, and fulness could be seen below the cord. An early laryngo-fissure was urgently needed.

Dr. WILLIAM HILL said he was inclined to think it was malignant. There were no glands on the outside; it was the sort of case well suited for an exploratory thyrotomy.

Sir FELIX SEMON suggested removing a piece first.

Dr. STCLAIR THOMSON said the cord was quite fixed, and the growth extended below the cord. He thought it a good case for laryngo-fissure.

The general opinion of members was that the case was very suitable for exploratory thyrotomy.

CASE OF MALFORMATION OF PALATO-PHARYNGEI MUSCLES.

Shown by Dr. FITZGERALD POWELL. A man æt. 22 presented himself for treatment at the hospital, suffering from suppuration of the middle ear, with hypertrophic rhinitis. This condition followed scarlet fever fourteen years previously.

On looking into his pharynx it was seen that the palato-pharyngei muscles forming the posterior pillars of the fauces on both sides, instead of passing down in the normal position, were drawn backwards and united together, leaving a small opening below the uvula into the post-nasal space.

The united muscles spread out over the posterior wall of the pharynx and became attached to it for some distance, when they parted and fell away in crescentic folds to their attachment to the posterior border of the thyroid cartilage.

The appearance on examination conveyed the impression that this condition was caused by extensive ulceration, and the history of severe scarlet fever deepened this impression, though on further and more prolonged inspection doubts arose as to whether this malformation was not due to congenital mal-development, the condition was so very symmetrical.

Mr. BABER thought it was the result of an ulceration, secondary to scarlatina rather than congenital. In the first year of this Society he

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had shown a similar case. He was not sure whether it was from scarlet fever.

The PRESIDENT had seen almost the same thing. He thought a deep ulceration, if in the centre, would cause that symmetry.

A Case of Epithelioma of the Pharynx.

Shown by Mr. ATWOOD THORNE for Dr. DUNDAS GRANT. The patient, a clerk æt. 58, came to the hospital on May 25th complaining that for two months he had had increasing pain on swallowing. He had also been losing flesh somewhat for about the same period.

On examination there is seen a craggy mass on the right side of the pharynx, extending to the base of the tongue on the same side. With the finger the mass is found to be of almost cartilaginous hardness. There is marked involvement of the glands on the right side of the neck.

The case was shown especially for the consideration of the advisability of operation.

A Case of Pachydermoid Laryngitis treated with Salicylic Acid.

Shown by Dr. DUNDAS GRANT (per Mr. ATWOOD THORNE). The patient, a man æt. 56, "chucker-out" at a music hall, came to the hospital at the beginning of April complaining of a "husky voice."

The cords were partially concealed by very swollen ventricular bands; they were obviously less tense than normal, and on their edges there was what looked like a layer of desquamating epithelium. The rest of the cords was red and succulent, and in the interarytænoid space the mucous membrane was swollen and sodden-looking. The nasal mucous membrane was in general hypertrophied, and there was a considerable excess of mucous secretion.

The patient was advised to give up all alcoholic drinks (in which he usually indulged somewhat freely), and twice a week, in gradually increasing strength, an alcoholic solution of sali-

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cylic acid has been applied to the thickening in the larynx. At the same time he has been ordered an alkaline lotion to wash out his nose. He has now quite regained his voice, and though the swelling has not altogether disappeared, the whitish thickening on the edges of the cords is hardly perceptible.

Case of Bilateral Abductor Paralysis, &c.

Shown by Mr. Richard Lake. The patient is a man, and has suffered from cough and dyspnœa for three months ; now both cords seem fixed in the cadaveric position : there is a breaking-down gumma of the right tonsil. There is slight ptosis of the left eye, the left pupil is large and inactive, there is paralysis of all the recti muscles and of the inferior oblique. Under iodide the conditions have improved.

A case of pachydermia laryngis in a tubercular patient was also shown by Mr. Lake.

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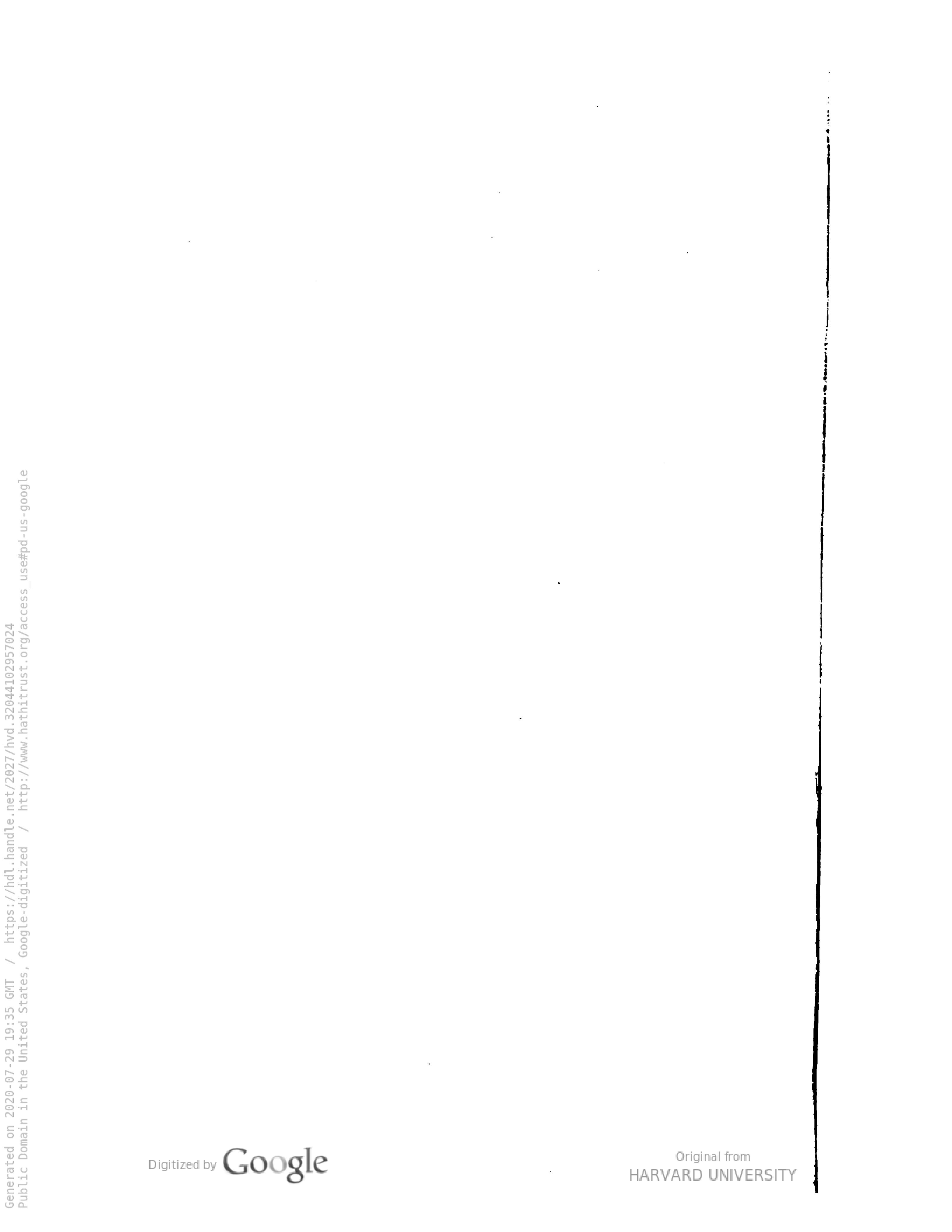

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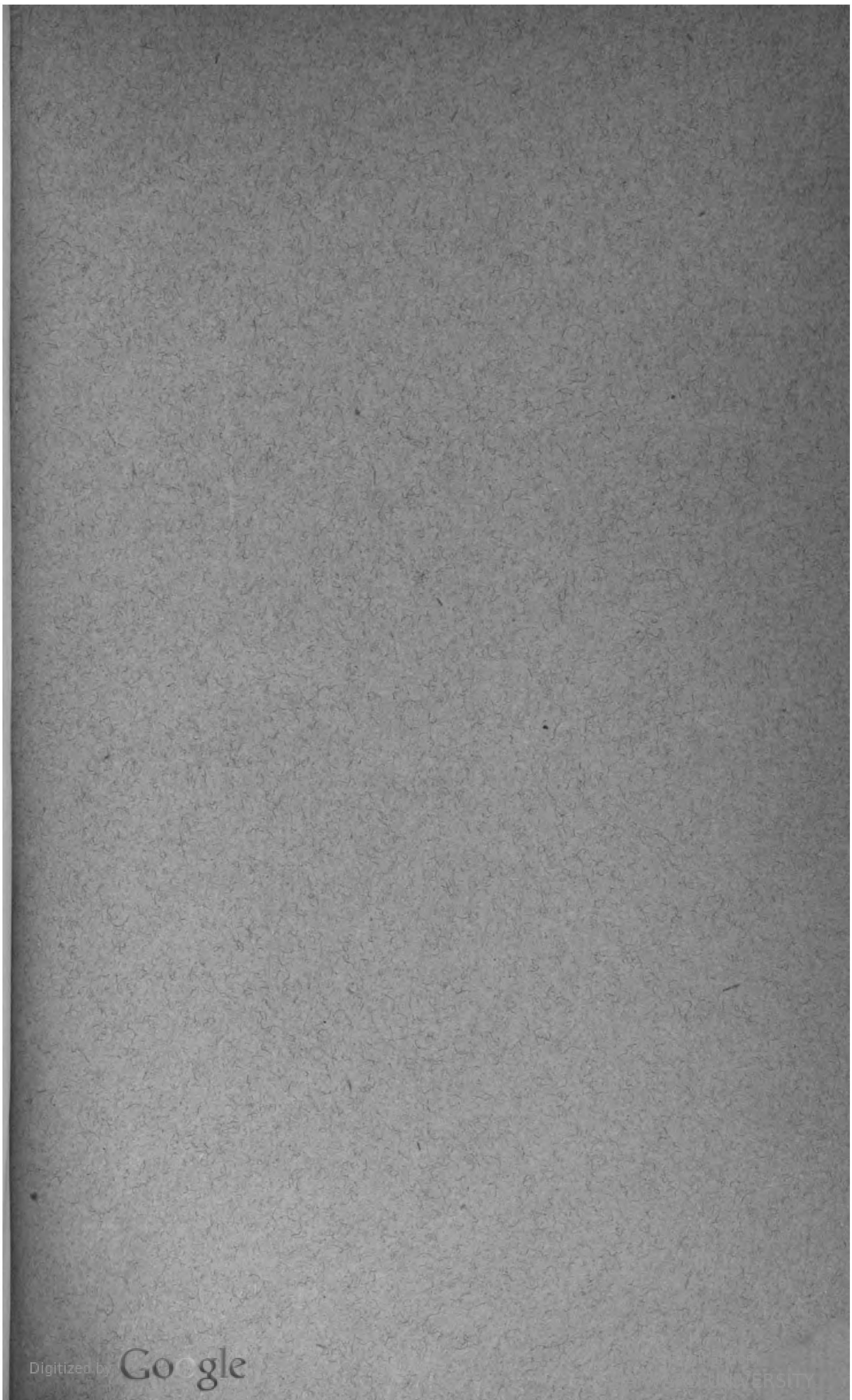

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