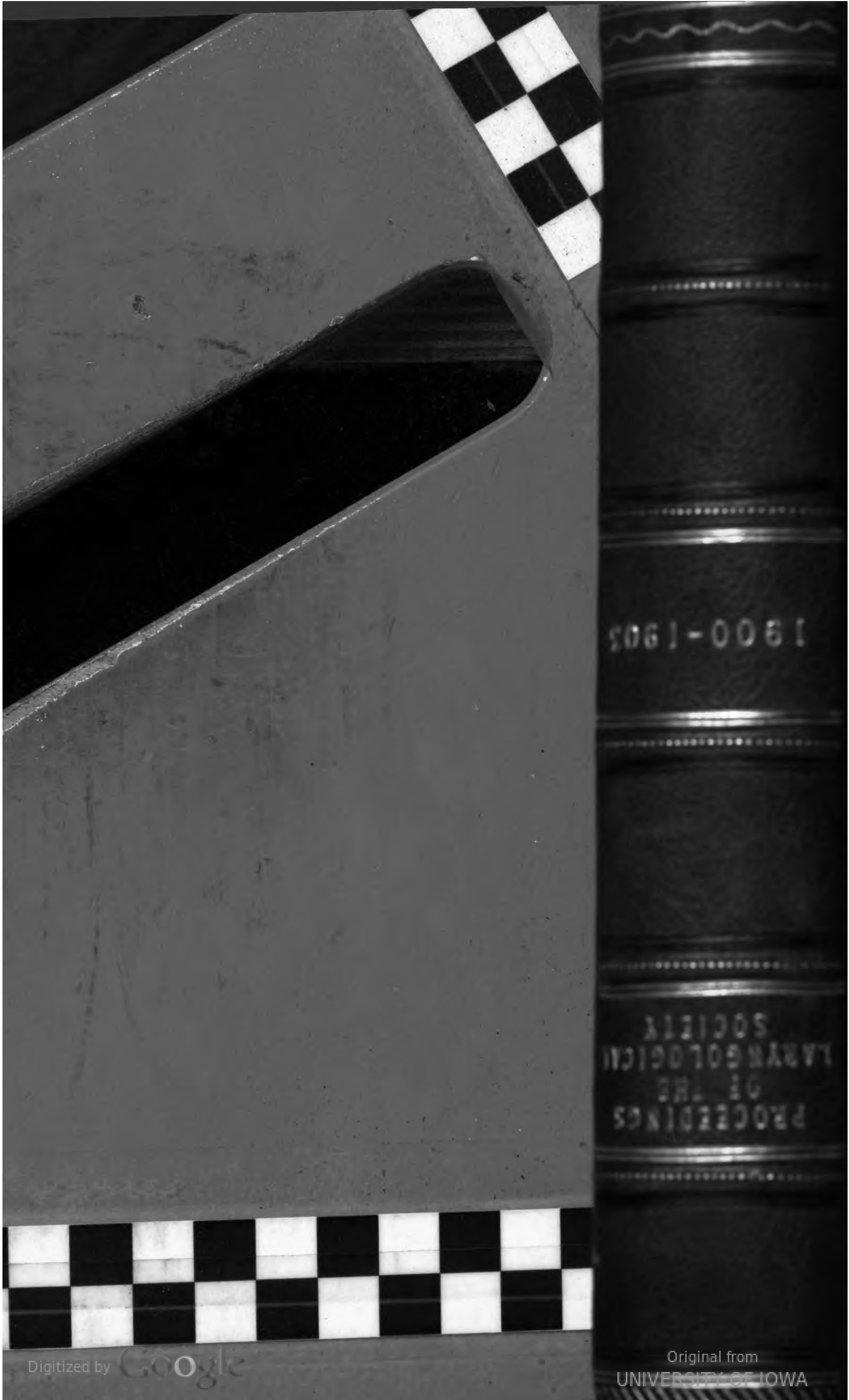

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PROCEEDINGS
OF THE
LARYNGOLOGICAL
SOCIETY

1900-1903

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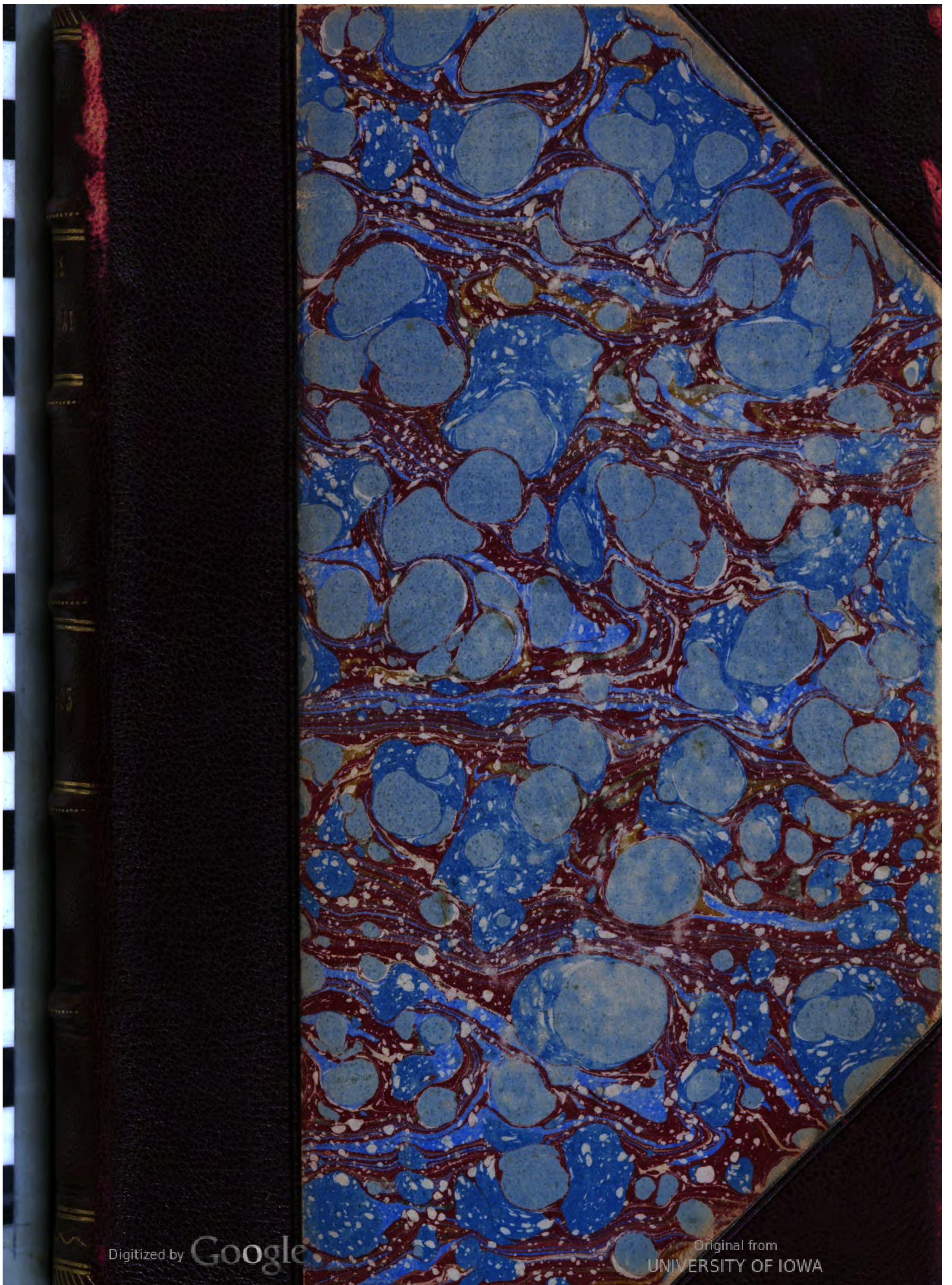

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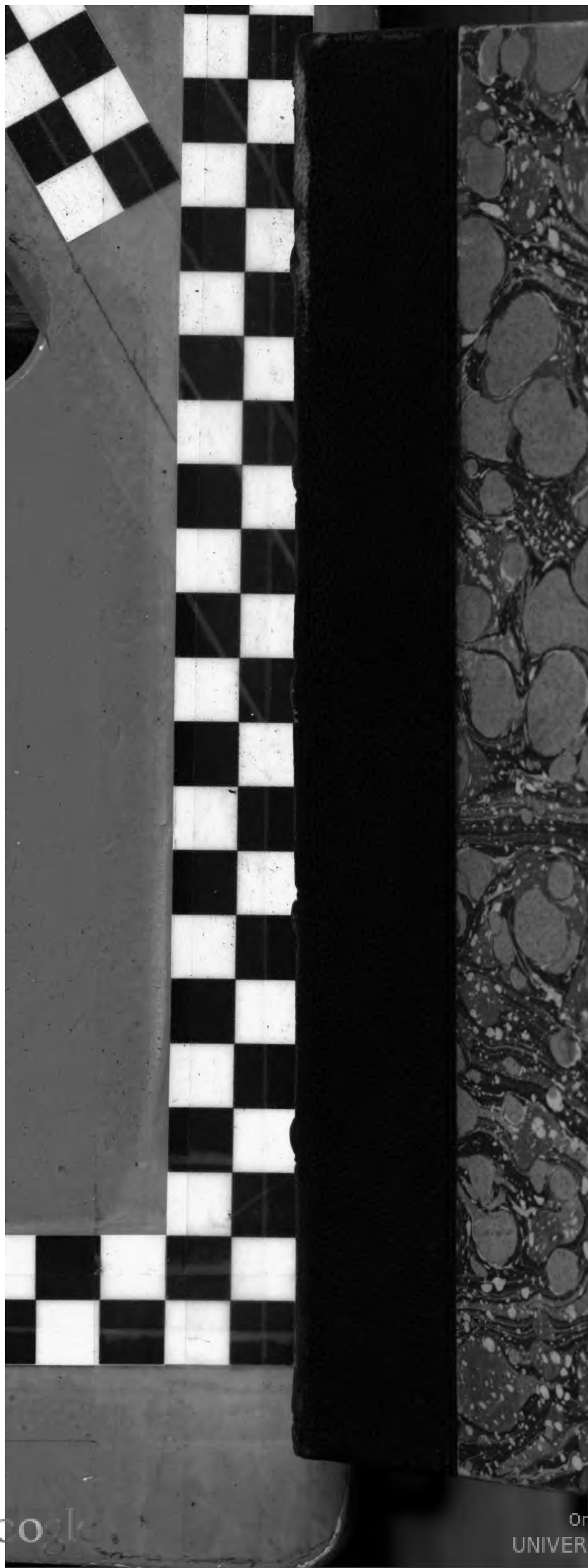

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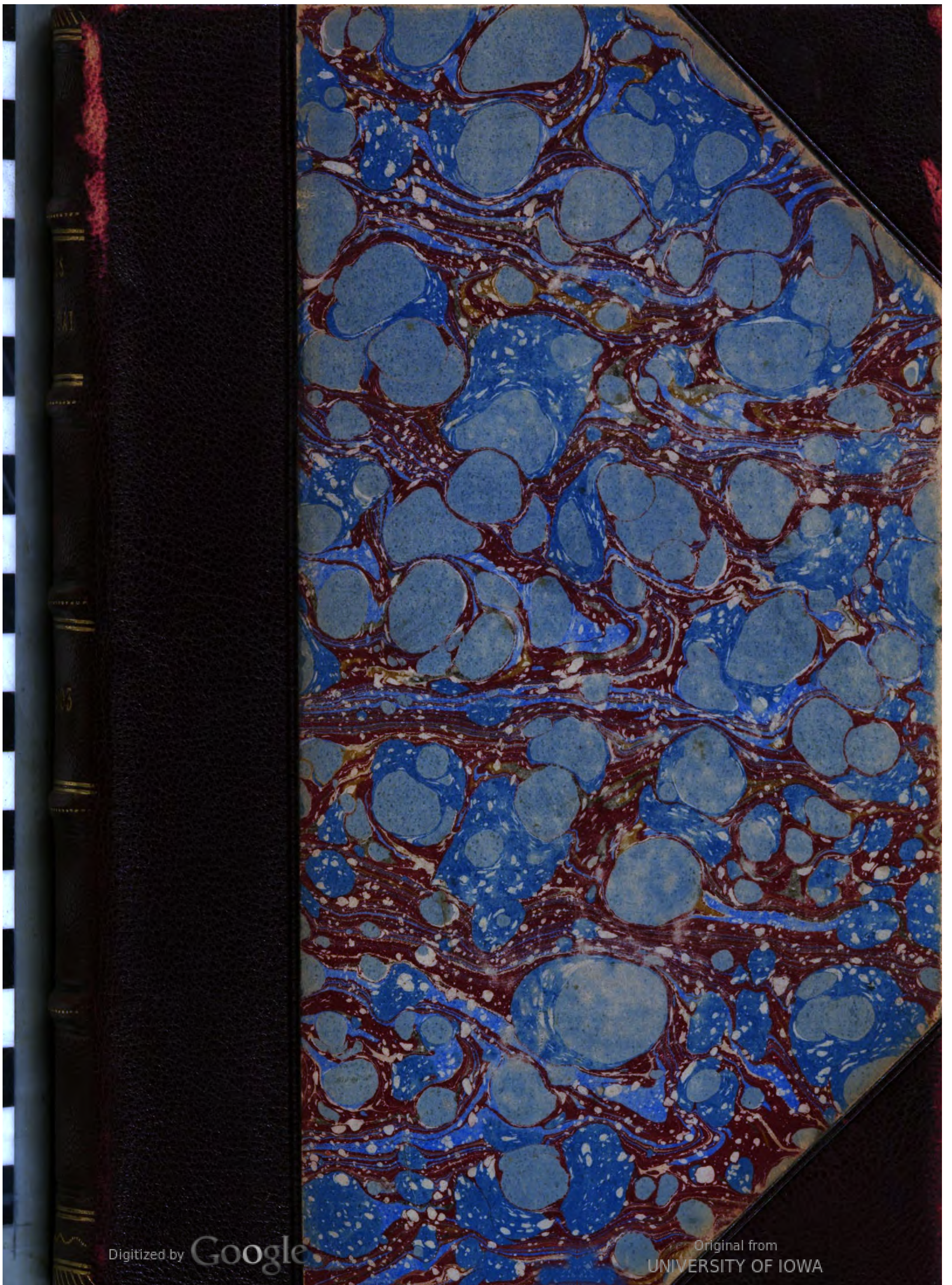

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY

OF

LONDON.

VOL. VIII.

1900—1901.

WITH

LIST OF OFFICERS, LIST OF MEMBERS, ETC.

LONDON:
PRINTED BY ADLARD AND SON,
BARTHOLOMEW CLOSE, E.C.

1901.

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OFFICERS AND COUNCIL

OF THE

Laryngological Society of London

ELECTED AT

THE ANNUAL GENERAL MEETING,

JANUARY 4TH, 1901.

President.

E. CRESSWELL BABER, M.B.

Vice-Presidents.

A. A. BOWLBY, F.R.C.S. GREVILLE MACDONALD, M.D.
E. LAW, M.D.

Treasurer.

E. CLIFFORD BEALE, M.B., F.R.C.P.

Librarian.

J. DUNDAS GRANT, M.D., F.R.C.S.

Secretaries.

E. B. WAGGETT, M.B. C. A. PARKER, F.R.C.S. (Edin.)

Council.

F. DE HAVILLAND HALL, M.D.
HERBERT TILLEY, F.R.C.S.
BARCLAY BARON, M.B.
WILLIAM HILL, M.D.
SIR FELIX SEMON, M.D.
LAMBERT LACK, M.D.

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PRESIDENTS OF THE SOCIETY.

(From its Formation.)

ELECTED	
1893	Sir George Johnson, M.D., F.R.S.
1894–6	Sir Felix Semon, M.D., F.R.C.P.
1897–8	H. Trentham Butlin, F.R.C.S.
1899–1900	F. de Havilland Hall, M.D., F.R.C.P.
1901	E. Cresswell Baber, M.B.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

SIXTIETH ORDINARY MEETING, *November 2nd*, 1900.

F. DE HAVILLAND HALL, M.D., President, in the Chair.

LAMBERT LACK, M.D., } Secretaries.
ERNEST WAGGETT, M.B., }

Present—39 members and 3 visitors.

The minutes of the preceding meeting were read and confirmed.

The ballot was taken for the following gentlemen, who were unanimously elected members of the Society:

Herbert William Carson, F.R.C.S., Craigholm, Upper Clapton, N.E.
Edward John Budd-Budd, Eagle House, 73, South Side, Clapham Common.

The following gentlemen were nominated for election at the next meeting of the Society:

Frederick J. J. Wilby, M.B., B.S.Durh., 23, Henrietta Street, W.
Braine Hartnell, Cotswold Sanatorium.
George Jones, 8, Church Terrace, Lee, S.E.
J. Stewart Mackintosh, St. Ives, Platt's Lane, Hampstead.

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The following cases and specimens were shown:

A Case of Mucous Polypus of Larynx.

Shown by Mr. Stewart. A woman æt. 78, for eleven years has had catching of the breath when laughing, and for three years increasing hoarseness. Examination shows a mucous polypus occupying the whole of the right vocal cord. In my experience laryngeal mucous polypi are comparatively rare, and very rare in old people. They usually occur in middle life. Mackenzie in his book gives only one case over 50, and that was in a woman aged 70.

The President suggested the removal of the growth. It was a cyst and could be readily taken away.

Mr. Stewart had suggested operation, but the patient said the tumour had been present from birth, and she would rather keep it.

Specimen of Cancer of the Œsophagus, causing Complete Laryngeal Paralysis.

Shown by Mr. W. G. Spencer. The patient from which the specimen was taken was admitted into hospital with rapidly progressive laryngeal dyspnœa. It was difficult to examine the larynx on account of the dyspnœa, and therefore no exact diagnosis could be made, but it was particularly noted that there was no dysphagia.

I explored the larynx by thyrotomy and found the left cord absolutely immobile and the right scarcely moving at all. The left vocal cord was completely removed and the patient recovered apparently well, his breathing being quite relieved. But soon after the wound had healed he developed a tracheo-œsophageal fistula which was quickly fatal.

The specimen shows extensive epitheliomatous ulceration of the œsophagus which has extended to the trachea and the glands so as to involve the recurrent laryngeal nerves. The position of the left vocal cord is occupied by a fine scar. The temporary relief to the patient was even more satisfactory than a tracheotomy could have been.

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The PRESIDENT said that the case was originally under his care. The causation of the paralysis was extremely obscure, nothing definite being ascertainable. The operation of thyrotomy and excision of the vocal cord as performed by Mr. Spencer, though objected to in the past, certainly gave the patient considerable relief, and it was, perhaps, the best thing that could be done.

Sir FELIX SEMON said they all knew that in cases of thyrotomy for malignant disease when a vocal cord was removed a cicatricial band formed at the level where the vocal cord was removed. Under these circumstances the advantage of the operation so far as the relief to breathing was concerned seemed to him very doubtful. If the patient had lived a little longer than he did, one would have expected a recurrence of the stenosis to occur. This theoretical reasoning found a practical corroboration in the experience that when a vocal cord was cut out in roaring horses no lasting benefit whatever to the breathing was effected.

Mr. SPENCER questioned whether in thyrotomy sufficient growth was always removed. In the specimen only a fine scar was to be seen. Had this patient lived longer would he have had a cicatricial band?

Sir FELIX SEMON remarked that it was impossible to remove more than was done in a case of malignant disease where everything in the neighbourhood of the growth was removed.

The PRESIDENT suggested the occasional devotion of a meeting to the exhibition of sequelæ of cases previously shown to the Society; such cases were apt to be lost sight of and much valuable information was thus wasted.

CASE OF PROGRESSIVE SINKING OF THE BRIDGE OF THE NOSE, FOLLOWING BILATERAL HÆMATOMA OF THE SEPTUM.

Shown by Mr. W. G. Spencer. About two years ago the boy had a fall on his face. There was no displacement nor fracture of the nose, but on each side a well-marked hæmatoma just within the anterior nares. These were absorbed without suppuration and the nose appeared to be unaltered by the accident; but a month ago the boy was again seen, as a progressive sinking of the bridge of the nose had occurred. On examination the septum is seen to be twisted, the muco-periosteum thickened, and the nasal passages much narrowed. There is no evidence of inherited syphilis.

The case is exhibited because the injury seems to have set up a chondritis and softening such as may happen in joints after slight injuries. There is always much doubt as to whether spurs

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and deviations of the septum are congenital or traumatic in origin. The case shows that these deformities may arise gradually some time after a slight injury and yet be really due to it.

The PRESIDENT related the case of a lady of about sixty, who had complained of a swollen septum which interfered with nasal respiration, and of pain in the arch of the nose, which was somewhat reddened. At the time he had not taken a grave view of the case. Ten days after seeing the patient there was a rapid increase of the swelling. An abscess formed; the cartilage came away, and in a fortnight the bridge of the nose was sunken. At his examination of the case he had used cocaine, to the application of which the patient had attributed the subsequent trouble. This was an extremely rapid case, in which there was no history of syphilis, and absolutely no cause to explain the mischief. It formed a considerable contrast to the gradual progression which had taken place in the case under discussion.

Dr. STCLAIR THOMSON asked the President whether in his case the nasal bones fell in or the end of the nose.

The PRESIDENT said the nasal bones had fallen in.

Dr. STCLAIR THOMSON had watched carefully one or two cases of hæmatoma of the septum. One was of interest by reason of the suppuration which had occurred: it seemed to be a hæmatoma, but was in reality an acute abscess. He attributed it to infection from a suppurating maxillary antrum. A portion of the cartilage came away. All the cases recovered without any injury to the appearance of the nose. He would suggest in this case that the collapse of the bridge was due to inherited syphilis. Certainly there was no distinct history, but the mother had had miscarriages and dead children, and she states that there is sometimes a nasty smell from the boy's nose. There was still a good deal of purulent matter about the middle turbinals.

Mr. PAGET said it was surely inconceivable that loss of the cartilaginous septum could have any effect on the shape of the arch of the nose.

Dr. DUNDAS GRANT asked what degree of disfigurement there was at the time of the injury? Might not the distortion be part of the original injury?

Dr. WATSON WILLIAMS had seen a patient in whom he could find no portion whatever of the cartilaginous septum. There was no external deformity of the nose. The patient was open and frank and denied any history of syphilis.

Mr. BABER said it was commonly held that no amount of destruction of cartilage was sufficient to account for collapse of the nose; the tip of the nose might be affected but not the bones. He was of opinion that it would be most interesting for members to see a photograph of the patient taken before the accident.

Dr. LACK said that nearly every hæmatoma and abscess of the septum was due to an injury. In his experience such injury was always attended by some subsequent deformity and depression of the

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tip of the nose, though he granted it might not be evident for a few weeks, until the swelling produced by the injury allowed the result to be seen.

Mr. VINRACE asked whether the pharyngeal condition existed at the time of the accident. There was now present a condition of the naso-pharynx which he thought must be of constitutional origin and not the result of injury.

Dr. WYATT WINGRAVE considered that deformity was not surprising since the structures were only partially developed. In adults deformity was rare, unless the traumatism or subsequent inflammatory changes involved more than the septum, such as the nasal bones and nasal process of the maxilla.

Mr. SPENCER, in reply, said the boy's nose was mainly altered in the cartilaginous portion; there was no alteration in the roof or bony part. He had watched the hæmatoma disappear, until the nose was quite free. Then arose marked progressive nasal obstruction, and later appeared a discharge of muco-pus and crusts, which he had left alone to show the members. There was no ulceration or abscess. Inquiries had been made as to congenital syphilis with negative results; but it was impossible to exclude it with certainty. One heard of general practitioners being blamed for not having the nose put straight in such cases. Here was a case where, although there was no obvious damage at the time or a month after, after two years had elapsed there was distinct deformity of the nose. In adults there might be destruction of the lower end of the septum without any alteration in the shape of the nose.

CASE OF LARYNGEAL GROWTH IN A MAN ÆT. 49.

Shown by Dr. BARCLAY BARON. Patient, a man æt. 49 years, who has drunk hard, but denies syphilis, noticed a little dryness of the throat about a year ago, and some obstruction in May last, when he had a good deal of nose bleeding. Since then the difficulty in swallowing has increased, but he can still swallow well-masticated meat; the breathing is obstructed, the voice is altered and there is pain shooting up into the right ear; the larynx is practically filled up with a large growth, with irregular surface covered with creamy secretion; the epiglottis is pushed towards the left side. The growth increases in size, but it is believed to be an innocent tumour.

The PRESIDENT said he had never seen such a large growth in the larynx.

Dr. WILLIAM HILL said that tracheotomy would probably be done unless members thought it unnecessary. Dr. Baron did not think it

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was malignant and asked for a diagnosis. It had not yet given serious trouble to the patient.

Dr. DUNDAS GRANT asked if there was any certainty as to which part of the larynx it grew from.

Sir FELIX SEMON said there was a distinct margin between the epiglottis and the growth.

Dr. WATSON WILLIAMS said it was attached low down and laterally to the ventricular band.

ETHMOIDAL CELL-CUTTING FORCEPS.

Dr. WATSON WILLIAMS showed some cutting forceps for opening up the ethmoidal cells, which had been made for him by Messrs. Mayer and Meltzer. The cutting ends were sharp-pointed, and turned up at an angle of 50° with the shank, so that they readily pierced the thin bony walls of the cells. He had found these forceps of great service in opening either the anterior or posterior ethmoidal cells in sinusitis and in radical operations on nasal polypi.

CASE OF LARYNGEAL TUMOUR.

Shown by Dr. HERBERT TILLEY. A female æt. 39, whose chief symptom was hoarseness. She also had a troublesome cough. Laryngoscopic examination showed a sessile tumour, occupying the anterior two thirds of the left ventricular band. It was congested, considerably raised above the surrounding surface, and had a granular mammilated surface. The vocal cords moved freely, although the left was sluggish compared with the right.

In answer to Dr. StClair Thomson, Dr. TILLEY said that suspicions of pulmonary phthisis existed, but that he was anxious to gain the unbiassed opinion of members who had only seen the growth, as many of its features did not suggest its tubercular nature.

CASE OF PROBABLE PRIMARY SPECIFIC ULCERATION OF THE TONSIL.

Shown by Dr. DUNDAS GRANT. A woman æt. 32, was first seen on October 11th, 1900, complaining of sore throat of three months' duration. It was followed at an interval of about one month by the appearance of a few brownish spots on the skin;

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more recently there has been a slight falling of the hair. On examination there was an enlargement of the right tonsil and an irregular ulcer occupying the region of its upper third. The glands at the angle of the jaw were slightly enlarged, and according to the patient's account had previously been larger still. The pain was most marked during swallowing. On the right anterior pillar there was an ill-pronounced opalescent patch, and the same, in a slighter degree, on the left one. There were no symptoms of genital inoculation, but the husband's tongue presented ample evidence of old-standing tertiary changes, with a slight erosion on each side. The primary inoculation dated more than twelve years back. During the first week the patient was treated by means of pills of mercury and opium, but the effect produced was comparatively slight. During the following week mercurial inunction was practised, with the result that at the end of that time the discomfort in the throat had very markedly diminished, and the ulceration on the tonsil had become less pronounced. The patient has advanced six months in gestation. Dr. Eddowes, who saw the rash during the first week, gave the opinion that it was a syphilide, but at present it is too indistinct to afford ground for a very definite opinion. The diagnosis is somewhat open to question, but there seems little doubt that it is specific, and of a primary rather than tertiary nature.

The President thought they were all agreed as to the diagnosis.

Dr. Dundas Grant said that the change which had taken place had deprived the case of much interest. If members had seen the case a fortnight ago, before the treatment which had confirmed the diagnosis so absolutely, he thought the opinion of the Society would have been the same as his own.

The President had seen a case of undoubted primary chancre of the tonsil in which the result of the treatment was very rapid. The patient was thought to have malignant disease of the tonsil, but the improvement was so great that after a week the tonsil regained its normal size. Four or five weeks later the diagnosis was confirmed by the appearance of a secondary eruption.

Case of Alveolar Epithelioma of the Ethmoidal Cells and Antrum.

Shown by Dr. Dundas Grant. The patient, a woman æt. 53, was first seen in October, 1900, on account of blocking of the

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left nostril, discharge, and loss of smell, with pain in the left nostril and cheek, swelling of the left cheek and in the orbit, pushing the left eye upwards and outwards. Her illness was of about nine months' duration, commencing with symptoms of cold in the head, and the formation of a polypus. At the end of July a polypus was removed, but on the next day the blockage was as complete as ever. Dr. Grant made a diagnosis of malignant disease, probably sarcomatous; but a specimen removed for microscopical examination was found by Dr. Wingrave to be of the nature of alveolar epithelioma. It was decided that a radical operation should be performed without delay. The superior maxilla was exposed. The disease was found to have eaten away the anterior wall of the antrum and a large portion of the floor and inner wall of the orbit. The incision was continued upwards on the inner side of the orbit, and the whole of the diseased tissue was scraped away from the ethmoidal cells, the lachrymal bone and os planum of the ethmoid being almost completely removed. The floor of the antrum was found to be free from disease, and the alveolar and palatal processes were therefore left in position, the rest of the superior maxilla being extracted. The raw surfaces were swabbed with chloride of zinc, grains thirty to the ounce; iodoform was insufflated, and the cavity was packed with iodoform gauze from the mouth, the external wound being carefully sutured. The packing was removed two days later, and the cavity was washed out with a weak Sanitas lotion. After other three days the stitches were removed, the whole wound having united with the exception of a small opening at the inner angle of the eye. The patient was discharged on the fourteenth day after the operation, and returned home complaining of no other discomfort than conjunctivitis of the left eye.

Mr. SPENCER said that the saving of the alveolar process was an advantage. The growth was a burrowing carcinoma of the most malignant type, and one which offered a very poor prognosis. If Dr. Dundas Grant had succeeded in removing the whole of it he was very fortunate.

Mr. H. BETHAM ROBINSON referred to a case recently under his care where the growth in the antrum extended into the ethmoid, and before operating it was impossible to define its exact limits. He had removed the ethmoid freely up to the cribriform plate, but even then

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the disease was not eradicated, for the growth appeared again some weeks later.

Dr. DUNDAS GRANT, in reply to Mr. Spencer, said that he thought he removed all the growth, but it extended so close to the cribriform plate that discretion had to be used in scraping it away. Up to the present there is no sign of recurrence.

CASE OF SARCOMA OF THYROID GLAND, EXTIRPATION, FATAL RESULT.

Shown by Dr. DUNDAS GRANT. The patient, a nurse æt. 64, was the subject of an intensely hard swelling of the thyroid gland of about six months' duration. There was a slight myxœdematous swelling of the face, and considerable dyspnœa with tracheal stridor, worse on exertion. The larynx was displaced to the left side and œdematous to such an extent that the vocal cords could not be seen. Swallowing was partially obstructed, and fluids tended to regurgitate into the larynx, giving rise to troublesome cough. There was no enlargement of the glands, and the thyroid rose during swallowing, though to a less extent than normal. The dangers of the operation being placed before the patient, she decided to submit to it rather than continue as she was. During the detachment of the left lobe of the thyroid, extreme laryngeal stridor supervened, and it was necessary to perform tracheotomy. The thyroid body was removed in its entirety, and on microscopical examination was found to be infiltrated with sarcoma. The patient rallied from the operation, but speedily began to acquire a very troublesome cough; fluids appeared to enter the air-passages through the larynx and through the tracheotomy wound in the trachea; the right lung became completely dull, and death took place on the fourth day. Regurgitation of fluids into the larynx is probably a very unfavourable symptom when operations on the air-passages are carried out, involving great risk of septic pneumonia. In this case it might have been better if a tampon cannula had been introduced instead of a simple tracheotomy tube, and if the extirpation wound had been left open and plugged with antiseptic gauze instead of being closed up. Tracheotomy could not have been performed before the thyroid gland was removed.

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CASE OF MALIGNANT DISEASE OF THE LARYNX.

Shown by Dr. DUNDAS GRANT. The patient, a man æt. 57, came under observation on August 2nd, 1900, complaining of hoarseness and pain in his neck, of gradual onset, and of three months' duration. The larynx externally was normal to the feel, but now Dr. Grant thinks it is slightly spread out. On laryngoscopic examination the epiglottis was seen to be folded in to a considerable extent on the left side. The arytænoids were much swollen, especially the left one, which shaded off into a large thickened aryepiglottic fold; the left cord was invisible, but there was seen with great difficulty in the midst of the thickened tissue, a fringe of a somewhat granular appearance, corresponding to the anterior half of the left vocal cord, or it might be growing out of the ventricle of the larynx. The right ventricular band was swollen somewhat, overhanging the cord. There was no history of specific infection and no history of phthisis in his family, although it was somewhat doubtful whether or not his father died of that disease. In his case, however, there was no evidence in the thorax, nor did the sputum contain tubercle bacilli. The nature of the case was not at all obvious, although the probabilities were in favour of its being carcinoma. The patient was put upon iodide of potassium (ten grs.) with perchloride of mercury (one drachm of the solution) three times a day. His weight decreased slightly, but when seen again in September there was practically no change in the condition; subsequently dyspnœa became marked, and it was necessary to perform tracheotomy. Dr. Grant had postponed this in view of the doubt which he felt that the disease might be tuberculous, in accordance with the impression it made upon an experienced colleague. The patient has improved very much in general condition since the tracheotomy, which is sufficiently exceptional in tuberculosis to make it justifiable to exclude that disease. There is little doubt that the disease is malignant, epithelioma or sarcoma, the extent of infiltration as compared with the amount of ulceration affording some probability in favour of the latter. The exhibitor abstained from the removal of a portion for microscopical examination, as the patient had not consented to a radical operation.

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Mr. SPENCER remarked that the man complained of pain in the ear, indicating infiltration of the posterior third of the tongue. He considered the case too advanced for successful removal.

Dr. LAMBERT LACK was doubtful about the diagnosis, but even if it were an epithelioma he thought it better left alone.

Dr. GRANT was anxious to elicit an opinion as to whether this case was best left with the tracheotomy tube as at present, or whether the risk of removing the larynx was justifiable.

The following microscopic specimens illustrating Dr. Grant's cases were shown by Dr. WINGRAVE:

1. Squamous epithelioma of larynx.

2. Alveolar epithelioma of maxillary antrum and nose. It apparently commenced in the glands of the inner wall of the antrum near the ostium.

3. Sarcoma of thyroid gland. Round-celled (small) variety, evidently commencing in the stroma. It had involved the whole of the gland, since none of the normal structure could be found. It was interesting, as it followed closely upon a sarcoma of the larynx, also under Dr. Grant's care, in which the thyroid gland was probably invaded secondarily, as much of its normal structure remained.

CASE OF LARYNGEAL PAPILLOMATA.

Shown by Dr. WYATT WINGRAVE. A girl æt. 8, was first seen in June, 1898, complaining of thick voice with occasional aphonia, gradual in onset, and of two years' duration.

Several small papillomata were seen at the anterior commissure, and one on the left cord in its anterior third. There were no adenoids, but the faucial tonsils were slightly enlarged. Since that date as many as twelve fragments have been removed, after each time the larynx appearing clear of growth.

The warts were treated also with formalin (one per cent.) and salicylic acid, the latter affording the better result but not removing the growth. In removal the ring curette proved more efficient than forceps or snare. Histologically each fragment was a digitated squamous papilloma. With regard to their pathology, Dr. Wingrave was inclined to consider them relics of

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an exaggerated vocal commissure, notwithstanding that the symptoms did not become marked until six years of age. Although there were no adenoids she was a confirmed mouth breather, a habit of which her mother has nearly broken her.

The slightly enlarged tonsils were removed in January last, but this did not seem to materially influence the course.

When last seen her voice was fairly clear and strong, and the larynx had been free from growth since October 2nd, when the last fragment was removed. At present there is a slight thickening in the anterior commissure.

Dr. Herbert Tilley inquired what anæsthetic was used in the case, and if a general one, what position was the patient placed in during the operation. He had recently removed a large papilloma from a child's throat (four years old) which on two occasions had almost caused asphyxia, and had been struck by the ease with which the operation could be performed when the patient was chloroformed deeply and maintained in the sitting position. Under such circumstances it was necessary to push the chloroform until the laryngeal reflex had just disappeared, and during the thirty seconds or so following to remove as much growth as possible before the reflex returned again.

Mr. Vinrace inquired why Mr. Wingrave ascribed the condition to a congenital cause, no symptoms having presented themselves until the child was five years old. It was difficult to understand how the original structure in its entirety failed to cause symptoms and alteration in the voice.

Mr. Wingrave, in reply, said that he had found cocaine was simpler, since the patient well tolerated inspection and manipulation. He did not consider the absence of voice symptoms for the first three years as evidence against congenital origin, since he remembered an instance in which symptoms of a congenital web of the anterior commissure were not recognised till the age of twenty-seven. He felt that the situation of the growth was much in favour of its congenital origin.

Laryngeal Case for Diagnosis (? Tubercular).

Shown by Dr. StClair Thomson. The patient is a draper æt. 48, who states that he has been hoarse for twelve months. There is slight though not marked dysphagia, but his weight has fallen from ten stone ten pounds to nine stone four pounds. The right vocal cord is nearly entirely concealed by a smooth, round, red, soft-looking swelling of the right ventricular band, aryepi-

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glottic fold, and arytænoid. This swelling on phonation impinges on the left ventricular band, on which it appears to have caused some abrasion. Glands are not enlarged. There is a specific history. The pulse is hurried (110), the temperature is 100·2°, but the chest sounds are normal. The sputum has not yet been examined. Under small doses of iodide of potassium the obstruction has in a week sufficiently diminished to show a small portion of both cords, which are now seen to be pale and slightly ulcerated. Dr. Thomson was therefore now inclined to the diagnosis of tuberculosis.

The PRESIDENT considered the appearance was that of malignant disease.

Dr. DUNDAS GRANT wished to support Dr. Thomson's own diagnosis of tuberculosis.

Dr. STCLAIR THOMSON said he had only seen the patient twice. There was so much obstruction and catarrh that he did not at first like to give him iodide, but on five-grain doses there had been some improvement in the last week. He wished for suggestions as to treatment. Probably everyone was agreed as to the necessity for tracheotomy. He would report again on this case at a later meeting.*

CASE OF FRACTURE OF THE LARYNX.

Shown by Mr. WAGGETT. A female æt. 52, in whom fracture of the thyroid cartilage had occurred as the result of severe pinching of the larynx between the fingers and thumb of a persecutor. Severe dyspnœa lasted for some days, external swelling was present, and much pain experienced.

At the present date, some two months after the injury, nothing abnormal could be seen by the mirror. External palpation of the somewhat enlarged larynx caused pain, and indicated the presence of an ununited fracture of the thyroid cartilage, separating the upper half of one ala from its fellow close to the anterior angle. The fracture was vertical above, curving to the right at its lower end. The semi-detached antero-superior portion of the right ala could be made to ride over the left ala. The voice was stated to have altered in character since the receipt of the injury,

* Since the date of meeting the report on the sputum shows the presence of tubercle bacilli.

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but the action of the vocal muscles showed no gross sign of impairment. He did not propose any surgical interference.

Dr. HERBERT TILLEY very much doubted if the feeling of crepitus in this case was not entirely due to the movement of the larynx on the vertebral column. He had, while the patient leant well forward, lifted the larynx away from the column, and could not obtain the crepitus, however carefully he manipulated the larynx, but immediately the latter touched the spinal column the crepitus at once became evident. It was difficult also to conceive that the inflammation, which was evidently produced by the traumatism, should have so completely resolved as to leave the cartilaginous fragments loose. One would have expected the traumatic perichondritis to have firmly welded them together.

Dr. FITZGERALD POWELL thought if fracture of the cartilage existed it would result in severe and continuous dyspnœa.

Mr. PARKER said that he quite agreed with Dr. Tilley with regard to the possibility of obtaining crepitus on lateral movement of the larynx in most people, but in this case the crepitus was even more marked on the patient's swallowing, which was unusual. He therefore thought there was a fracture of the thyroid cartilage.

Dr. DUNDAS GRANT thought he felt a crepitus, as if there was fracture of the lower cornu of the thyroid cartilage, just above where it articulated with the cricoid.

Mr. WAGGETT, in reply to Dr. Tilley, said that he believed the crackling or crepitus of which the latter spoke had nothing to do with the fracture, but was such as could be detected when the larynx of any thin person was pushed from side to side over the underlying structures. In the present instance a fine crackle was produced when by lateral pinching the thyroid cartilage was distorted, an act which caused a portion of the right ala to ride over the left, leaving a sharply defined groove between the two.

In answer to Dr. Powell he drew attention to the history of severe dyspnœa confining the patient to bed for three weeks.

CASE OF HÆMORRHAGE ON THE VOCAL CORDS.

Mr. CHARLES PARKER showed a case of hæmorrhage on the vocal cords in a woman æt. 35, a school teacher. The hæmorrhages were situated about the middle of the upper surfaces of either cord. The patient complained of hoarseness and aching of the throat after using her voice. There were no signs of any tendency to hæmorrhages elsewhere.

In answer to Dr. Lack, Mr. PARKER stated that he felt confident that when he first examined the case there was a hæmorrhage only on

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the left cord. She was examined by several people, and being rather intolerant strained and choked a good deal, and on finally examining the case Mr. Parker found that a hæmorrhage had occurred on the right cord. This was more than a month ago, and yet both hæmorrhages remained unaltered.

The PRESIDENT had never before seen such an interesting example of this condition.

Dr. GRANT had brought before the Society the case of a young lady with sudden loss of voice—as if an hysterical attack of aphonia—which was accompanied by an effusion under the mucous membrane of the cord.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *December 7th*, 1900.

F. DE HAVILLAND HALL, M.D., President, in the Chair.

LAMBERT LACK, M.D., } Secretaries.
ERNEST WAGGETT, M.B., }

Present—35 members and 5 visitors.

The minutes of the preceding meeting were read and confirmed.

The following gentlemen were unanimously elected members of the Society:

John Stewart Mackintosh, St. Ives, Platt's Lane, Hampstead.
Frederick J. J. Wilby, 23, Henrietta Street, W., and The Wych, Avenue Road, Highgate.

THE PRESIDENT said that Sir Felix Semon, who was unavoidably absent, was anxious to point out that the treatment of nasal polypus depended on its precise variation, and hoped the result of the discussion would be to draw some distinction between the different forms of nasal polypi, which required different treatment. The title of the subject under discussion suggested only nasal polypi in general, without any reference to the various forms.

He then called upon Dr. Lambert Lack and Mr. Cresswell Baber to open the discussion upon

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THE TREATMENT OF NASAL POLYPUS.

Dr. LAMBERT LACK said:

Mr. President and Gentlemen,—I deeply appreciate the high honour conferred on me by the Council in inviting me to open the discussion on this important subject. Many members will no doubt have interesting remarks to make, and therefore I shall detain you as short a time as possible while I briefly enumerate the results of my own investigations, and leave the discussion to others.

The rational treatment of polypus must depend upon the view we take of its pathology. This subject was fully discussed at the meeting of the British Medical Association in London in 1895, when the general opinion seemed to be that polypi were in some way the products of inflammation, but both Woakes's theory of "necrosing ethmoiditis" and Grünwald's of sinus suppuration were considered disproved or inadequate, and in fact the discussion only showed the truth of Mackenzie's statement that the cause of polypus was still unknown.

The theory I wish to maintain is that the ordinary nasal polypus is essentially a *simple localised patch of œdematous mucous membrane*, and that this œdema is a result of disease in the underlying bone.

The first point is proved by both clinical and microscopical examinations. Histologically polypi consist of loose fibrous tissue, the meshes of which are filled by serous fluid. The growth contains vessels and glands, and is covered by the normal epithelium of the part. The glands are more numerous near the attachment of the growth, and vary in number in different polypi, sometimes, particularly in chronic cases, being very numerous. In addition to this there are signs of inflammation, the vessel walls are enlarged and thickened, and there are scattered collections of round-cells, especially marked around the vessels and glands. The glands are sometimes healthy, sometimes undergoing degeneration. The acini may be dilated from obstruction of the ducts due to pressure of the inflammatory exudation, and the cysts commonly seen in polypi are thus derived. Thus it is seen that polypi contain all the structures of the normal mucous membrane *plus* a certain amount of

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inflammatory exudation, serum, and round-cells; and further, a polypus passes gradually and imperceptibly at its edge into the normal mucous membrane.

It is obvious that growths containing such diverse and highly differentiated structures are neither tumours nor granulations. The latter in the nose, as elsewhere, consist of round-cells, spindle-cells, young vessels, and the early stages of fibrous tissue. Moreover, as seen after intra-nasal operations, or when produced by the irritation of a foreign body, a sequestrum, etc., they are quite different from polypi. Again, clinically there is every stage between œdema of the mucous membrane and a polypus,—a slight œdema, a marked localised œdema, a broadly sessile polypus, and a typical pedunculated polypus. It is purely a question of degree, a small diffuse, non-moveable mass being usually described as œdema, whilst a larger, more sharply defined, more moveable growth is considered a polypus. Also the microscopic structure of the two is identical. Grünwald asserted that by tightly packing an antrum œdema of the lower lip of the ostium maxillare could be produced, and that this œdematous tissue had the microscopical characters of a polypus.

The second point, that polypi are due to disease of the underlying bone, was first, I believe, definitely asserted by Woakes; but his views have obtained very little credence. However much exception may be taken to Woakes's own work and investigations, it seems to me his theory of bone disease is the most adequate explanation hitherto offered of polypi, and especially of their tendency to recur, and further that the independent evidence of Thurston and Martin, based upon microscopic examination, ought not to be lightly overlooked.

More than two years ago, when I took up this work, I collected pieces of bone from over thirty cases of nasal polypi and prepared them for microscopical examination. In every case bone changes were found of the nature of a rarefying osteitis. Briefly, the sections showed that the process commences as a proliferation of the cells in the deeper layer of the periosteum. In places numerous large cells or osteoclasts appear in contact with the bone, and gradually eat it away, forming irregular little bays along its edge. At the same time the bone cells themselves enlarge and become more numerous, and give the bone a more

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cellular appearance. As this process of rarefying osteitis extends the bone ultimately becomes disintegrated, and the fragments, surrounded on all sides by osteoclasts, are slowly eaten away and absorbed. No true necrosis was seen. The appearances were found in both extensive and simple cases of polypi. Thus the pathological evidence supporting that of Thurston and Martin is fairly complete, in spite of some few contrary observations of Zuckerkandl, Luc, etc.

Since this paper was written these observations have been confirmed by Cordes ('Archiv für Rhin. und Laryng.' of last month), who has described some investigations with almost identical results, except that he did not always find bone changes in mild cases of polypi.

The following are some of the clinical signs of bone disease:

(1) Digital examination under general anæsthesia. If the finger be passed carefully up into the ethmoidal region in cases in which no operation has ever been performed, it often impinges on soft jelly-like tissue in which spicules and loose pieces of bone can be plainly felt, although it is very rare to feel rough bare bone.

(2) The probe may be used in a similar way, but it is obviously much less reliable. Very great care must be taken in employing it and in drawing deductions from its use. A blunt ended probe and one which can be easily bent to pass in any direction must be used, and even then it is difficult to avoid perforating the softened mucous membrane. The ease, however, with which this is done, and the feeling of bare bone obtained, is quite different from the normal condition.

(3) In a severe case of polypus in which no operative interference has ever been attempted, if the polypi be carefully removed with the snare without touching the bone in any way, it is sometimes possible to observe that the entire middle turbinate has disappeared, and its place has been filled up by masses of small polypoid-looking growths.

(4) The results of operations as regards recurrence when the diseased bone is completely removed. This further proves that the bone disease is the cause of the polypi, and not *vice versâ*, as some have stated.

The probable history of a case of polypus is as follows:

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In an acute inflammation of the ethmoidal region, and especially in the severer and more lasting forms of it occurring in connection with the exanthemata, erysipelas, influenza, and septic affections, such as sinus suppurations, it is probable that the periosteum covered only by the thin mucous membrane, and even the bone may be involved. In such cases the middle turbinate is especially liable to be affected, and on examination this structure appears large and rounded, and covered by a thickened œdematous mucous membrane. Microscopical examination of such a middle turbinate shows the early stage of the rarefying osteitis above described, and the overlying œdematous mucous membrane has all the microscopical characters of a typical nasal polypus.

As the disease slowly progresses the bone becomes disintegrated and at the same time expanded, and the cell commonly present in its anterior end may become distended and form a bony cyst.

The osteitis spreads to the neighbouring parts until the whole ethmoid may become affected. The outlines of the bone are lost, the middle turbinate can be no longer recognised, but loose pieces of bone, polypi, œdematous granulations, and gelatinous mucous membrane fill the whole upper part of the nose. In this extremely slow but progressive process the bone is slowly but surely eroded and absorbed. In some cases the disease is ultimately arrested, and then the bone becomes very dense and sclerosed. Such a condition is found in cases in which only a single polypus or perhaps two polypi are present, and in these cases, as is well known, recurrence of the growth after removal is rare.

As just said, the œdematous mucous membrane overlying the affected bone in the early stage is indistinguishable microscopically from a polypus, and clinically the two conditions pass from one to the other by imperceptible stages, and can only be artificially divided. Moreover œdematous infiltration in these parts is apt to become large and bulging, as the mucous membrane is extremely loosely attached and easily thrown into folds. After a time these swellings, well supplied with nourishment, apparently take on a more or less independent growth; the increase in size is doubtless assisted by the dependent

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position of the growths and the action of gravity. Their tendency to become pedunculated is also partly due to the action of gravity, and partly, perhaps, to the effect of blowing the nose, which would tend to make the growth swing about. These considerations explain the chief facts in the clinical features of polypi, their liability to recur after simple removal, the fact that they grow only from the ethmoidal region of the nose where the bone is covered by a thin muco-periosteum, and that they are more common on the middle turbinate and about the regions of the ostia of the accessory sinuses where the mucous membrane is excessively lax.

Treatment.—If this theory of the pathology of nasal polypus is accepted the whole question of treatment must be reconsidered, for it follows that our efforts must be directed towards the eradication of the bone disease and not simply towards the removal of the polypi, one of its effects.

For the sake of convenience the following four groups of cases may be taken:

(1) Cases in which one or two polypi only are present, which are of long standing, in which there is no sign of active disease still present, and in which it is probable that the initial bone disease has completely passed off. In such cases simple removal with the snare may be practised. It is a matter of every-day experience that recurrence in such cases is rare.

(2) Simple cases of early bone disease, in which there is enlargement of the anterior end of the middle turbinate, with overlying œdema of the mucous membrane, or the early stage of polypous formation. The affected part should be removed, and this generally resolves itself into a typical amputation of the anterior end or more of the middle turbinate.

(3) Cases in which a few polypi only are present, and in which there is apparently a very limited area of bone disease. These cases may also be treated with the snare, but an attempt should always be made to hitch the wire loop as high as possible round the base of the growth, so as to encircle the piece of bone from which it grows. After the polypi and as much bone as possible have been removed in this way, at a subsequent sitting the affected region should be thoroughly examined by probing and illumination, and all diseased bone and mucous membrane

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should be clipped away by Grünwald's forceps. The middle turbinate should be removed if diseased, or if necessary to give access to the affected region. In other cases it may be necessary to scrape away the affected part, and in such circumstances nitrous oxide anæsthesia should be employed, and the operation performed with a ring-knife under good illumination.

The results of operation in these three groups of cases is almost invariably good, and the operation itself apparently in no way a serious one.

(4) In the cases of extensive bone disease in which there are many polypi involving an extensive part of the ethmoid a more radical procedure is necessary. In such cases simple removal of polypi is useless, as recurrence rapidly takes place, and I believe it is better in the first place to give a general anæsthetic, and to remove not only the polypi but the whole of the affected part of the ethmoid bone.

This operation should also be practised in cases in which recurrence has followed other operations for the removal of polypi, and cases associated with suppuration in the ethmoidal cells or in other accessory sinuses. In the former case it is necessary to open the ethmoidal cells for the suppuration itself, and in the latter it is especially necessary to clear the approach to the ostium of the affected sinus.

The operation is performed as follows. The patient being anæsthetised, the ethmoidal region is thoroughly examined by the finger, both through the nose and also through the post-nasal space, to determine as far as possible the extent of the disease. If the middle turbinate be present it may be removed by means of the spokeshave, and any large polypi should be removed by means of the forceps. Then the lateral mass of the ethmoid should be thoroughly scraped away by means of a large ring-knife, such as Meyer's original adenoid curette. This is the only effective instrument; sharp spoons are quite useless. In this way large masses of polypi, degenerated mucous membrane, and fragments of bone are removed. The finger is introduced from time to time to observe the progress, to feel for any spicules of bone and soft patches, and the scraping is continued until all friable tissue has been removed. Healthy parts of the ethmoid are easily distinguished by the finger and even by the curette,

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as they are smooth, firm, resistent, and give little hold to the knife. In some cases the operation is completed by a smaller ring-knife, but this must be employed with the greatest care. Of course great caution must be used when it is felt that the region of the cribriform plate is being reached, but the whole inner wall of the orbit may be scraped away with impunity.

The operation should be performed with the patient turned well over on to his side, and in cases where the posterior part of the ethmoid is unaffected a large sponge may be pushed up into the post-nasal space. Directly the operation is over hæmorrhage is arrested by packing the nose with a strip of gauze soaked in glycerine-iodoform emulsion, and a piece of lint soaked in evaporating lotion is then applied to the face. This gauze packing should be changed every second or third day, and the nose irrigated. If it is easily tolerated it may be continued for a fortnight, in other cases it should be omitted earlier.

Results.—The large majority of cases run an afebrile course. In a few cases numerous granulations appear in the field of operation, and may even become exuberant. If the operation has been thoroughly performed these usually disappear spontaneously in a few weeks, and meantime the patient experiences no discomfort from their presence. After five to eight weeks a large dry cavity, lined by healthy adherent mucous membrane, will be seen in the upper part of the nose.

One would theoretically expect operation in such a region to be somewhat dangerous, but although I have operated now between fifty and sixty times, and others have also performed it, no symptoms causing real anxiety have yet been seen. Of ill results following the operation the following have been noted. A black eye is not uncommon, but usually subsides in three to four days, under cold applications. In one or two cases acute suppurative otitis occurred, but passed off under treatment. Such a result may follow any similar operation. In a few cases a considerable rise of temperature has occurred, but only in cases in which sinus suppuration has been present. Such cases have readily yielded when the packing has been omitted and nasal irrigation adopted.

In one case of extensive ethmoidal caries, with suppuration in the ethmoidal cells, and probably also in the frontal sinus, an

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orbital abscess accompanied by necrosis of a portion of the inner wall of the orbit followed some three weeks after the operation, and a week or ten days after the patient had left the hospital. This is not a very rare occurrence in cases of ethmoidal cell suppuration, but it may have been due to or hastened by the previous operation. The abscess was opened externally, a sequestrum removed, and a cure followed.

In no cases have any cerebral symptoms been noted, and no death has occurred. Even if the operation entail some danger there is some, and probably a greater risk in leaving the disease alone, or in employing the small nibbling operations which are commonly recommended. The risk of operating is probably greater in cases in which suppuration is present, but the necessity for it, and the danger of leaving the disease alone, is also greater. I am more fearful, if the operation is widely adopted, that it should fail to cure from want of being practised with sufficient thoroughness, than that it should cause fatalities by being performed too boldly.

The results as regards recurrence are very good. In all simple cases of polypi a cure has resulted, and this has been permanent for several years in some cases, in which snare operations had been repeatedly followed by recurrence. Such cases I have already shown here, and I hope at later meetings to show more. In suppurative cases recurrence has been rare, and when it has occurred the disease has not been the intractable affection it was before operation. In such cases occasional removal with the snare will usually give immunity for months, until if the suppuration be cured the polypi no longer recur. In a few cases I have operated a second time, but in every case in which I have performed the first operation myself, the bone has appeared quite firm and dense, and there has been practically nothing to remove.

The only alternative procedure—repeated small operations, such as nibbling away with forceps, so commonly advocated—may perhaps effect a cure in time, but it has many and great disadvantages. The operation is always painful, as cocaine acts by no means satisfactorily in these cases. Ten, twenty, and even more sittings are often required, as very little can be done at a time. This is extremely tedious and discouraging to the patient,

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and the constant pain and dread of it causes general ill-health. Little or no benefit following the earlier operations, the patient often abandons treatment. In cases associated with suppuration each operation exposes a raw surface, over which pus flows, and there is necessarily a tendency to septic absorption, and to the spread of the bone affection. Finally, fatal results have occurred from meningeal infection apparently directly due to operation, and I believe these repeated timid procedures are more dangerous than a single severe but curative measure.

In conclusion, then, I would urge that this operation, carried out with due precaution, should be performed in all cases of nasal polypi in which there is extensive disease of the ethmoid bone, in which recurrence of polypi has repeatedly followed other methods of removal, and in which suppuration is present in the ethmoidal cells or other accessory cavities.

[Dr. Lambert Lack's paper was illustrated by (1) a series of diseased middle turbinate bodies, showing the transition stages between simple œdema and true polypus, and (2) a series of microscopic slides of sections of the bone underlying polypi, showing various degrees of periostitis and osteitis.]

Mr. Cresswell Baber said: Gentlemen, the subject of the treatment of mucous polypi of the nose is one of perennial interest, because of the exceeding commonness of these growths, and of the difficulty they often present in treatment.

The Treatment resolves itself into two stages: (1) removal of the growths; (2) after-treatment with the view to preventing their recurrence.

(1) Removal of the growths. It is pretty generally agreed this should be carried out with a snare, hot or cold. I am always in the habit of using the cold snare, and with a rather thick steel wire. I have repeatedly made up my mind to use the galvanic loop, but have always, after a short trial, come back to the cold, chiefly because I find no special advantage from the hot, and considerably more trouble in using it. My own practice is to snare out the growths as carefully as possible at sittings with about a fortnight's interval, even removing small roots in the middle meatus by this method. The adjustment of the snare

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when a somewhat thick steel wire is used scarcely ever meets with any difficulty, but in the event of such an occurrence the polypi may be drawn forwards with a sharp hook or a fine pair of catch forceps.

In getting the loop round a polypus projecting through the choana a finger in the naso-pharynx is of course invaluable, and if it be impossible to secure a polypus in this position, by this method, Lange's blunt hook may be used, or, if necessary, a pair of forceps guided by the finger. The use of forceps for the removal of polypi is not, in the ordinary way, to be recommended.

(2) After-treatment. The routine after-treatment hitherto adopted consists in burning the so-called roots of the polypi with the galvanic cautery. This method is only suitable for cases in which the point of origin of the growths is visible, for to plunge a cautery blindly into the interstices of the ethmoid bone seems to me a useless and dangerous proceeding. The same remark applies, perhaps with less effect, to the use of a chemical caustic, such as chromic acid. It has been my habit for some years to use a spray of rectified spirit (as first recommended by Miller), varying from 25 per cent. to full strength, for its shrinking properties on the mucous membrane, and I think with benefit.

A word of caution is necessary to the effect that in old people (those over seventy) it is advisable either to leave the growths alone, or to operate on a small amount at a time, partly on account of shock, and partly on account of the hæmorrhage, which, though it may be minimised by extract of supra-renal capsule used in addition to cocaine or eucaine, is not a negligible quantity. The question of shock is more important still in galvanic cautery operations on the middle turbinate body, and should always be considered, especially as these growths are often found in persons with asthma and weak hearts.

We next come to the question whether any further treatment is advisable. This must depend on the diagnosis which we are able to make in each individual case. Mucous polypi, which according to most recent authors may be defined as the result of an inflammatory serous infiltration of the mucous membrane of the ethmoid, seem liable, speaking clinically, to be produced by almost any irritation. They may be caused not only by disease

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confined to the ethmoid, but also by the irritation of the discharge from an empyema of the antrum, or of the frontal or sphenoidal sinuses, and by such different conditions as foreign bodies in the nose and malignant disease.

They are not, as assumed by some observers, necessarily associated with suppuration of an accessory sinus, or even with suppuration at all. These different conditions must therefore be carefully searched for before any further treatment is undertaken.

Having excluded non-ethmoidal causes, the form of the disease in which the morbid changes are confined to the ethmoid remains to be considered. Our knowledge of the pathology of this affection is still imperfect; but it is generally considered by recent observers that the inflammatory trouble giving rise to mucous polypus may be limited to the mucous membrane, or that chronic proliferating periostitis, and osteoplastic or rarefying osteitis (or both), may also be present. Hajek considers that, except in constitutional dyscrasiæ (tuberculosis and syphilis), these processes result from the extension of the inflammatory infiltration of the mucous membrane and the periosteum into the bone and its medullary spaces. According to the latest published researches, those of Cordes, the bone may be primarily affected from typhus, influenza, scarlet fever, and other exanthemata; or secondarily from the mucous membrane. This author, by the way, does not confirm the presence of rarefying osteitis, although he admits that absorptive changes constantly accompany the osteoplastic processes. When all the polypi have been thoroughly extirpated, and the exposed mucous membrane either burnt or removed, and no recurrence takes place, it is assumed that the mucous membrane only is implicated, and no further treatment is necessary. It is impossible to ascertain the percentage of these cases, because, as a rule, the patients do not return to the surgeon more than once or twice for inspection. It must also be borne in mind that very long intervals between the recurrences (if not actual absence of the same) occur in cases in which to all appearance the ethmoid bone has undergone distinct hyperplastic changes. A single polypus projecting into the choana often does not recur in my experience, but as a rule it is impossible to foretell the likelihood of recurrence. If

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frequent and rapid regrowth occur, we may take it for granted that the bone is affected with osteitis, as above mentioned, or at least that the mucous membrane in the cells, which escapes our vision, is participating in the disease. In these cases the only method of preventing recurrence is to remove the affected bone and cells, and this is indicated whether we regard the bone or the mucous membrane as the starting-point of the disease.

In the former case, the bone requires removal, as the source of irritation, in the latter because without removing the bone, the mucous membrane in the cells, which is giving rise to the trouble, is inaccessible. The first step is the removal of the anterior half of the middle turbinated body with forceps or scissors, and snare, if it has not been done already for examination or treatment of the frontal or maxillary sinuses. This little operation renders the anterior ethmoidal cells more accessible. If this is insufficient, the ethmoidal cells and walls may be removed with Grünwald's or similar forceps, and curetting them with scoops of various shapes, due regard being had to any possible injury to the cribriform or orbital plates. In my experience the removal of the middle turbinated body is satisfactory, but the other measures are less so, on account of the hæmorrhage which so rapidly obscures the view, and prevents much being done at one time. Neither of these measures, however, as far as I know, gives a certain guarantee against recurrence. When the discharge from the ethmoidal cells is distinctly purulent there is more necessity for opening them freely, as suppuration in these cavities is not devoid of danger to the surrounding parts. Of the exact procedure recommended by Dr. Lack, *i. e.* the removal of all the ethmoidal cells at one sitting with a Meyer's ring knife, I have no personal experience; I presume that such an operation would only be employed in cases of frequent and rapid recurrence, but even in these cases I think it is only to be recommended under two conditions: (1) if it can be shown that the operation gives immunity from recurrence; (2) if it can be performed without risk of injury to the contents of the cranial or orbital cavities. Whether it has a deleterious effect on any remaining sense of taste or smell perhaps Dr. Lack will be able to tell us. At the same time it must be admitted that any operation which, without danger, will prevent recurrence

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of these growths will be a great boon to sufferers from this disease.

Although for the sake of clearness I have divided the ethmoidal cases from the cases of polypus due to disease in the other sinuses, it must be understood that the two conditions often co-exist, and that the relation between them is not yet clearly established.

On the whole, I think that the chief advance in the treatment of mucous polypi lies in the direction of a more accurate diagnosis of the cause in each case, which is the only guide to rational treatment.

In these few remarks I have omitted all reference to papillomata and other non-malignant growths which are sometimes called polypi, in order to keep the discussion to the important subject of mucous polypi, neither have I made any reference to the treatment of empyema of the larger accessory cavities, or of polypi contained in them.

If the discussion draws forth the opinions of members on the comparative value of the different methods of removing mucous polypi, and of the various forms of after-treatment, especially in regard to the removal of bone from the ethmoid, it will not have missed its object.

Mr. W. G. Spencer agreed with the treatment set forward by Dr. Lack, but not with his pathology of polypus, which, he thought, remained unknown. The inflammatory theory required a great deal of further evidence for its firm establishment. By the acceptance of the latter, the pathology of the nose was entirely separated from the pathology of other mucous membranes, and of the polypi which occurred in them. No doubt the nose was the favourite locality for the formation of muco-polypoid growths, yet there were varieties of this formation in other mucous membranes, *e. g.* of the rectum, bladder. In the latter there was fairly strong evidence that they originated in the submucous tissue, whether they began as actual fibromata or were always of a myxomatous nature. It was generally agreed that the shape of polypi was due to the action of gravity, but their occurrence in several places, and sometimes on each side of the nose, in the frontal and ethmoidal cavities and maxillary sinuses, afforded little clinical evidence of a previous primary inflammation of the bone or periosteum. When this was present the resulting growths were not typical mucous polypi, although, as in the case of other tumours, inflammatory conditions and incomplete removal promoted recurrence. But there must be an essential difference between the

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vascular granulations, however œdematous, which occurred after, *e. g.* syphilitic necrosis, injury, or the presence of a foreign body in the nose, and an ordinary mucous polypus. Again, the mucous polypi were certainly the most frequently occurring, and Dr. Lack had referred to the difficulty in some cases of distinguishing them from inflammatory conditions of the inferior turbinate, which was of course very commonly inflamed, yet not the common site of the polypi. There was no sharp line of distinction between true mucous polypi (nasal or naso-pharyngeal) and those which ultimately turned out to be sarcomata. Even carcinomata in the nose had very often projecting polypoid masses indistinguishable microscopically, or very nearly so, from the simple polypi.

Turning to the question of the bone change, it was an oft-discussed matter, and difficult to prove either way. In the specimens shown by Dr. Lack, which he had not very carefully examined, he saw no reason which would cause him to make up his mind on the subject. The changes in the bone were secondary, but not primary in his opinion. Polypi in other situations had nothing to do with the periosteum or with the bone, yet Dr. Lack would try to show that nasal polypi were the result of perichondrial or periosteal disease. Changes in the bone varied, but a great deal of the permanent bone of the nose was cancellous, and some of the specimens appeared to present this normal cancellous bone. Very little information on this point had been added to the subject of the old controversy between Dr. Woakes and Dr. Sidney Martin. No doubt many of the specimens showed secondary atrophic osteitis occurring in connection with the pedicle of the polypus; the larger the polypus became the more marked the appearance was. So he thought that very little trustworthy clinical evidence had been adduced to prove that polypi were preceded by inflammatory changes. The true untouched muco-fibromatous polypus had more the appearance of a real benign tumour, single or multiple as the case might be.*

With regard to treatment, he was in accord with Dr. Lack's method in extensive cases, where it was of great value to commence the treatment by a thorough removal under an anæsthetic. He thought, however, that recurrence might take place in some cases. Its value lay in the reduction of the number of sittings hitherto necessary for the patient when there was extensive change present. It was necessary to remove the pedicle of the tumour, and because of the convoluted structure of the nose to remove a large amount of bone in order to get at the pedicle. He preferred to insist upon the necessity of removing the whole of the pedicle, viewing it as a tumour, rather than, as Dr. Lack held, of removing bone primarily diseased.

Mr. CHARLES PARKER said: I should like to add what weight I can to the reasonings and conclusions advanced by Dr. Lack. I have, I think, seen every case on which he has operated during the last

* Gérard Marchant, in 'Traité de Chirurgie,' Duplay et Reclus, 2me ed., 1898, t. iv, p. 670.

Ziegler, 'Lehrbuch d. allg. u. spec. pathol. Anat.,' 9te Aufl., 1898, Bd. ii, S. 626; also H. Mackenzie, "A Case of Diffuse Papillomatous Degeneration of the Nasal Mucous Membrane," 'Lancet,' 1896, vol. ii, p. 460.

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three years, and have watched their progress afterwards; moreover I have myself frequently adopted the measures he advocates for the cure of polypi. The microscopic specimens before us to-night clearly prove that accompanying polypi there is a bone disease, presumably of the nature of rarefying osteitis. The fact that simple removal of polypi does not cure the disease points to the conclusion that the origin of the trouble has been left behind; and on the other hand, the old and recognised fact that if the bone underlying the attachment of a polypus can be removed with the polypus recurrence is far less likely to occur, suggests that in this case the cause *has* been removed. Again, it is undoubtedly possible to trace clinically every stage of a polypus, from a mere œdema of the mucous membrane covering the anterior end of the middle turbinated bone, to a definite fully formed pedunculated polypus, and to prove that there are as definite, though less marked, bone changes when the mucous membrane is only œdematous as when it has degenerated into true polypus; from which it is, I think, fair to argue that the bone trouble precedes the polypus. Therefore one must conclude that both the microscope and clinical experience favour the view that the bone disease is the cause rather than the result of polypi. This being so, operative measures must have for their object the removal of every portion of diseased bone, and this in a confined cavity like the nose can only be done by some such method as that put before us to-night. In several cases in which I have adopted Dr. Lack's treatment I have had reason to realise the futility of my previous efforts to cure the case with a snare; for having by this latter means removed all visible definite polypi and brought the case to that point where on examination one sees only a lot of small polypoid excrescences springing from the ethmoid bone, and situated where the middle turbinated should be, I have proceeded to the more radical operation, and have been astounded by the quantity of large polypi removed by means of the ring-knife—literally handfuls. It was evident that directly the lower, visible polypi had been removed, and thus pressure relieved, others had descended by gravity to take their place, and, judging from the number afterwards taken away with the ring-knife, there were sufficient polypi to last these patients a lifetime had I continued treatment by means of the snare. As to the operation, I follow the same procedure as Dr. Lack, and do not think his methods can be improved upon. As to the results, I think they are very satisfactory. In all my own cases, and those of Dr. Lack's which I have observed, there has invariably been very great improvement, and in the majority of cases I think the word "cure" is none too strong. Considering the chronicity of these cases, and the frequency with which they are operated upon, I think the patients themselves become good judges of the results, and after this more radical operation they all agree in saying that they have not been so comfortable for years, even if they cannot be classed amongst the cured; and so far I have never seen any really serious ill results. Finally, I think this operation should be employed in all cases where recurrence has occurred more than three or four times, in all cases of multiple polypi accompanied by suppuration, from whatever source, and in those cases where the

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middle turbinated has disappeared and its place been taken by mucous membrane in a state of polypoid degeneration. In these latter cases there is sure to be very extensive disease hidden from view.

Dr. DONELAN desired to add his tribute of congratulations to the readers of the two papers. He thought the operation described by Dr. Lack would prove a valuable one in the severer cases, while in others the snare would continue to be used. Notwithstanding the specimens, he felt the theory that the disease originated in the bone was "not proven;" and the fact that one of the authorities quoted by Dr. Lack had admitted that the bone was not affected in the slighter cases, led one to believe that the disappearance of the turbinals was due to more familiar causes, such as pressure and impaired blood-supply, rather than to a rarefying osteitis. Instances had been given of mucous polypi in the rectum, and at another point in the antipodes of our interests, where the only "osseous" structure was the os uteri; but he thought examples of mucous polypi unconnected with bone might be found nearer home—as, for instance, on the soft palate,—and he had at present a case in which he had removed five or six polypi from the angle between the cartilaginous septum and the ala, and at some distance from the nasal bones. If the rarefying osteitis were admitted to occur as extensively as Dr. Lack claimed, he would like to ask him what prevented the process from extending more widely through the cranium.

Dr. SCANES SPICER had hoped that, in order to promote the fullest ventilation of the subject, some one would have risen to advocate the opposite side of the case to that put forward by Dr. Lack. He himself could not do so, for he agreed with Dr. Lack practically *in toto*. But, in justice to previous workers on nasal problems, he must point out that operative procedures identical with those described by Dr. Lack had been performed in suitable cases both in England and Germany, at all events, for many years. Ever since an advance copy of Grünwald's work on 'Die Lehre von den Naseneiterungen' had been sent to him for review in 1895 he had tentatively used all the methods and instruments described by that author, and amongst them his method of attacking severe cases of polypus and suppuration of ethmoidal labyrinth—surely the same thing as polypus and suppuration of lateral mass of ethmoid. [See cases 149, 151, 155, which can now be read in Lamb's English translation of Grünwald's work.] Further, after a large experience of these methods, he had himself exhibited cases at the Laryngological Society in which these very procedures had been carried out on the ethmoid body for multiple polypoid degeneration combined with ethmoidal suppuration,* *i. e.* after having formally excised the middle turbinated bones, to curette away with due caution any diseased tissue in the subjacent ethmoidal labyrinth; and he had further supported and advocated the adoption of these measures (*loc. cit.*) in suitable severe cases—which a further experience now enables him to even more strongly recommend. He therefore felt it incumbent on him to make it clear that in consequence of Grünwald's work these methods were known to some nasal

* 'Proc. Laryng. Soc. Lond.,' vol. iv, pp. 79—81, 1897.

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workers at least five years ago, and have been tried, and to a large extent adopted—in order to clear English rhinology from the unjust imputation of being so many years behind the times.* Nevertheless he heartily congratulated Dr. Lack on his bold and powerful advocacy of the application of sound surgical principles to these nasal disorders, on his admirable re-statement of the whole problem, and on his painstaking re-investigation of the histological changes. Here Dr. Lack's results appeared to him to agree with those of Grünwald and Woakes, except for the difference with the latter as to the amount and frequency of necrosis. As far as he knew, he believed the credit of first maintaining the causal connection between ethmoid bone disease and polypus belonged to Dr. Woakes. He had the more pleasure in stating this, for he was by no means a supporter of the latter in his use of the term "necrosing ethmoiditis." In a few cases the speaker was well aware of real necrosis—large sequestra—in cases quite free of syphilitic taint, and it was the comparative rarity of genuine necrosis that had led him to question the propriety of applying the epithet "necrosing" to a condition of which necrosis was only a late and occasional accident. He feared that Dr. Woakes had delayed that recognition of his work (which was justly his due) for many years by that unfortunate term—unfortunate in that it was taken to imply that he taught there was some special necrosing pathological process found in the ethmoid and confined to it, which was essentially different to any known to occur elsewhere in the body. The speaker thought that if the changes observed had been originally described in terms of general surgical pathology as "muco-periostitis," "rarefying osteitis," "sclerosing osteitis," "dry caries," etc., and had been recognised as not affecting the ethmoid only, but many of the adjacent bones of the head, the meaning would have been at once grasped, and full recognition accorded. With reference to the performance of the operation in question, the speaker has from the first adopted the methods and instruments of Grünwald, with some modifications. The neck of the middle turbinated is first cut through with Grünwald's forceps;† the cold wire snare is then passed well into the slit made, over the genu, and back over the middle turbinated as far as possible, and then tightened up so as to cut off the anterior half. The posterior half is then removed with the turbinotome when diseased. Polypi, cysts, abscesses, granulations, cholesteatomatous débris, soft bone, and necrotic pieces, are then cautiously but thoroughly curetted and removed with Grünwald's spoons and curettes,‡ until no polypus or other diseased tissue is left, and healthy firm bone is felt. Of course great caution is necessary to avoid getting into the orbit or through the cribriform plate. The speaker nearly always operated under a general anæsthetic and in the sitting posture, and staunched hæmorrhage as he went, so as to have the parts well in view, and kept the anatomical relations well in mind. Occasionally he operated with cocaine only. He had seen no bad result. On the other hand, the patients had been mostly well satis-

* Speaker's review of Grünwald's 2nd ed., 'Journal of Laryngology,' May, 1896.
† Table II, fig. 1, 2nd German ed.
‡ Table II, *loc. cit.*

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fied with the result of the operation, in the way of much greater relief of symptoms, of prolonged freedom from recurrence, and of diminished suppuration, and in many cases of cure lasting now over three or four years. He preferred not to plug after the operation, and it was very seldom necessary. He insufflated iodoform, and applied parolein and soothing ointments freely, to prevent the secretions consolidating into hard dry scabs, which were difficult to get away, and sometimes led to epistaxis in dislodging. After the first day he used sprays and irrigations of weak warm alkaline antiseptic lotions. To revert to the ætiology of polypus, each speaker had referred vaguely to "disease of the bone" without giving any clue as to what the cause of this disease was. There was too great a tendency to avoid this vital point. One must not assume that disease is some inexplicable inherent vice until the position has been excluded that it is a departure from the normal due to some defective adjustment of the organism to the external, or some traumatism from outside. Are such to be found in traumatisms due to falls and blows, initiating changes in the muco-periosteum which are not recovered from, and become chronic? Are polypi, etc., more common in erect humans than in quadrupeds, which are less liable to nasal injury from falls and blows? Are not the rapid and extreme variations of temperature of our inspired air, the irritation of dust and pathogenic organisms, and the chronic congestion due to nasal stenosis enough to explain the persistence of an existing traumatic muco-periostitis, if not to initiate the latter, with its sequels of polypus and bone disease?

Mr. DE SANTI, whilst admitting the excellence of the paper by the opener of the discussion, could not but feel some disappointment that there was nothing new in it. Firstly, as regards the treatment of nasal polypi, he had for a long time past considered and taught that more radical measures for their removal were required. The removal of polypi by galvano-caustic loop, or by the cold wire snare, was extensively practised up to the present time, but he considered that, though in certain cases these methods were suitable, they were generally only palliative and not curative in result. Certainly, in his opinion, the cold-wire snare was infinitely preferable to the galvano-caustic loop, as the *fons et origo* of the polyp could be torn away by it, whereas with the galvano-caustic loop the origin of the polyp was left. Taking into consideration the great frequency of recurrences in these cases, the numerous sittings required if the snare be used, Mr. de Santi strongly advocated removal by some such radical measure as described by Dr. Lack. To say that radical measures were new was totally wrong; the older surgeons, such as Mitchell Banks, Jacobson, etc., had strongly advocated removal of the middle turbinals with all the polypi that might be growing from them, and though it had been the custom for laryngologists to decry these operations and speak of them as barbarous, Mr. de Santi was glad to hear at this meeting that laryngologists were inclined to favour the more frequent use of general operative measures. Dr. Lack's operative procedure was hardly new; the speaker himself had on several occasions scraped out masses of polypi under general anæsthesia, sometimes with the sharp spoon, sometimes with the ring-knife, and he also used

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forceps and scissors. In Mr. de Santi's opinion, therefore, radical operation should be resorted to much more frequently for the cure of nasal polypi. Under the older methods of treatment by the snare the patient became a regular "annuity" to the surgeon, and at the end, after an expenditure of much time and money, and suffering a good deal, was often no better. As regards the pathology of nasal polypi, he considered there was not the slightest evidence of rarefying osteitis as the cause. Why should there be rarefying osteitis? Surely such a condition would have an origin such as syphilis, injury, etc. He looked upon any rarefying osteitis that might be present as secondary to the polypi, and not a primary condition. As a matter of fact he came to the conclusion that nothing was really known as to the pathology of nasal polypi; at all events he himself was quite ignorant of their causation, and he believed that to be the condition of most members of the Society present.

Dr. Herbert Tilley thought that Mr. de Santi should have drawn a definite distinction between Dr. Lack's operation and the somewhat promiscuous intra-nasal operations with which Mr. de Santi had credited other surgeons. In the presence of so distinguished a surgeon as his former teacher, Mr. Christopher Heath, the speaker hesitated to deprecate too strongly the use of forceps in the removal of nasal polypi, because in his student days he had constantly seen them used. He was constrained, however, to point out the ease and perfection with which nasal polypi could be painlessly removed by means of a wire snare, guided by means of a reflected light. This was a very different proceeding from the use of forceps. Under the latter circumstances he had frequently seen healthy mucous membrane and pieces of middle and inferior turbinate bones removed, while more often than not, only a few polypi were removed, and inefficient removal was talked of as "recurrence of the growths." The operation advocated by Dr. Lack was an entirely different procedure, in that it was scientifically conceived, and should be carefully and skilfully executed; furthermore, the operation was limited to diseased structures. The speaker could testify to the efficiency of the operation in those cases where careful removal by means of a snare had failed to produce immunity from recurrence. He had obtained some excellent results in such cases. He thought that in some cases, possibly the majority, mucous polypi originated in the mucous membrane, and that the bone was secondarily involved. The inflamed bone would then keep up the formation of polypi, even though the latter were from time to time removed. In support of this view he adduced those somewhat exceptional cases where mucous polypi grew from the septum, and those common cases in which they lined the walls of suppurating accessory cavities in which the underlying bone was not as a rule diseased. As to the primary cause of the inflammation, he had as yet no definite opinion to offer. That well-marked bone changes were met with in cases of nasal polypi seemed obvious, and he could not understand how members could differ from this view after examining the microscopic specimens illustrating these bone changes which had been placed at their disposal by the introducer of the debate.

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Dr. StClair Thomson still suspended his judgment on the subject of debate, and would therefore limit his remarks to some side points. He knew that it had gone out of fashion to quote authorities on scientific, and particularly on medical mattters; any appeal to authority might savour of dogma. Still, he thought it would be well before entirely accepting the views which had been advanced in the debate to recall the teaching of two well-known and trustworthy rhinologists. Hajek had thoroughly investigated the pathology of polypus, and had consistently taught that the inflammation spread from the outside inwards, and not from the bone outwards. Then Grünwald, in the latest edition of his book, which showed enormous research, expressed the opinion that "polypi, in a majority of all cases, are almost as good as pathognomonic of empyemata of the accessory cavities, or focal suppuration in the nasal passages." From his own experience the speaker was inclined to agree with this, for the more expert he became in recognising empyemata, the fewer cases he had of recurring polypi. In cases where the polypi had been most persistent, their growth ceased at once when the offending accessory sinus had been drained. Possibly the operation recommended owed some of its success to the fact that the removal of the middle turbinal facilitated drainage from the frontal and maxillary cavities, and for suppurating ethmoiditis it was, of course, particularly suitable. He understood Dr. Lack to say that one of the indications for the operation was suppuration in an accessory sinus. Unless the sinus happened to be the ethmoidal cells, Dr. Thomson thought the detection of suppuration elsewhere was, on the contrary, a contra-indication. Mr. Baber had drawn attention to a practical point, which the speaker did not remember to have seen mentioned in most text-books. This was the danger of collapse and also of hæmorrhage in operating on nasal polypi in elderly subjects. Those who had not met with this occurrence would hardly believe what alarming symptoms sometimes ensued from removal of a simple nasal polypus in an old person.

Dr. FitzGerald Powell said that he thought they were under a debt of gratitude to Dr. Lambert Lack for having brought forward this scientific and practical method for the treatment of nasal polypi. Although he may not have been the first to remove by scraping diseased bone and polypi from the nose, he was, undoubtedly, the first to teach them, in a systematic and scientific manner, the best method for obtaining an early and radical cure. He had himself, since its introduction by Dr. Lack some years ago, been in the habit of practising this operation, from time to time, in suitable cases, and his experience was that it was most efficacious, entirely safe, and having the great advantage that it caused much less suffering to the patient than the repeated sittings, with the application of cocaine, and the cold snare, with their attendant pain and mental agitation. Much had been said as to the danger of the operation, and the likelihood of injury to the cribriform plate of the ethmoid, but, having regard to the anatomy of the skull, it would be a difficult matter, and force would have to be used to push a large Meyer's ring-knife up so far. On the other hand, it would not be difficult to injure the orbit, but with care this can be avoided. With regard to the pathology, he

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had no doubt that in a large number of cases, a condition of rarefying osteitis, or perhaps necrosis resulted, the causation of which might well be ascribed to syphilis, tubercle, traumatism or sepsis. But on the other hand, he thought it quite possible that a condition of inflammatory œdema might arise in the mucous membrane, blocking the orifices of the mucous follicles, and to this cause he ascribed in some cases the presence of one or two small polypi, such as he had found growing from the septum or the upper edge of the posterior choana and projecting into the post-nasal space. He had removed them with the cold snare at one sitting, and had had no recurrence after two years. During the operation there was a considerable amount of hæmorrhage, and after the commencement of the curetting he was not able to see very much, and had to rely on what he could feel with the finger and the curette. He considered it very necessary for the control of the hæmorrhage to plug the nose, and he always did so, using strips of iodoform gauze, which he kept in the nose generally for two days, changing the gauze after the first twenty-four hours. Occasionally a recurrence of the polypi did take place after the operation, but they were few in number, and could be removed by the snare or a second scraping, which effectually removed the tendency to recur.

Mr. Waggett said that *apropos* of Dr. StClair Thomson's remarks *re* ethmoidal cell disease, it was interesting to note a paper by Lichtwitz, in which attention was drawn to the unexpected frequency of accessory sinus empyema, as detected in the *post-mortem* room. That author stated that, whereas in the Special Clinics of Chiari and himself, only 2 per cent. of the total number were noted as empyema cases; the evidence of general *post-mortem* rooms showed that class of disease to be vastly more frequent. The reports of Harke, E. Fränkel, and Lapelle recorded over 100 cases from a total of 700 autopsies. Among sixty-three cases detected in the *post-mortem* room only one had been suspected during life. With regard to the general question of the relation of mucous polypi to bone changes, it was interesting to note that some of the speakers, while admitting such a relation, asserted that the bone changes were of secondary origin and due to the polypoid degeneration of the mucous membrane. In the face of Dr. Lack's thesis the assertions of dissentients should be supported by evidence. It was not surprising that the ethmoid bone, which differed in many respects from any other bone in the skeleton, should be subject to a pathological change of the character of a rarefying osteitis not met with elsewhere.

Dr. William Hill hoped that a wrong impression would not be created outside the Society by reason of the general terms in which those who approved of radical measures on the ethmoidal cells had spoken on this occasion. The object, of course, of those who attacked a case of polypous disease with ethmoidal suppuration, whether according to the method of Lack or Grünwald, or other operation similar in principle, was to remove the whole of the disease under general anæsthetic at one sitting. As a matter of personal experience, however, he felt bound to admit that this ideal was not always attainable, even at a long sitting. He had the advantage of possess-

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ing a slender little finger, with which he explored the nasal fossæ during the course of an operation; but in spite of every precaution he had often either left some polypi behind or insufficiently opened the ethmoidal cells, so that further operations under anæsthesia were sometimes necessary; and there was generally some trimming up to be done with snare or punch forceps at subsequent sittings under cocaine. The snare operation alone was only useful in simple cases, and was rarely, if ever, radical in recurrent and suppurative ones. In clinical teaching, whilst calling the attention of students to the inartistic and sanguinary methods of treatment adopted by those general surgeons who used *blindly* to push forceps up the nose and remove all they could lay hold of, including an occasional turbinal, diseased or otherwise, the speaker had always been careful to call attention also to the fairly good results attending such measures, in spite of the absence of technique; and what was more remarkable, as far as he could gather, no fatal result had attended the use of the forceps, even in inexpert hands; and generally speaking, the operation had not led to harmful sequelæ, though doubtless it often failed in its object from imperfect removal. In conclusion, he agreed with those speakers who insisted that where ethmoidal suppuration was present some radical measure, such for instance as that advocated by Dr. Lack, was essential to insure a cure of nasal polypus.

Dr. Dundas Grant said that there could be no doubt that Dr. Lack's operation ought to be looked upon as a received surgical procedure, the only possible difference of opinion being with regard to its indications. Those laid down by Dr. Lack pointed to suppuration of the ethmoidal cells. With regard to the necessity for radical operation in cases of recurrent polypi, he thought it might sometimes take other forms, *e. g.* there were cases in which the polypi could only be eradicated after an opening had been made into the antrum. Dr. StClair Thomson indicated that free washing out of the antrum had caused disappearance of polypi; he had himself also observed this. In other cases that had not occurred, and several times he had thought it justifiable to open the antrum of Highmore and clear away its entire inner wall with the unciform process for the purpose of eradicating polypi situated in the middle meatus. Sometimes there might be polypi growing from the front of the sphenoid bone. He related a case in which he had removed such a polypus. With regard to polypi in the post-nasal space, a general anæsthetic was in his opinion necessary, the left forefinger being introduced into the naso-pharynx. The difficulty in putting the snare round such a polyp was considerable, and the forceps, passed through the nose under the guidance of the finger in the naso-pharynx, was the only instrument which could be used under a short anæsthesia like that of nitrous oxide gas. In order to get complete removal of polypi and to get a snare applied to as many polypi as possible, it was often necessary to remove the anterior part of the middle turbinate body. There was sometimes another form of obstruction which had to be removed, and that was the polypoid swelling on the anterior lip of the hiatus semilunaris, which sometimes projected to a considerable degree into the nasal cavity; and the only way of removing it satis-

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factorily was that recommended by Killian, which he (Dr. Grant) had himself done several times. It was to pass the point of a sharp pair of scissors right into the middle of the growth, and to remove the upper and lower half separately by means of the snare. This had enabled him to reach and remove a polypus which was inaccessible both to vision and to touch until that was done. Nobody, he was sure, would regret more than Dr. Lack if it became the custom for all and sundry to perform his operation on every patient who had polypi of the nose. In a wisely selected number of cases, however, it was absolutely indispensable and offered the most promising results.

Dr. Bond heartily supported Dr. Lack in his method of operating, but there were certain cases in which one might come to grief. Dr. Lack's method of operating was different from Bank's, which latter consisted in taking hold of the middle and upper turbinates and pulling away with forceps as much as possible from the top and middle of nose. Dr. Lack's operation was a different thing altogether, but one might have trouble in operating if one did not pick one's cases somewhat carefully. The most serious cases were those referred to by Dr. StClair Thomson, namely cases of polypi occurring in old women over sixty. In such a case the front of the nose on each side was commonly seen to be filled with what seemed to be ordinary polypi, but the case was often one of malignant disease with polypi in front. If in such a case Dr. Lack's procedure was used under the belief that the case was one of general nasal polypi the operator would be surprised at the result. There were other cases where the nose was very much obstructed, and a little œdema and granulomatous tissue might be seen in front, with syphilitic necrosis, etc., behind. On scraping away vigorously in such a case a violent hæmorrhage might occur. He had seen one instance of such a case. Somewhat active treatment at the posterior part of the nose was carried out, and the sphenoid cavity opened and packed, but with damage to the vessels inside the skull. Dr. Lack's operation was, in his opinion, an admirable and successful one. He wished to mention that there was no danger of damaging the cribriform plate, etc., if the operation were done with ordinary skill; such danger was in large part imaginary. The second point he remarked on was that the cautery had ceased to be used and recommended, as in times past, in the treatment of nasal polypi. It was recommended in the text-books as of use in treating polypi, and cauterisation of the stumps was advocated. He believed the latter to be a great factor in the production of bone disease. He thought curetting of the mucous membrane should be employed more than it had been. In conclusion, he thought the individual factor played a very important part in the comparative success of the operation; one operator would get good results from Dr. Lack's method, whilst another would get much the same result from operations with extensive curettings carried out at several sittings.

Dr. Wyatt Wingrave said, with reference to the pathological aspect of the discussion, Dr. Lambert Lack's specimens illustrated one phase only of polypus formation. Many of the sections showed only normal cancellation changes, a process of osteoporosis which is essential to the development of the accessory sinuses, and continues

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until very late in life. The "osteoclastic" operations so well seen in this rarefying process are often misinterpreted as being morbid; but it is only when greatly exaggerated that it should be so construed. In some of the slides the periosteal and osteoblastic activity was well marked, but this he considered as bearing only a coincidental relationship to the simple form of polypus. For all practical purposes polypi might be divided into two groups:—(1) simple; and (2) granulation. While the first group retained to a great extent many of the local histological features, the second group consisted almost entirely of small cell tissue in various degrees of myxœdematous degeneration, so that when fully developed they could not easily be distinguished from the simple variety. It was in the granulomatous group that the osseous changes were the more marked, so that the polypus was only symptomatic of deeper sinusal changes. Reference had been made to the necessity for exercising care when removing polypi in the aged. Whilst emphasising this, he thought that in addition to the risk of hæmorrhage from senile changes in the blood-vessels, there was also a danger due to advanced cancellation. The rarefication was often so extensive that the turbinals proved to be as brittle as "biscuit," and great care had to be exercised in limiting the amount of bone removed with the polypus.

The PRESIDENT congratulated the Society on a most useful discussion; he thought that from this time forward a more or less new departure would go forth to the world as being the view held by certain members of the Society, stamped with the approval of the Society. The only thing to be afraid of was that this somewhat radical method of treatment might be adopted by men who had not the skill of the great majority of the members of the Society. It was a point which ought to be emphasised, and which had been emphasised at a previous meeting of the Society. It was a method only to be employed in exceptional cases, and by those who had an exceptional amount of experience of intra-nasal disease. Another important point was the care to be exercised when polypi occur in old people. This had been overlooked in the past. The stress laid upon this was an additional gain to science and medicine.

Dr. H. LAMBERT LACK, in reply, thanked the members of the Society for the reception of his paper, which was more favourable than he had expected. In reply to Mr. Baber, he said he had watched some of his cases as long as six years, and so far from destroying the power of smell, in some of the most chronic cases, in which the patient had smelt nothing for years, it had returned after the operation. With Mr. Spencer's remarks he could not agree; but there was not time to go into them all. He doubted whether anything at all comparable to a nasal polypus ever arose apart from bone, for the rectal polypus was an adenoma, and these and other similar "polypi" were true tumours. The old idea that nasal polypi were tumours he thought had been given up years ago, and therefore he had not considered it worth while to allude to it. The structure and whole history of nasal polypi quite precluded such a theory. He had, however, very carefully separated granulation and inflammatory growths from nasal polypi, as they were both microscopically and clinically

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quite distinct. Again, Mr. Spencer said that there were all stages between a nasal polypus and sarcoma. There was no evidence to support that view. A nasal polypus might be removed year after year and still never become a sarcoma. Several speakers, whilst reluctantly admitting that bone changes take place, claim that they are secondary to, and not the cause of, polypi, and yet can bring no evidence. On the contrary, when the diseased bone was removed, recurrence of polypi did not take place, but when the polypi alone were removed the bone changes continued and the polypi recurred. He had not claimed that he was the first to advocate the removal of bone. This was done one hundred and fifty years ago by Morgagni and Valsalva. Morell Mackenzie had published (in his book on 'Diseases of the Horse') notes of several cases of recurring polypi in which, after he had removed the underlying bone, recurrence no longer occurred, in spite of which Mackenzie advocated the cautery in all cases. Further, Ferguson and Pirogoff had recommended the removal of the bone. But they had not advocated the thorough operation which the speaker had proposed, and neither had Grünwald. When he started to investigate the subject of the pathology of polypus he had an open mind, but on discovering the changes in the bone which were illustrated under the microscope to-night, he came to the conclusion that Woakes's views were in large part correct. Where Martin had not found bone changes, perhaps it was because Woakes had removed the bone in other than polypus cases, as he ascribed many diseases to "necrosing ethmoiditis." He agreed with Dr. Powell that it was not at all easy to push a large ring-knife through the cribriform plate, and such an accident could be avoided with a little care. Dr. Tilley had said that in cases of polypi in the accessory sinuses bone disease was not always present, though the bone had never been removed for microscopical examination, and thus there was no conclusive evidence that osteitis was not always present. He could recall cases of polypi in the sinuses in which bone disease was undoubtedly present. In two cases the sphenoidal sinuses were affected, and in both the anterior wall of the sinus was extensively carious; and in two other cases in the antrum the inner wall was extensively destroyed. This evidence, as far as it went, contradicted Dr. Tilley's statement. Dr. Thomson seemed to approve Grünwald's theory. He did not think it was the general experience that sinus suppuration was invariably present in polypi. With the most careful examination it was in all probability found in less than 50 per cent. of the cases, and probably the same cause that produced the one might produce the other. Mr. Waggett had quoted *post-mortem* evidence to show the enormous frequency of sinus suppuration, which only showed that *post-mortem* records could not be accepted. The reasons of this frequency seemed to be that the accessory cavities had their openings at the top, and therefore the secretion formed depended entirely on the action of the ciliated epithelium for its removal. Thus when just previous to death this action ceased, or became inefficient, fluid accumulated in the cavity, and German authors seemed to accept the least trace of any sort of fluid as evidence of sinus suppuration. He agreed with Dr. Hill that one might have to trim up

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the case afterwards with a snare; but in most of his cases he had removed everything at one operation. He would try and avoid Dr. Bond's three classes of dangerous cases, and certainly would never operate in the old or the feeble. In replying to Mr. Wingrave, Dr. Lack said that although some of the bone in his sections was normal, abnormal places were to be found in every section if looked for.

Mr. Cresswell Baber, in reply, said, with regard to the question of the starting-point of the inflammatory trouble causing polypi, whether in the mucous membrane or in the bone, he thought the clinical evidence seemed in some cases to favour the former theory, the reason being that, as he had pointed out, mucous polypi were met with under so many different conditions. Two of the latest observers, Hajek and Cordes, found cases in which the mucous membrane only was affected; in these cases, then, how could the bone be the cause? He was interested in Dr. Lack's operation, and thought it was one to be tried in suitable cases; before it was done the state of the larger sinuses ought to be investigated. He was glad that several members agreed with him as to the necessity for caution when removing polypi in the aged.

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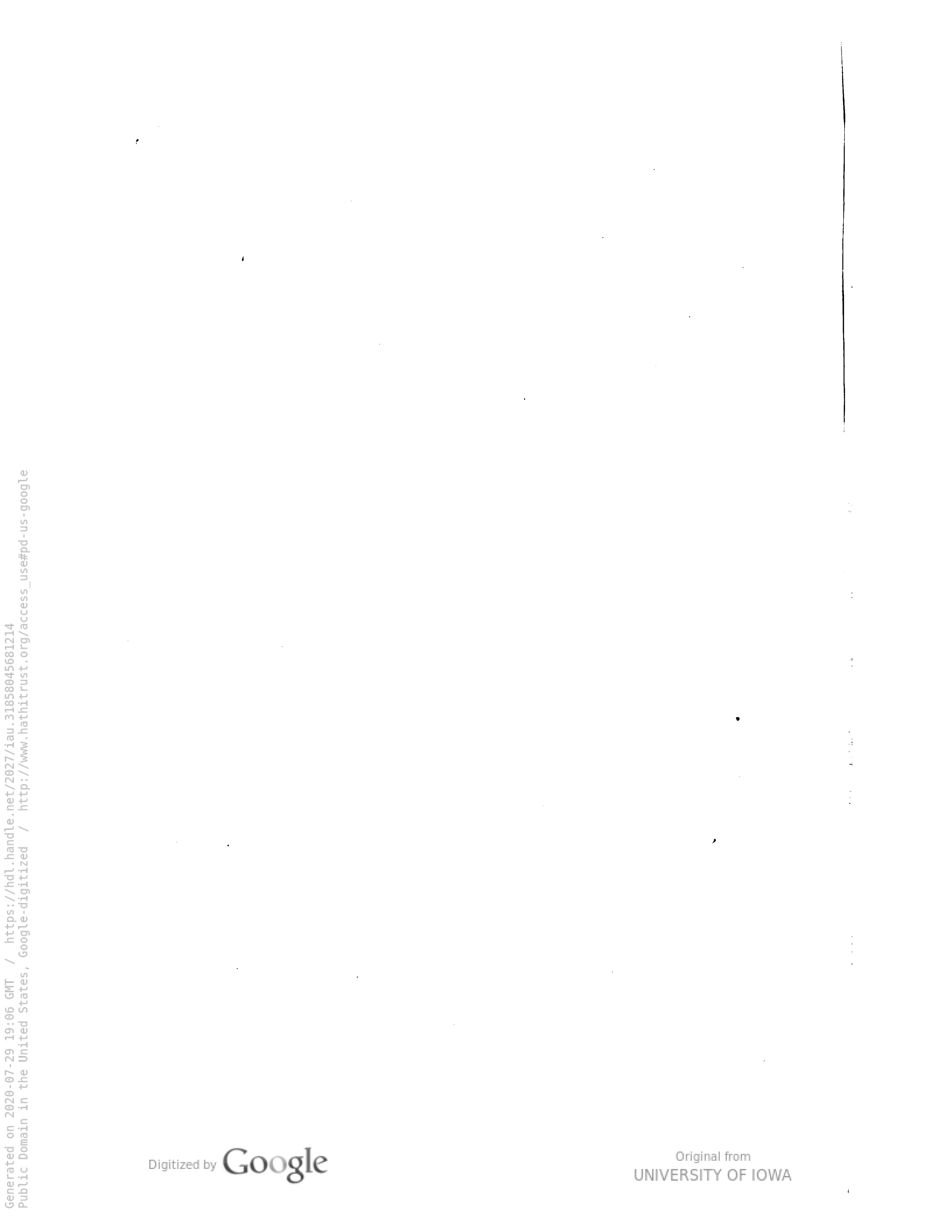

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ANNUAL MEETING, *Friday, January 4th,* 1901.

F. DE HAVILLAND HALL, Esq., President, in the Chair.

Present—17 members.

The minutes of the last Annual Meeting were read and confirmed.

Drs. Bronner and Brown Kelly were appointed scrutineers of the ballot, and the following officers were appointed for the year:

President.—E. Cresswell Baber, M.B.
Vice-Presidents.—A. Bowlby, F.R.C.S.; E. Law, M.D.; and Greville MacDonald, M.D.
Treasurer.—Clifford Beale, M.B.
Librarian.—Dundas Grant, M.D.
Council.—F. de Havilland Hall, M.D.; Herbert Tilley, F.R.C.S.; Barclay Baron, M.B.; William Hill, M.D.; Sir Felix Semon, and Lambert Lack, M.D.
Secretaries.—Ernest Waggett, M.B., and Charles A. Parker, F.R.C.S.(Ed.).

The report of the Council was then read and adopted.

REPORT OF COUNCIL.

The Council has the pleasure to report that the Society continues in a most prosperous condition. During the year thirteen new members have been elected, while one member has resigned and two have died. In April the Society received with deep regret the news of the death of Dr. McNeill Whistler, a former Vice-President and an original member.

The attendance of members at the Ordinary Meetings has been exceptionally large, and the clinical material abundant. The Ordinary Meeting in December was devoted to a discussion on "The Treatment of Nasal Polypi," which was well attended by members, many of whom took part in it.

Increased facilities have been provided for the exhibition of micro

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scopical sections which have been freely taken advantage of, and a Cabinet to contain the specimens has been purchased and placed under the charge of a curator.

At a Special Meeting in March it was resolved that "it was desirable that at all International Congresses there should be full and separate sections for Laryngology and Otology."

The Council have been recently engaged in the consideration of the rules of the Society, which, owing to alterations and additions at various times, required general revision and rearrangement.

The following report of the Treasurer was read and adopted:

The total receipts of the Society from subscriptions, entrance fees, etc., during the past year has been £134 8*s.* There are still ten subscriptions outstanding and one entrance fee, but nearly all the outstanding subscriptions for 1899 have now been paid in.

The total expenses amount to £133 13*s.* 2*d.*, leaving an excess of income over expenditure of 14*s.* 10*d.* for the year. To this has to be added the balance brought forward from last year, viz. £215 16*s.* 3*d.*, making a total credit balance on January 1st, 1901, of £216 11*s.* 1*d.*

The Balance-sheet, duly audited and found correct by the auditors, Dr. Jobson Horne and Dr. Furniss Potter, is appended.

BALANCE-SHEET, 1900.

INCOME.	£	s.	d.	EXPENDITURE.	£	s.	d.
Balance from 1899	215	16	3	Rent	31	10	0
10 Entrance Fees	10	10	0	Adlard	56	0	3
110 Subscriptions	115	10	0	Reporting	18	18	0
5 ,, (1899)	5	5	0	Baker—Microscopes	6	10	0
2 ,, (1901)	2	2	0	Newton—Lantern, etc.	2	10	0
1 Subscription overpaid	1	1	0	Pulman—Binding	4	7	2
				Entertainment at Annual Dinner	5	5	0
				Cheque returned (Dr. W. Williams)	2	2	0
				Clarke—Indexing	1	10	0
Total Receipts for 1900 . £134 8 0				Burgoynes—Chemicals	0	14	7
				Rogers—Spirit Lamps, etc.	0	11	11
				Mathew (porter)	1	1	0
Balance Jan. 1st, 1901 . 216 11 1				New Cheque Book	0	8	4
				Hon. Secretary's Expenses:			
				Dr. Lack	1	1	9
				Mr. Waggett	0	11	7
				Hon. Treasurer's Expenses	0	11	7
				Total Expenditure for 1900	133	13	2
				Balance	216	11	1
	£350	4	3		£350	4	3

Dec. 31st, 1900.

Audited and found correct, { W. JOBSON HORNE. E. FURNISS POTTER.

E. CLIFFORD BEALE, *Treasurer.*

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The Librarian's report as under was then read and adopted.

The following "Exchanges" have been regularly received during the year 1900:

Archiv für Laryngologie und Rhinologie.
The Journal of Laryngology, Rhinology, and Otology.
Revue hebdomadaire de Laryngologie, d'Otologie, et de Rhinologie.
Archivii Italiani di Laringologia.
Annales des maladies de l'oreille, du larynx, du nez, et du pharynx.
Bollettino delle malattie dell' orecchio, etc.
The Laryngoscope.
Archivio Italiano d' Otologia.

It has been found impossible to have them all bound up to the present date, but this will be effected with the least possible delay.

The following works have been presented to the library:

By the President (Dr. de Havilland Hall).

Morell Mackenzie—Semon. Die Krankheiten des Halses und der Nase.
Gustav Spiess. Kurze Anleitung zur Erlernung einer richtigen Tonbildung in Sprache und Gesang.
Gustav Spiess. Ueber den Einfluss einer richtigen Stimmbildung auf die Gesundheit des Halses.
L. Schrötter. Vorlesungen über die Krankheiten des Kehlkopfes.

By Sir Felix Semon.

Internationales Centralblatt für Laryngologie for the year 1899.

I have also communicated with the editors of the 'American Annals of Laryngology, Rhinology, and Otology,' and of the 'Revue Internationale de Laryngologie,' but without success.

The following have been presented by the authors:

Pini, Alberto. Sulla olfattometria.
Goldstein, M. A., M.D. Modern Therapy of the Tympanic Cavity.
" " Nasal Hæmorrhage and the Hæmophilic Diathesis.
" " The Radical Treatment of Follicular Tonsillitis.
" " Otitis Media—Diagnosis and Treatment.
" " What not to do in Ear, Nose, and Throat Work.
Grazzi, Prof. V. Gli effetti dei bagni in generale sull' organo acustico.
" " Ricordi de VI° Congresso Otologico Internationale.
" " Sulla Laringite Tubercolare.
Hajek, Dr. M. Pathologie und Therapie der entzundlichen Erkrankungen der Neben höhlen der Nase.
Perez, Dr. Fernand. Recherches sur la bactériologie de l'ozène.
Pieniazka, Dra Przemystawa. Laryngoskopia oraz Choroby Krtani i Tchawicy.
Polyak, Dr. Ludwig. Jahrbücher der Gesellschaft der ungarischen Ohren- und Kehlkopfärzte, 1899.
Semon, Sir Felix. Die Nervenkrankheiten des Kehlkopfes und der Luftröhre.
Udden, J. A. An Old Indian Village (2 copies).

The following Proceedings of Societies, etc., have also been added:

Sitzungsberichts der Wiener Laryngologischen Gesellschaft, 1899.
American Laryngological Association, 1899.
Brighton and Sussex Medico-Chirurgical Society, Session 1899-1900, Fifty-third Annual Report.
Sixth International Otological Congress.
Gesellschaft der ungarischen Ohren- und Kehlkopfärzte.

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Niederländische Gesellschaft für Hals-, Nasen-, und Ohrenheilkunde.
Verhandlungen der Laryngologischen Gesellschaft zu Berlin.
Medical Society's Transactions, vol. xxiii.
Catalogue of Accessions to the Library of the Royal College of Physicians.
The Hospital (autumn special number).
Journal of the International Pyschical Institute (November, 1900).
Bibliographia Medica, Index medicus, tome 9, No. 1, janvier 1.
Voyages d'études médicales, 1900.

Several members have availed themselves of the resources of the library, and in several cases where these resources have fallen short I have had the pleasure of lending works to members out of my own private collection.

I propose bringing before the meeting the question of procuring more extensive accommodation for our books in the rooms of the Royal Medical and Chirurgical Society, and have been negotiating with Mr. MacAlister in regard to it.

The suggested new rules were then read, discussed, and confirmed.

The meeting then adjourned.

SIXTY-SECOND ORDINARY MEETING, *January 4th*, 1901.

F. DE HAVILLAND HALL, M.D., President, in the Chair.

LAMBERT LACK, M.D., } Secretaries.
ERNEST WAGGETT, M.B., }

Present—32 members and 2 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were nominated for election at the next meeting of the Society:

Eugene Steven Yonge.
Arthur Ainslie Hudson.

The ballot was taken for the following candidates, who were unanimously elected members of the Society:

J. C. R. Braine-Hartnell, Cotswold Sanatorium.
George Jones, 8, Church Terrace, Lee.

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The following cases and specimens were shown:

Clonic Spasm of Palate, Pharynx, and Larynx in a Woman Æt. 30.

Shown by Sir Felix Semon, M.D. I am indebted to my colleague, Dr. Risien Russell, under whose care the patient is at present at the National Hospital for Epilepsy and Paralysis, for permission to show her to-day. In order to avoid the case being duplicated, I beg to state expressly that the same patient was demonstrated by Dr. Russell before the Neurological Society a few months ago.

The patient, a married woman, who has had six children, of whom three are dead, and one miscarriage, and whose previous and family history are unimportant, came to the hospital in January, 1900, complaining of clicking noises in her head and curious movements in her abdomen. These movements were darting in character, as if there were something alive, and passed from the stomach into the throat, head, back, and limbs with great rapidity. In October, 1899, she first noticed the clicking noise in her throat, which has continued ever since. It has apparently nothing to do with the darting movements in the abdomen.

On examination, the patient is a fairly well-nourished woman with red hair, who lies or stands with her head thrown well back, the neck and chin thrust forward, the latter generally inclined to one side or the other, and the mouth is kept slightly open. A constant slight clicking sound goes on with an average frequency of about four per second. On looking into the mouth this sound is seen to be produced by rapid vertical movements of the soft palate associated with similar movements of the floor of the mouth. These movements go on whether the jaws are open, even widely, or closed; but if the chin is depressed into its natural position with the mouth closed the noise ceases, and the movements of the floor of the mouth cease, although she says she can still feel the palate moving.

The clicking sound is audible when she speaks, between the single words, but is said to cease, as well as the movements, during sleep. The movements on the whole are rhythmical, but

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are occasionally interrupted by momentary irregular intervals, hardly lasting longer than a second or two, after which they re-commence.

The epiglottis makes similar movements synchronous with those of the soft palate. These movements also take place in a vertical direction. The arytænoid cartilages and the vocal cords move with equal frequency and very energetically, but their movements are from side to side, not up and down; like those of the palate and the floor of the mouth, they are occasionally interrupted for a moment, after which they begin again. Usually they are so energetic that, during quiet respiration, the inner surfaces of the arytænoids, when the inward movement is executed, touch one another, but the oscillatory movements continue even when the glottis is wide open. During phonation everything appears normal.

Externally the mylo-hyoid can be seen and felt contracting, whilst the whole larynx is constantly being spontaneously moved a little up and down, and at the same time somewhat forwards and backwards, the movements being energetic enough to be communicated to the examining finger.

Her memory, attention, and intelligence are good, but she is distinctly depressed. She has no delusions except that she is sure she has something alive inside her.

The optic discs are healthy, the muscles everywhere well developed, and the movements well performed without incoordination or tremor. Reflexes everywhere normal, gait normal except for the position of the head described above, and nothing abnormal found on examination of the abdomen.

Speculation as to the cause of this peculiar clonic spasm, as to its mechanism, and as to the exact localisation of the focus of irritation appears, in the present state of our knowledge, idle.

It is only desired to put the case on record.

Dr. Lambert Lack wished to call the exhibitor's attention to a paper he contributed to the 'Laryngoscope' in 1898, in which, under the title of "Pharyngeal Nystagmus and Allied Conditions of the Pharynx and Larynx," he had described several cases similar to the one now shown. The speaker and Dr. Bond had each brought a similar case before the Society, although their cases were less marked and the movements were limited to the pharynx and soft palate.

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As far as Dr. Lack had been able he had collected in the paper referred to all the previously recorded cases of spasmodic and tremulous movements of the pharynx and larynx. He found they could be divided into two distinct classes: (1) the most severe and extensive cases, which were usually due to some gross lesion of the central nervous system, *e. g.* cerebellar tumours, etc.; and (2) the milder cases, which were of reflex origin and apparently due to some small local lesion, *e. g.* post-nasal catarrh, pharyngitis sicca, etc.

Dr. HERBERT TILLEY related a minor case of the same affection occurring in an adult, in which only the left side of the pharynx showed constant spasmodic movements which extended the whole length of the pharynx. The affection supervened on a carriage accident—the patient was thrown out and suffered severe concussion and bruising. The patient's speech was becoming very indistinct, knee-jerks absent, tongue tremulous, and the pupils responded to Argyll-Robertson's test. The diagnosis in the case referred to seemed to point to incipient general paralysis of the insane.

Dr. WATSON WILLIAMS believed that instances of clonic pharyngeal spasm were not so very uncommon in general paralysis. The vocal cords were more rarely implicated. It seemed to him that these convulsive tics were possibly the analogue (bulbar) of psychic tics (cortical), and they were sometimes associated, for echolalia and coprolalia had been observed in association with clonic pharyngeal spasm by Kellogg.

Dr. CLIFFORD BEALE called attention to the fact that the movement of both larynx and pharynx ceased directly the patient's attention was drawn to the acts of phonation or respiration. The cases which Dr. Lack had referred to differed in this respect from the one under discussion.

Dr. SCANES SPICER considered the sucking noise to be produced in the larynx by the separation of the moist opposed surfaces of the arytænoid pyramids, for the sound continued unaltered when the soft palate was firmly pinned against the spine. He had an impression that Sir Felix Semon had shown a somewhat similar case before, but unilateral, and in which the orbicularis palpebrarum of the same side was affected.

Mr. CRESSWELL BABER remarked that pharyngeal spasm was not uncommon; it was described as a clicking noise, and as objective tinnitus; he had not seen laryngeal spasm, or any case in which the spasm took place so rapidly.

The PRESIDENT was sure that they were all thankful to Sir Felix Semon for bringing forward this unique case.

Sir FELIX SEMON, in reply, agreed with Mr. Baber's observations. He had seen several cases of "clicking" palate, but in these the spasm was limited to the soft palate and did not affect the larynx. He was grateful to Dr. Lack for drawing his attention to his paper in the 'Laryngoscope,' which was unknown to him. He was unaware that anything like his case had been previously described, although he knew that Gerhardt had mentioned tremulous movements of the vocal cords as the only sign of a cerebral tumour pressing upon the temporal convolutions.

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[*P.S.*—Since making the above statements, I have learned from Dr. Lack's very interesting paper in the 'Laryngoscope,' June, 1898, that several similar though not quite identical cases have been described.—F. S.]

Chronic Frontal Sinus Empyema treated by Kuhnt's Radical Operation.

Shown by Dr. Herbert Tilley. A woman æt. 46, upon whom this operation had been performed. The symptoms complained of were constant left supra-orbital headache, chronic discharge of pus, and nasal obstruction (due to polypi) upon the left side.

In performing the external operation the anterior bony wall of the sinus was completely removed, the pathological products curetted away, a large opening made into the nose, the sinus walls painted with chloride of zinc, gr. xl ad ℥j, the cavity packed with iodoform gauze, and the soft parts finally sutured with catgut for the other half of the wound. The end of the gauze was led out of the inner angle of the wound.

After five days some six inches of the gauze were removed, and the remainder of it after a further interval of four days. The sinus cavity seemed quite healthy, and external pressure was now applied to the soft parts so that they were pressed on to the posterior wall of the sinus, to which they had firmly adhered, thus obliterating the cavity. The patient was in the hospital seventeen days, and there has been no discharge of pus from the nostrils since the day of operation, five weeks ago.

Case of Cured Maxillary (Double), Ethmoidal, and Frontal Sinusitis.

Shown by Dr. StClair Thomson. The patient was a gentleman æt. 41, who had suffered from nasal suppuration for eight years. Twice in Natal, where he lived, he had had the alveolar tooth socket drilled, and the right antrum washed out for some months. The pus soon returned when the washing was discontinued. It was found that the frontal sinus on the same (*i. e.* right) side was affected, and in hopes that the maxillary antrum only acted as a reservoir, it was simply drained through a tooth

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socket while the frontal sinus was opened from the outside. As a result of this operation pus ceased to descend from the fronto-nasal duct which was obliterated, and the exposed part of the sinus filled with cicatricial tissue. But still pus oozed from the external corner of the frontal wound, and on placing the patient again under chloroform it was found that this proceeded from a diverticulum of the main frontal sinus, with which it communicated by a narrow neck which had been overlooked at the first operation. This pocket, running outwards and backwards above the outer orbit, had been opened up and plugged so that it healed from the bottom, just as a mastoid wound does. It was a slow process, taking three months, but there was no disfigurement.

The maxillary sinus on the same side had been treated by the Caldwell-Luc operation, and the ethmoidal cells had been curetted. The left maxillary antrum was simply drained, as it appeared to be only of recent infection from the right side.

It would be seen that the patient was not disfigured externally, as the incision was well under the eyebrow. Internally the right nasal chamber had not been interfered with physiologically by the removal of the anterior ends of the inferior and middle turbinals. There was no pus in the nose, but a little dry scab formed daily over the ethmoidal-cells opening. The patient expressed himself as struck by the recovery of the sense of general well-being. He said that he felt ten years younger than at the beginning of treatment, and now knew that he was then growing prematurely old.

Sir Felix Semon suggested to Dr. Tilley that it would be worth while in cases of this nature, in which the whole of the anterior wall of the frontal sinus was removed, to put in a plate either of aluminium, platinum, decalcified bone, or of ivory. Such devices acted well in other parts, and why should they not in the frontal sinus region? Disfiguration might thereby be lessened considerably, or even be totally avoided.

Dr. Watson Williams remarked that at the Portsmouth meeting of the British Medical Association in 1899 reports of two cases of diffuse suppurative osteitis, following operations for frontal sinus empyema, were reported. He desired the opinion of members of the Society as to the possibility of increasing the risk of such an occurrence by putting pressure upon the frontal sinuses, after opening, curetting, and cleaning them, as in the radical cure.

Mr. Cresswell Baber said it seemed as if surgeons were now coming

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back to the operation of Kuhnt, who removed the whole of the anterior wall of the frontal sinus. He himself had shown at the Society a most refractory case, in which cure had resulted from resorting to this radical operation after all other measures had failed. The depression was not marked in his case, and the results were satisfactory. He asked, was it advisable to make a large opening into the nose or not? In the radical operation the discharge escaped on to the surface, and the sinus was filled with healthy granulation tissue. He took it for granted that the anterior part of the middle turbinate was removed previous to operation on the frontal sinus.

Dr. Scanes Spicer thought that in both of these cases he would himself have removed much more completely the front part of the middle turbinated and anterior ethmoidal cells before operating externally on the frontal sinus. He had seen many cases presenting all the symptoms and signs of frontal empyema get well after this procedure without the need of an external operation; and had found that even if this did not happen, the drainage of the frontal sinus into the nose was much facilitated by such free removal. While acknowledging the necessity for complete resection of the anterior wall in rare cases, he dreaded the deformity resulting, and thought that clearing out the anterior ethmoidal region well would render it still less often necessary.

Dr. StClair Thomson, in reply, said that the anterior half of the middle turbinate was removed before the operation on the frontal sinus. The suggestion of Mr. Baber was one to be considered—whether it was not much more desirable to obliterate the fronto-nasal duct, and cut off all communication with the nose. He started in this case with the Ogston-Caldwell-Luc operation on the frontal sinus, and passed his little finger up the nose into the sinus. During the treatment he changed his mind, and succeeded, by exerting a little pressure, in cutting off the frontal sinus from the nose. The patient ran no risk of being reinfected because he now had no sinus. The idea of Sir Felix Semon was worthy of attention. He had a patient who told him that the bank clerk next to him had a platinum plate in his forehead, and feels very well. Other substances besides platinum might be used. In the 'Medical Press and Circular' of recent date solidified vaseline was suggested for this purpose.

In answer to various questions Dr. Tilley said that he would only recommend so complete an operation in exceptional cases, because of the deformity produced. In some seven cases which he had previously shown to the Society equally good results had been attained with no deformity, and in these instances far less of the anterior wall had been removed. He had performed Kuhnt's operation in this case really to satisfy himself as to how much deformity it produced. He considered that there was very little, in fact no risk of septic osteomyelitis ensuing if the external wound was not sewn up at the close of the operation. To avoid the complication it was also wise to make a large opening into the nose, which had the additional advantage of breaking down the anterior ethmoidal cells, which were always diseased, and which, if left alone, were very liable to reinfect the sinus, however carefully the latter was treated by curetting and disinfection.

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Case of Epithelioma of the Tonsil and Glands in the Neck; Operation; Recovery.

Shown by Dr. Lambert Lack. The patient, a man æt. 50, came under my care one month ago, complaining of a painful lump in the throat. An ulcer was seen in the position of the right tonsil, about the size of a florin. It spread on to the posterior pillar of the fauces, slightly on to the lateral wall of the pharynx, and downwards to within a quarter of an inch of the tongue. The edges of the growth were hard and everted. No enlarged glands could be felt in the neck. As the man was willing to be operated on, and the case appeared to be an eminently suitable one, a piece of the growth was at once removed for microscopic examination. The sections showed the growth to be an undoubted epithelioma.

The operation that was performed may be divided into four stages:

1. An incision was made along the anterior border of the sterno-mastoid, and the large vessels in the anterior triangle freely exposed. Some enlarged glands were found, and, together with the fascia over the vessels, were cleanly cut away. Ligatures were placed on the external carotid and some of its branches, but were not tightened. A pad of gauze was packed in between the carotids and the lateral wall of the pharynx.

2. Tracheotomy was performed, and a Hahn's cannula inserted.

3. The cheek was slit back from the angle of the mouth to the ramus of the jaw. A large sponge, with tape attached, was pushed into the larynx.

4. The pillars of the fauces were cut through with scissors, and the growth partly cut out with scissors and partly separated from the lateral pharyngeal wall by dissection with the finger. The wound in the mouth remained separated from the wound in the neck by a thin layer of fascia. There was no bleeding to speak of.

The temporary ligatures on the carotids were removed, and the wound in the neck and cheek sewn up. The tracheotomy tube was retained until the following day. After twenty-four hours the patient was able to swallow, and his further progress

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was uneventful. The wounds in the neck and cheek healed by first intention. The patient was allowed up on the seventh day, and left the hospital on the fourteenth day.

The patient was brought forward to illustrate the excellent immediate result that can be obtained by such an apparently severe procedure. The whole safety of the patient depends upon the wound in the neck not communicating with, and being infected from, the wound in the mouth. The danger of hæmorrhage is entirely avoided by the temporary ligature of the vessels and the tracheotomy. The case also illustrates again the fact that even considerably enlarged glands in the neck may not be palpable, and the consequent necessity for an incision in the neck in every operation.

The PRESIDENT thought they would all agree in congratulating Dr. Lack upon the success which had attended his case. It was a perfect result, and one could not wish for a better either with regard to the completeness of the removal or the rapidity of the healing.

BILATERAL WEBBING OF THE FAUCES.

Shown by Dr. HENRY J. DAVIS. This is a woman, æt. 52, with bilateral webbing of the fauces. The webbing may be entirely the result of old ulceration, but the symmetrical appearance of these fine bands of tissue would seem to indicate cicatrisation following ulceration of some congenital malformation of the faucial pillars, *e. g.* an accessory palato-pharyngeus.

Since childhood speech has been indifferent, and she had "a sore throat for ten years at one time," which favours this supposition. She is suffering from tinnitus and deafness.

The PRESIDENT had no doubt at all that this was a case of ulceration of scarlatinal origin. He had seen a similar case following small-pox, but scarlet fever was the most frequent cause. He did not think for one moment that its origin was congenital.

Dr. STCLAIR THOMSON had seen a similar case, which was even and regular, in which he could discover no history of syphilis or scarlatina. He had discussed the case with Mr. Bland-Sutton, who informed him that this defect did not correspond to any developmental defect.

Dr. FITZGERALD POWELL had shown a somewhat similar case to the Society some time ago. At the time he thought the abnormality must be developmental in character, the posterior pillars of the fauces being attached low down to the posterior wall of the pharynx

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on both sides, each being very regular in outlines. The trend of the opinion of the Society on that occasion was that it was probably the result of scarlatinal or other ulceration. He thought Dr. Davis's case was due to this cause.

Sir FELIX SEMON, with great respect for Mr. Bland-Sutton's opinion, begged to differ from the statement attributed to that authority. He thought that such cases might be developmentally explained; there was no doubt of the existence of quite a number of cases with slits in the anterior pillars of the fauces, absolutely symmetrical, without any ulcerative agency to account for their presence. He promised to bring before the Society a drawing of a case of his own bearing on that point, and he remembered that similar cases had been described by Professor Lefferts. With regard to Dr. Davis's case he would be probably found to be in a great minority; but he agreed with Dr. Davis that this case very likely represented a mixture between arrested development and acquired ulceration.

Dr. WATSON WILLIAMS' impression was that this was a mixed case, in which there had been nine or ten years ago a sore throat with an ulcerative process going on; but the symmetrical condition of the faucial webbing suggested a congenital origin. The patient said she had not noticed it before. He himself had had a patient brought before his notice who did not know he had anything the matter with his throat, but he was found to have almost absolutely symmetrical webbing on either side of the fauces, very similar to this patient; in that case the condition was of congenital origin. He promised to show the Society a drawing of this case.

Dr. CLIFFORD BEALE thought it was a matter of considerable interest to determine whether these cases were due to scarlatinal poison in the first instance. In favour of such a view was the distribution of the splitting of the palate, which followed the lines of inflammation of the soft palate, so often seen at the onset of scarlatina. Against the theory, however, was the fact that, although in the course of hospital practice, one may examine a very large number of throats which have been affected at some time with scarlet fever, such clefts, apart from cicatricial contraction, were rare.

Dr. HERBERT TILLEY was of opinion that the pharyngeal appearances were the result of ulceration, and most probably post-scarlatinal in origin. He had recently seen an almost identical case in a lady who had consulted him for deafness, which was also post-scarlatinal in origin.

Mr. BABER had no doubt that it was due to previous ulceration in the throat.

Dr. DUNDAS GRANT suggested that a drawing should be made, because the case presented its features in a remarkably striking way. It seemed to him that the congenital condition was represented on the right side of the throat, but on the left side that there had been an abscess contemporaneously with the acute suppurative otitis due to scarlet fever, which she had as a child. He had seen in the fever hospitals several cases among children where such a condition existed as that on the tonsil of the left side produced by scarlatinal peritonsillar abscess.

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Dr. Davis said the patient had always had some impediment of the speech and a periodical sore throat; one such "had lasted for ten years about fifteen years ago." What she complained of was tinnitus and internal and middle-ear deafness. He would try and get a drawing.

Case of Enlarged Thyroid cured by Iodide of Potassium.

Shown by Dr. Davis. This young woman came under my care last June, at the London Throat Hospital, with a large pulsating asymmetrical swelling of the thyroid, causing dyspnœa, stridor, and considerable functional derangement; a very rapid pulse but only slight proptosis were present. The "tumour had been growing for eight years, but had suddenly grown rapidly, getting larger whenever she had a cold."

The patient asked for time to consider operation, which at that time seemed the only treatment. She was treated with five grains of Potass. Iod., five grains of Ferri et Ammon. Cit. in a mixture; and she was ordered to rub equal parts of Ung. Potass. Iod. and Ung. Hydrarg. Biniodidi into the neck every night. She also inhaled the vapour of iodine crystals in a saucer.

In six weeks the tumour disappeared, all other symptoms rapidly subsiding. The iodide treatment was left off four months ago, and the thyroid showed signs of swelling, which again vanished under the same treatment.

The girl, beyond being slightly anæmic, is now perfectly well.

Mr. Spencer said he should not use the word "cure," although good results, as in this case, did very often follow treatment by iodide of potassium and thyroid tabloids; but recurrence happened sooner or later, and surgery ultimately had to be relied on for the treatment of the masses containing cysts, etc. The tumours had a tendency to subside and come back, especially in young patients, such as that of Dr. Davis.

Dr. Davis said he did not literally mean "cure," which perhaps was not quite correct. All symptoms had disappeared under iodide, then recurred; and under a further course of iodide and ointment (biniodide) had again disappeared. The patient was now under no treatment. There was a small cystic swelling on the right side, which was hardly noticeable. When he first saw the patient, in June, the goitre was a very large one.

Dr. StClair Thomson said that in decided thyroid tumours medicinal treatment was of little use. He had lately had the opportunity of discussing the subject with Professor Kocher, of Berne,

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whose experience in the question was unsurpassed, and who said that patients must make up their minds between putting up with the inconvenience of the growth or submit to the knife. He preferred cocaine as an anæsthetic.

Dr. FitzGerald Powell said in his experience medicinal treatment by iodides and iron was certainly of great use. He had had a number of cases of cystic goitre in which the cysts had been reduced, but this was not always the case, and then operation became necessary. The iron was largely answerable for the improvement in some of the cases, especially those occurring in young women with menstrual disorders and anæmia.

Dr. Bennett supported the last speaker. He believed that permanent benefit frequently followed the use of iodides. One case especially occurred to him, in which the patient consulted a leading London specialist, who advised operation. The patient afterwards desired to try medical treatment first, and he had given iodides with excellent result. The patient had remained free from the trouble now for several years.

Dr. Ball said that formerly he was in the habit of treating those cases with iodides internally and iodine preparations externally, and that he often got apparent cures. For the last seven or eight years he had completely abstained from employing any special treatment, and he had got precisely the same results. Some cases improved spontaneously, as they did formerly under iodide treatment. He had absolutely no belief in the efficacy of any specific medicinal treatment of goitre.

Dr. Donelan remarked that medicinal treatment produced no permanent benefit. It caused a contraction of the gland, which might be compared to the effect of the injections which were formerly so much in vogue. The gland diminished, and remained small for a considerable time, and treatment was abandoned; but later the growth increased more rapidly than previously. These cases, in his opinion, did as well without as with medicinal treatment; the severe cases all eventually came into the hands of the operating surgeon.

Sir Felix Semon called to mind that Sir Morell Mackenzie once told him that he had injected iodine in the case of a patient who had previously asked him if there was any danger in it. Sir Morell Mackenzie, speaking from the experience of hundreds of cases, had replied decidedly in the negative. The patient thereupon consented, but died five minutes after the injection in the consulting room. Speaking from twenty-five years' experience, he could say that he had cured a good many cases permanently by iodide.

Dr. Scanes Spicer wished to emphasise the view that many of these thyroid enlargements were inflammatory in origin, being attended with local pain, tenderness, and rise in temperature. Such symptoms soon disappeared on rubbing in some mild preparation of iodine, even if they were accompanied by some of the signs of Graves's disease, such as tachycardia, palpitation, and exophthalmos. He had no doubt they sometimes went away by themselves, as Dr. Ball had observed.

Sir Felix Semon wished to define his previous statement a little

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more accurately. His experience was that soft and absolutely parenchymatous goitres, especially when occurring in young girls, were favourable for the iodide treatment. With iodine and iodide of potassium—internally and externally—in the form of ointment and mixtures he had effected a good many cures. In cases where cysts or fibroid elements developed, the medicinal treatment, needless to say, was not nearly so successful. In the case under discussion he could not see any inflammatory action whatever.

Dr. BRONNER said many cases which had resisted iodide of potassium were controlled by tabloids of iodothyrin.

Dr. WATSON WILLIAMS mentioned a case of goitre which had been cured many years previously by purely medicinal treatment at the hands of Sir Felix Semon. There was now not a vestige of the tumour.

The PRESIDENT referred to the injection of iodine. At one time he had used it extensively, but entirely abandoned it, owing to the death of a well-developed young guardsman, who died within a minute of the injection.

A CASE OF SWELLING OF LEFT CHEEK AND EYELID.

Shown by Dr. DAVIS. For two years this patient, a female æt. 23, has had a puffiness of the left lower eyelid, with swelling over the root of the nose and left upper jaw. On the supposition that she had antral disease the antrum was opened through the socket of an extracted molar. She wore a plug, and was under treatment for nine months. No disease was found, and nothing in the nose—beyond some slight enlargement of the middle turbinals—can be found to account for the disease. The nasal duct is free. The swelling is worse in the morning and late at night, but varies in the course of the day, and it appears to me to be lymphatic in nature. Her condition is unaltered by treatment. There is no albumen in the urine, and the general health is good. It may be a case of angioneurotic œdema.

Dr. BRONNER said these cases were fairly common, but seen more by ophthalmic surgeons. They always occurred in young women. Their nature was unknown, and they were generally unilateral.

Dr. SCANES SPICER had seen the condition associated with ethmoidal cell suppuration.

Dr. WATSON WILLIAMS regarded it as a case of recurrent erysipelas. It occurred in fairly definite attacks at the outset, followed by periods of quiescence, and leaving more and more persistent thickening. He

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had had two or three cases, but did not know what to do for their treatment.

Mr. de Santi had shown a case to the Society in a similar condition, except that it was more extensive; it resembled the description given by Dr. Watson Williams. His case was apparently due to a mosquito bite. He considered the condition was one of lymphatic œdema, and probably due to the specific cocci of cutaneous erysipelas.

Dr. Davis said the swelling had gradually increased eight years, and had then suddenly grown more rapidly. After taking iodide internally, and Ung. Pot. Iod. and Ung. Hyd. Biniod. externally, for about a month, it began to disappear rapidly.

Recurrent Angiofibroma involving Ventricular Bands and Vocal Cords.

Shown by Dr. Furniss Potter. The patient, a man æt. 42, came under observation in the summer of 1899, complaining of hoarseness, which had come on gradually. On laryngoscopic examination the anterior third of the glottic space was seen to be filled, and the anterior thirds of both cords were obscured by (what appeared to be) a trilobed tumour, which on further examination with probe, and on subsequent removal, was found to consist of two parts, one attached to the left ventricular band —on microscopic examination reported as simple papilloma,—the other attached chiefly to the right ventricular band, and involving also the right vocal cord, the upper surface of which presented a ragged, torn-looking surface.*

The case has been under constant observation, and has continued to recur, notwithstanding that several removals have from time to time been effected with snare and forceps whenever the growth has become sufficiently protruding to be seized with instruments.

The surface now involved is more extensive than when first seen, the anterior commissure and left ventricular band and cord (?) being considerably affected.

During the last few months the patient states that he has had several attacks of hæmorrhage, on which occasions he has coughed up about a teaspoonful of blood. He suffers from much vocal disability, which seriously interferes with his occu-

* A section of this was exhibited at this Society November, 1899, and was reported on by the Morbid Growths Committee as angiofibroma.

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pation—a builder's foreman,—which necessitates much use of the voice.

He would be glad to have any suggestions for further treatment other than what had been pursued.

The PRESIDENT would call this case by another and more grave name, *i. e.* malignant disease of the larynx.

Dr. CLIFFORD BEALE commented on the free movement of the cords in the case, and asked how far one was justified in ignoring the rule that cancerous growths of the larynx usually produced impaired movements. The appearance of the growth itself certainly suggested malignant disease.

Sir FELIX SEMON said he had defined his position with regard to the question of mobility of the affected vocal cord in malignant disease of the larynx so often and so precisely before, that he was sorry there could still be any doubt on that point. It depended entirely on the depth of the infiltration whether or not there was any impairment of movement. If the disease was somewhat superficial there might be free movement, even though the affection be already rather extensive; whilst, on the other hand, in a case of deep infiltration there might already be defective movement, though the actual outgrowth was still small. The question, therefore, stood thus: the absence of defective movement was no counterproof to the existence of malignant disease, whilst its presence in cases where it was doubtful whether a growth was innocent or malignant was a valuable aid to diagnosis.

Mr. WAGGETT said Dr. Potter asked him to get the opinion of the Society whether it was desirable to do a thyrotomy, in order to see what the condition really was.

Mr. SCANES SPICER inquired if the patient had had a course of iodide of potassium.

Mr. DE SANTI said the sooner thyrotomy was done the better. He advised an exploratory thyrotomy.

RECURRING NASAL POLYPI.

Shown by Mr. DE SANTI. A girl, æt. 18, suffering from persistently recurring nasal polypi. She had been under constant treatment at various hospitals for four and a half years before coming under his care at the Westminster. The polypi had been removed innumerable times by means of the snare.

He found large masses of toughish polypi in both nostrils, occupying the whole of the cavities; there was marked "frog face;" microscopically they consisted of mucous and fibrous

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tissue. He took the patient into hospital, and under a general anæsthetic turned up the nose by dividing the reflection of the mucous membrane of the lower lip and gums, and thus got at the polypi; these were removed with the aid of suitable forceps and curetting. The patient remained free from the growths for some six to seven months; they then recurred, and subsequently another free removal under an anæsthetic was carried out: there was immunity from the growths for eight months. Now the patient is again in much the same condition as before. From the general appearance of the polypi and the free suppuration going on, Mr. de Santi considered there was accessory sinus suppuration. In connection with the last meeting of the Society, when the treatment of nasal polypi was under consideration, he brought the case forward as showing the results of the different methods of treatment and their failure. He was anxious to know if Dr. Lack's method of operation would be generally recommended, though one of Mr. de Santi's two operations consisted, in his opinion, in very much the same technique as Dr. Lack's.

Dr. HERBERT TILLEY had no doubt but that the case was one of chronic suppurative inflammation of the accessory sinuses. He had proved this as regards the frontal sinus, because the withdrawal of a probe passed into it was followed by a free flow of pus. Unless these accessory cavities were efficiently dealt with the polypi would continue to recur as they had done formerly. The breadth of the upper portion of the patient's nose was very suggestive of chronic ethmoiditis.

Mr. DE SANTI asked Dr. Tilley if he was of opinion that the nasal polypi were secondary to frontal sinus suppuration in his case.

Dr. TILLEY said emphatically that this was his view.

GROWTH OF RIGHT CORD IN A MAN ÆT. 35. (PATIENT AND SPECIMEN.)

Shown by Dr. W. H. KELSON. Patient was shown at the end of last summer session, and, as there was some difference of opinion about the case, the President had requested that it be shown again, but as the patient is a teacher the growth was removed from the right vocal cord in August. The microscope showed it to be a papilloma.

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Dr. FitzGerald Powell remembered having seen this case when it was shown to the Society at a previous meeting. There still appeared to be a small portion of growth remaining below the anterior commissure which might have to be removed.

Dr. Kelson thought there might be a small papilloma below the cord on the right side. The patient had recovered his voice, and had passed an examination in singing, and so he thought it better to leave it alone at present.

Lupus of the Pharynx.

Shown by Mr. R. G. Johnson for Mr. Richard Lake. This patient states she has suffered from "ulcerated sore throat" with dysphagia since November, 1899. There is no history of phthisis or of syphilis, congenital or acquired.

In April, 1900, the tonsils were removed, immediately after which her voice became affected.

At the present time there are well-marked signs of phthisis at the left apex.

On examination the whole of the uvula, both posterior pillars of the fauces, the left tonsil, a small part of the soft palate to the left of the uvula, the surface of the lingual tonsil, what remains of the epiglottis, the ary-epiglottidean folds, with the arytænoids and ventricular bands, are seen to be involved in a lupoid process, which is, however, in a fairly stationary condition.

Dr. Davis had seen the case in the Middlesex Hospital; a piece was removed from the tonsil, examined, and pronounced to be lupus.

Case of Bilateral Abductor Paralysis.

Shown by Dr. J. B. Ball. A young man, æt. 24, admitted recently to the West London Hospital for a hæmatocele of the testicle. Surgical interference being considered desirable, ether was administered. While under ether, and before the operation was begun, his breathing stopped, and he became cyanosed. Artificial respiration was performed, and air began to enter with loud stridor. Artificial respiration was kept up for about ten minutes, but the stridulous breathing continued for three quar-

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ters of an hour. The next day Dr. Ball was asked to examine the larynx. The condition present is that of bilateral abductor paralysis. It is not quite typical, however. There is some obliquity of the line of the glottis, and some asymmetry of the cords. The history points to the condition having existed for a very long period, if, indeed, it was not congenital. The patient states that, as long as he can remember, his breathing is noisy and difficult on the least exertion. His mother states that as an infant his breathing was always troublesome and frequently crowing in character, and that when he was born he was not expected to live owing to his difficult breathing. The knee-jerks are present, and there is no sign of disease in the chest. Patient has not had syphilis.

Mr. SPENCER said it was a very curious-looking larynx. One cord was completely paralysed. The left cord, however, retained a good deal of movement. It might be congenital or syphilitic in origin. The question was, what would happen to the boy? Was it safe to allow it to go on as it was? There was not much room there, and with a little inflammation he might soon get into a dangerous condition.

Dr. WATSON WILLIAMS thought the right vocal cord appeared quite fixed, and there was certainly movement of the left cord. He suggested that some old inflammatory mischief caused fixation of the right cord, and that the present condition of the left, viz. abductor paralysis, was due to some more recently developed affection. The increased pulse rate, 96 a minute, suggested the existence of a bulbar lesion.

Sir FELIX SEMON said he had laid it down many years ago as a rule that in every case of bilateral abductor paralysis, if medical or surgical treatment did not succeed in actually restoring the activity of the abductors, it was the duty of the laryngologist to perform tracheotomy as a prophylactic measure, and rid the patient of the risk of suffocation. Since then, however, he had seen several cases in which fairly severe bilateral abductor paralysis had existed for many years with impunity. He reminded the Society that he himself had shown to it two such cases a few years ago, one of which he had already shown on the occasion of the International Medical Congress of 1881, *i. e.* fully twelve years before his last demonstration. This had made him somewhat doubtful as to whether his previous dogmatism was justified; although, on the other hand, several cases had been recorded in which the non-observance of his rule had led to sudden death by asphyxia. His course now was to tell patients plainly how matters stood, and leave them to decide. Certainly it did not increase the amenities of life to go about for years with a tracheotomy tube. On the other hand, an attack of simple laryngeal catarrh

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might put the life of the patient in danger at any time, as actually happened in the case from which he had deducted his rule.

Dr. WATSON WILLIAMS mentioned a case *apropos* of Sir Felix Semon's remarks. The patient was brought to the Royal Infirmary at Bristol, and had marked inspiratory dyspnœa with stridor. On examining the larynx he found well-marked bilateral abductor paralysis. No reason for it could be discovered. Bearing in mind the dictum laid down by Sir Felix Semon, he was tracheotomised. He was able to breathe very comfortably, and in the course of a fortnight, owing to the left thyro-arytænoideus internus having become paralysed, he was able to do without the tube.

Dr. BRONNER recommended the use of large intubation tubes in cases of abductor paralysis with difficulty in breathing. The tube should be worn for a few hours daily, or constantly if possible, for a few weeks; this in many cases permanently relieved the dyspnœa.

The PRESIDENT: It was a very difficult question to decide what should be done. There was a well-known member of Parliament some ten or eleven years ago, with more or less mechanical fixation of the cords; adduction was good, but abduction very incomplete. He was able to speak in the House. The condition dating from small-pox had existed upwards of thirty years. He caught a slight cold, and died from laryngitis. Probably if something had been done his life would have been spared.

SPECIMEN OF CYST. ? DERMOID.

Shown by Dr. FITZGERALD POWELL. The specimen shown was removed from the floor of the mouth of a girl æt. 16 years. The swelling which it caused was first noticed thirteen months ago, and had been gradually increasing in size.

When first seen I found, on examination, a considerable rounded swelling, extending from below the symphysis to just above the hyoid bone; it was moveable, soft, and fluctuating, and on looking into the mouth it was seen to push the floor upwards, and could be felt well back under the tongue; it had somewhat the appearance of a ranula, but was more regular in shape, and occupied both sides of the frænum linguæ.

I removed the cyst by a median incision through the skin, extending from just below the symphysis to just above the hyoid. The superficial structures were carefully divided, bleeding points secured, when the white glistening cyst wall was exposed, and by sweeping the finger round the growth it was easily enucleated and brought out. The wound healed by first intention, and little scar was left.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

SIXTY-THIRD ORDINARY MEETING, *February* 1*st*, 1901.

E. CRESSWELL BABER, M.B., President, in the Chair.

ERNEST WAGGETT, M B.,
CHARLES A. PARKER, F.R.C.S.(Ed.), } Secretaries.

Present—28 members and 4 visitors.

The minutes of the preceding meeting were read and confirmed.

The ballot was taken for the following gentlemen, who were elected members of the Society:

Eugene Steven Yonge, M.D., C.M.(Edin.), 3, St. Peter's Square, Manchester.
Arthur Ainslie Hudson, M.A., F.R.C.S.(Edin.), 3, Ellerdale Road, Hampstead, N.W.

It was proposed by the PRESIDENT, seconded by Sir FELIX SEMON, and carried unanimously, that the following be sent to the King's Most Excellent Majesty:

"The members of the Laryngological Society beg to offer to your Majesty their expression of sincere sympathy in the great sorrow that has befallen the Royal Family and the Empire, and to submit to your Gracious Majesty their respectful congratulations and allegiance upon your accession to the Throne."

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The following cases and specimens were shown:

A Case of Nasal Polypi with marked Deformity.

Shown by Dr. Donelan. The patient, a waiter æt. 23, had noticed increasing nasal obstruction since about 1892, which became complete in 1896, causing great spreading of nasal bones and the same marked deformity as now existed. A large number of polypi were then removed with the snare, but recurrence gradually took place.

In December, 1900, he came to the Italian Hospital, Queen Square, with complete obstruction due to the nose and post-nasal space being crowded with polypi.

The patient underwent a preliminary clearance of polypi, and the middle turbinals were removed, any polypi that escaped being subsequently snared, and finally, on January 9th, the nares and ethmoidal sinuses were thoroughly curetted. It was, however, to be feared that recurrence was again about to take place. Dr. Donelan requested the advice of members as to further measures.

The President said it was a case in which the polypi had come back after an operation of a radical nature had been done. It seemed to him that, before any further operation was undertaken on the ethmoid, the condition of the large sinuses ought to be investigated.

Dr. Herbert Tilley agreed with the President that the intra-nasal appearances afforded strong evidence of primary accessory sinus disease. He asked if the antra had been transilluminated.

Dr. Wm. Hill said a very interesting point was the cause of the enlargement of the maxillary bones, the nasal processes of which were enormously prominent and thickened. If polypi were really a sign of bone disease, one could understand disease extending in these advanced cases to other bones of the nose besides the ethmoids. Great enlargement of the "uncinate body," so evident in this case, was diagnostic of sinus disease, more especially of the antrum.

Dr. Dundas Grant said it was an interesting question as to how much deformity might be produced by a benign growth. Deformity of the face was classed among the signs of malignancy; the deformity in the case under discussion was frequently produced without there being anything of a malignant nature.

Dr. FitzGerald Powell said this was an exaggeration of a condition not infrequently seen as the result of the expanding pressure of polypi, accompanied by rarefying osteitis. The best results would be obtained by free curetting with a ring-knife, which would relieve the tension, remove diseased bones, and check suppuration. At the

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same time attention should be directed to the maxillary sinuses, which should be drained if necessary.

Dr. BRONNER said that in the provinces cases of very great deformity frequently occurred. It generally disappeared even in adults in the course of a year or two after the removal of the polypi.

The PRESIDENT had seen these cases of deformity, and considered them due to dilatation from the pressure of the growths. He had not, like Dr. Bronner, seen the deformity disappear.

Dr. VINRACE wished to know whether Dr. Donelan attributed the deformity to anything except obstruction and the long time during which the condition had existed.

Dr. STCLAIR THOMSON supported Dr. Bronner in his remarks. Within the last three weeks he had had under his care a case in which marked deformity was present. He had operated on one side of the nose, and more or less completely cleared it of polypi, and left the other alone. In the former the condition subsided, and in the latter it remained unaltered. In his (Dr. Thomson's) case the nose was so distended that there was a separation between the nasal bone and the nasal process of the superior maxilla on each side. The difference between the two sides was remarkable even after a few days.

Dr. DONELAN thought from the first that the ethmoidal sinuses were certainly affected, and after the first curetting it became obvious that they were so on both sides. The left antrum was also affected, but he did not think the frontal sinuses were. The deformity was due, he thought, to the pressure of the mass of the growth. It was four years since the nose was completely cleared, and, as far as the patient could tell, there was no improvement in the deformity; there certainly was not any since it was cleared before Christmas last.

A FATAL CASE OF EXOPHTHALMIC GOITRE.

Shown by Dr. DONELAN. The patient, an Italian girl æt. 16, was admitted into hospital on December 20th, 1900. There was no family history of goitre, and no history of any previous illness of importance. In September, 1899, the history begins with symptoms of palpitation, oppression, and dyspepsia, which were relieved by treatment and never caused much inconvenience. In September, 1900, during her father's absence she lived with some relatives who treated her cruelly, and on one occasion seized her by the throat and nearly strangled her. She had noticed no previous enlargement of the throat, but from that time the growth of the thyroid was rapid and continuous.

She first attended the hospital on December 14th, 1900, when she complained of the ordinary symptoms of exophthalmic goitre.

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There was considerable thyroid enlargement, the neck measuring fifteen inches, moderate exophthalmos, a rapid pulse (140), and a mitral systolic murmur without apparent loss of compensation. She was advised to rest and to take a mixture containing ten minims Tr. Belladonnæ and five minims Tr. Digitalis. She rapidly became worse, and was therefore admitted into the hospital on December 20th. She had tremors affecting the head, neck, and thumbs, violent cramps of limbs and body lasting five to seven minutes, vertigo with a tendency to fall to the left, marked retinal pulsation, and traces of optic neuritis.

Von Graefe's sign was present, but Stellwag's absent. The pulse rate gradually increased from 140 to 160; nervous vomiting became persistent on the fourth day; finally she became comatose, and when with difficulty roused she complained of intense headache. She died, apparently of heart failure, on the sixth morning after admission.

The treatment consisted of belladonna and digitalis as before until vomiting became persistent. Citrate of potassium as recommended by Dreschfeld failed to check this, and rectal feeding was carried out, and ice applied to head and spine.

Extract from report of post-mortem made by Dr. Pareira:—
"Brain intensely congested. Cerebellum very large and congested. Pineal gland much enlarged. Careful sections failed to show any other abnormality in these organs or in the medulla. Cervical sympathetic atrophied, thoracic normal. Thyroid gland much enlarged. Trachea much compressed though dyspnœa had not been present. A few small cysts in thyroid. Thymus gland persistent and much enlarged. Stomach atrophied. Uterus ill-developed and infantile. No corpora lutea in ovaries."

Dr. Donelan did not consider this disease was due to the fright caused by the assault, though doubtless the symptoms were thereby accelerated. There were evidently symptoms a year before, pointing to the commencement of the condition which, when thoroughly established, is called exophthalmic goitre. Without reviewing the various theories that had been put forward to account for this group of symptoms, the exhibitor desired to call attention to an important pathological feature, namely, the persistence and enlargement of the thymus gland. This persistence is found in practically every fatal case in

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which it is carefully looked for, and enlargements may also occur as in the present instance. He would not presume to add another to the existing theories, but he thought the pathology of the disease had to be sought for in an earlier period of life. The thymus gland is a fœtal structure disappearing normally *pari passu* with the development of the thyroid. Its persistence is obviously evidence of an abnormal condition occurring in infant, if not in uterine, life. Evidence should be collected with a view to showing whether the failure of the thymus to undergo the normal retrogression reacts on the thyroid gland and nervous system through the medium of the blood in such a way as ultimately to produce these well-known symptoms.

Sir FELIX SEMON said it was new to him to learn that in cases of exophthalmic goitre one almost regularly found an enlarged thymus. He would like to ask Dr. Donelan to give more information on that interesting point.

Dr. DONELAN said, in reply, that he had just lately looked up the literature of the subject, and, as far as he was able to ascertain, it was generally mentioned that the thymus gland was persistent in the majority of cases. Some authors, amongst whom might be mentioned Osler, said it could be found in *all* cases if carefully looked for. Up to the present no pathological changes had been described as occurring in the gland. He thought the association of the enlarged thymus with subsequent increase in the thyroid was a point to be noted for further investigation. It might have something to do with the real cause of the disease. The thymus in this case was, he believed, unusually large.

SPECIMEN OF MUCOUS PATCH ON THE TONSIL.

Shown by Dr. WYATT WINGRAVE. The section conforms to the classical descriptions of histological details, in that the stratified surface epithelium is considerably thickened, and exhibits all stages of necrosis, from simple cloudy swelling to complete vacuolation and disintegration. The nuclei are broken up into granules, while the protoplasm remains clear and liquefied, but the invading leucocytes are few and multinucleated.

The subjacent structures exhibit but slight activity beyond distension of the lymph spaces and multiplication of the mononucleated lymphocytes.

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Cutting Trephine for operating on Spurs and Deviations of the Nasal Septum.

Shown by Dr. Bronner. This trephine was used in conjunction with Spiesz's nasal speculum. The short blade of the speculum was placed in front of the spur, and the long blade over the lower turbinated bone. The trephine was worked by an electro-motor. The operation could be performed with cocaine or eucaine, and was practically painless. Spurs and deviations of the nasal septum were very common, and caused nasal obstruction, preventing the passage of the Eustachian catheter. The lumen of the trephine was about the same size as that of the largest intubation tube. Messrs. Down and Co. were the makers of the trephine.

The President thought Dr. Bronner's trephine was about the best form of such instruments to use, especially with the speculum shown, and the Society was indebted to the exhibitor for bringing it forward. Personally he always preferred a saw, and used a straight and not an angular one, because the latter "locked" so easily. After anæsthetising locally, a line was marked with the galvanic cautery where the sawing was to take place. This diminished the hæmorrhage, especially if a solution of supra-renal capsule were also used. He did not think that, theoretically, a circular trephine was the best instrument to remove a spur from a flat surface like the septum, although in practice it might answer perfectly.

Dr. StClair Thomson wished to elicit the opinion of members who had tried both the trephine and the saw. He himself had no experience of the trephine, but he had heard complaints of it "jamming," and of its liability to stop suddenly. Would those members who had tried both say whether they were in favour of the trephine?

Dr. William Hill had used the nasal trephine, with and without serrated edges, a great deal in times gone by. It, unfortunately, did not leave a really level surface, even when several pieces were removed. He therefore generally used a saw now, but he often felt that if he had a dental engine or motor ready at hand he would use a trephine, on account of its being more expeditious and less painful than the saw.

Dr. Herbert Tilley pointed out how very efficiently a nasal spur may be removed if a deep groove be first made with an intra-nasal saw, and the "spokeshave" then applied behind the groove and rapidly withdrawn. The cutting edge keeps accurately in the groove already made, and a flat surface is left upon the septum. This

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method can be used for bony and cartilaginous spurs, but in the first case a deeper groove should be made with the saw. In a fairly tolerant patient the operation could be performed with cocaine alone.

Dr. BRONNER, in reply, said in using the trephine the "jamming" was not so great as with the saw if a sufficiently powerful motor were used. It was practically painless with cocaine or eucaine, and the quicker the instrument rotated, the less was the pain caused. In treating a deviated septum it was often necessary to apply the trephine twice, in order to remove a sufficiently large piece of cartilage. The cartilage in these cases was generally very thick.

CONGENITAL SYMMETRICAL GAPS IN BOTH ANTERIOR PILLARS OF THE FAUCES, WITH COMPLETE ABSENCE OF TONSILS.

Shown by Sir FELIX SEMON. The patient was a girl æt. 11, who was seen by the reporter on September 28th, 1881. There was a tubercular family history, and the patient herself was very strumous-looking. She was brought to the hospital on account of naso-pharyngeal catarrh.

On examination of the throat two large ovoid gaps were seen to extend almost through the entire length of the anterior pillars of the fauces. They were perfectly symmetrical, and their edges were absolutely soft. Nowhere in the throat was there any evidence of scarring. A probe introduced through either of these gaps entered into the niche reserved for the tonsils. There was, however, not the least trace to be seen of any tonsillar tissue in these receptacles on either side. Neither mother nor child knew anything of the existence of the abnormality.

His reasons for considering the defect in the light of a congenital arrest of development were not merely the absolute symmetry of the gaps, and the absence of all scarring as well as of any history of ulcerative disease, but particularly the complete absence of the tonsils.

On looking through the literature at his disposal he has found that in three out of about twenty cases of an analogous kind, noted in the 'Internationales Centralblatt für Laryngologie' since 1884, a similar absence of the tonsils was expressly reported.

This fact seemed to him very striking, and considerably added

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to the view that these gaps must be regarded as a result of arrested development, a view in which most of the observers who had seen similar cases agreed. Possibly they may represent the inner openings of incomplete branchiogenous clefts, a possibility which Chiari suggested when describing a case of this sort in 1884 ('Monatsschrift für Ohrenheilkunde,' August, 1884), although he then admitted, as the reporter does now, that a fully satisfactory explanation cannot yet be given. (The reporter is indebted for the drawing accompanying this description to Mr. E. Waggett, who has very kindly drawn it on an enlarged scale from a sketch made at the time.)

The PRESIDENT said it looked undoubtedly like a case of malformation.

Dr. STCLAIR THOMSON said that in calling the case "congenital," Sir Felix Semon had anticipated the decision of the question. In his opinion it was a doubtful point, and until a similar condition was detected in early infancy the question would remain open. It was new to him to hear of the absence of tonsils in this condition, and he briefly narrated the particulars of symmetrical gaps in a woman in whom the tonsils were still remaining. Since the last meeting he had seen two cases; one was bilateral and symmetrical, and had some slight scarring on the pharynx, though there was no previous history pointing to ulceration. The other case occurred in a medical man, who was willing to come to the Society. He had a gap on one side only, which had existed as long as he could remember. He has never had scarlet fever or syphilis.

CASE OF SEROUS CYST OF INFERIOR TURBINATED AND FLOOR OF THE NOSE.

Shown by Dr. H. J. DAVIS. This patient, a woman æt. 25, has suffered from graduallv increasing nasal obstruction for some years. Ten days ago, when she came to the Middlesex Hospital, there appeared to be a marked hypertrophy of the anterior end of the right inferior turbinate, the floor of the nose being involved in the swelling, which was as large as a pigeon's egg, and was firm and resistent to the probe.

The tissues did not shrink under cocaine, and the swelling being mistaken for a growth an attempt was made to remove a piece for examination, which failed. An aural paracentesis

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knife was then passed into the upper part of the swelling; a jet of greenish clear fluid spurted out of the nostril, and the swelling rapidly and entirely collapsed.

The cyst is slowly refilling, and can be seen as a fluctuating projection in the floor of the nostril. The patient has had no further treatment beyond the primary puncture.

Dr. MacBride thought the case must have been of great interest before the cyst was evacuated. He believed himself to have been the first to describe this form of cyst a number of years ago. To him the special point of interest was the origin of such cysts; it was difficult to imagine where they could originate. Had Dr. Davis formed any theory as to the causation? He might mention that Dr. Brown-Kelly, of Glasgow, had found glands with very long canals in this region of the nose, which he thinks may explain the occurrence of cysts. One of his (the speaker's) earlier cases kept on refilling, and had to be dissected out by raising the upper lip.

Dr. Davis, in reply, said he had considered the origin to be due probably to retention of secretions in one of the glands—a retention cyst, in fact. In this case the cyst was much more prominent two days ago, but the woman had had some sanious discharge from the nose that day, and it had again collapsed. If one looked carefully, one saw that the under surface of the inferior turbinate had been expanded, and the cyst was evidently of considerable depth beneath that bone.

Case of Mucocele of the Frontal Sinuses.

Shown by Dr. Lambert Lack. This boy has already been shown at the Ophthalmological Society before operation. There is marked divergence of the eyes, and the bridge of the nose is widely distended, especially on the left side. When he first saw the case the mass of the growth seemed bony, but there was a fluctuating area at the upper and inner corner of both orbits. The history was four years' duration with steady increase. The diagnosis—mucocele of the frontal sinuses with dislocation downwards and outwards of both lachrymal bones—was confirmed by operation. The left frontal sinus was enormously distended, its anterior bony wall being practically absorbed, its cavity extending backwards and inwards behind the right frontal sinus, and downwards in the direction of the infundibulum. The mucoid contents were evacuated, and a large opening made through into the nose and maintained by a

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plug which is still worn. This sinus is now secreting pus, but is becoming more dry, and as the opening into the nose is probably permanent it may be possible to shortly close the external wound. The right sinus was smaller, and an attempt was made to obliterate it without making a communication with the nose, but it has not yet healed. The infundibulum on the left side was probably first obstructed, and the right infundibulum obliterated by the pressure of the expanding left sinus. These cases are rare, and I should be glad to receive any suggestions to hasten the cure.

Dr. HERBERT TILLEY thought, considering the long duration of the treatment, and the nature of the operation already performed, that nothing short of a further radical operation offered any prospect of cure. He therefore suggested that, as the patient was a growing lad, and as much of the present deformity would be permanent, a more extensive removal of bone was indicated.

Dr. MACBRIDE asked Dr. Tilley to explain exactly how he proposed to proceed. The left frontal sinus was of very great depth. This case was just one of those where the frontal sinus was so deep that it seemed to him that the method proposed by Dr. Tilley practically amounted to performing Kuhnt's operation, but then the upper wall of the orbit would have to be removed; if the soft parts were allowed to fall in on the sinus, there would still be a considerable space which could not be filled up or covered. He thought there must be a cavity left owing to the depth of the sinus. He had operated on a good many frontal sinuses, and he found those described in the text-books were perfectly easy to deal with; but in a large proportion of cases one had cavities containing pus behind the orbit, and one could not let the soft parts fall in in such cases.

In answer to Dr. MacBride, Dr. TILLEY said he would propose a horizontal incision over the lower central part of the forehead, which should join the incisions already present and partially healed. The soft tissue covering the lower part of the forehead could then be drawn upwards, and a complete removal of the anterior bony walls of both sinuses carried out. The septum could simultaneously be removed, and so allow the soft parts to fall on to the posterior walls of the sinuses, and bring about their obliteration. The receding angle between the roof of the orbit and the lower part of the posterior wall would, he thought, fill up with granulation tissue, which would eventually organise; and even if a small cavity eventually remained in this position, it would probably be harmless if free drainage into the nose was secured. In such a growing lad the deformity, he thought, would not be greater than at present, and it was obvious that something must be done to ameliorate the present condition of things.

The PRESIDENT said that it seemed to him that the only way of obliterating the sinus was by Kuhnt's operation, which consisted in the removal of the whole of the anterior wall except about an

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eighth of an inch along the supra-orbital ridge. The periosteum and skin should be carefully stitched down, a rubber tube, projecting at the inner angle, being kept in the wound. Granulation tissue would form and obliterate the sinus. This must leave a certain amount of depression. The case he had done and shown to the Society was satisfactory as far as the result was concerned. The case was one of a large mucocele, and if the same procedure were carried out in the case under discussion he thought the patient would get equally well.

Dr. VINRACE inquired what were the urgent symptoms demanding operation, and suggested it might have been better to leave the case longer before proceeding to such grave surgical measures.

Case of Persistently Recurring Nasal Polypus with Suppuration in Frontal and Ethmoidal Sinuses; Operation; Result.

Shown by Dr. LAMBERT LACK. This patient is shown as a contrast to the case exhibited by Mr. de Santi at the last meeting of the Society, which I take it was intended as a direct challenge to me. The two cases are very similar. This patient had had polypi for many years, commencing when she was about fifteen, accompanied by profuse sinus suppuration, and for three years had had them removed as often as every fortnight, but in all that time had been unable to breathe through her nose. Two years ago when I first saw the patient I scraped out the nose under gas. The operation had to be done as an out-patient, and therefore was not so thorough as I could have wished, but in spite of this the patient has had free nasal respiration ever since. On three occasions small pieces have subsequently been removed with a snare, but now for more than two years there has been no return of the polypi. After the operation the discharge from the nose also greatly lessened, but did not completely cease until the frontal sinuses had been obliterated. This operation, which I always recommend where practicable, as I believe it to be the only sure curative measure, entails the complete removal of both the anterior and inferior walls of the sinus, but in spite of this the deformity may be scarcely noticeable, as this case shows. My experience of this operation makes me think that a deformity such as occurred in the case Dr. Tilley showed at the last meeting is quite exceptional.

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Dr. StClair Thomson thought the case showed the necessity for care in specifying beforehand the amount of relief we might secure, and how we should be slow to claim a complete cure in these cases. There was a distinct fœtid odour from the nose of this patient; although she had washed out her nose twice already that day there was pus in each middle meatus; and she informed him that although the operation had been done nearly two years ago, she still had to syringe her nose three times a day. Now both Dr. Tilley and he had shown completed cases of operation for frontal sinusitis at the last meeting, but candour compelled him to say that neither of them was then completely cured. In Dr. Tilley's case there was some pus in the middle meatus. His own patient had washed out his nose in the morning before coming to the meeting, and by 5 o'clock the secretion had not accumulated in such quantity as to be distinctly evident. This secretion could not possibly come from the frontal sinus, as he (Dr. Thomson) had seen that the fronto-nasal duct was quite obliterated before allowing the operation wound under the eyebrow to heal up. It must, therefore, have come from the ethmoidal cells, and these had, since last meeting, been well curetted; a slight crust of dried mucus still formed over them, but the patient did not require to syringe his nose more than once a week. In Dr. Lack's case there was distinct pus, though doubtless the patient's sufferings had been greatly relieved.

Dr. Herbert Tilley was surprised to hear (for the first time) that the case he showed at the last meeting was not a complete cure, and he ventured to think that Dr. Thomson had some other case in his mind. Dr. Lack had spoken of his case as a cure, and in spite of dissenting opinions the speaker was inclined to agree with him if the word was not too rigidly applied. In the case referred to, no pus came from the sinuses, but one or two ethmoidal cells were not clear from disease, and they would probably cause little trouble. This led to the question asked by one member, "When is a surgeon justified in advising an external radical operation upon a chronic frontal sinus empyema?" Dr. Tilley thought the answer mainly turned upon the patient's views on the subject, and cited a case under his care for the last two years of a young engineer, who was just beginning to get on in his profession. This patient had applied to him on account of nasal obstruction, purulent discharge, a chronic headache, and inability to concentrate his mind on his work. The nostrils were full of polypi, and pus flowed freely from both frontal sinuses. On irrigation by the right fronto-nasal canal the fluid returned from the left nostril, demonstrating a septal perforation allowing free communication between the sinuses. In due course all the polypi were removed, also the middle turbinals on both sides, and a quantity of the ethmoidal cells. The patient (who was seen six weeks ago) says he is "cured" because his headaches have gone, he feels quite well, the discharge has "practically ceased," and he only uses one handkerchief a day. Examination of the nasal cavities reveals a drop of pus at the lower end of each fronto-nasal canal, and the speaker thought that he was not justified in advising a radical operation under such circumstances, for the patient was really in very little danger,

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and not inconvenienced by his condition. The speaker thought that in such cases the nose should be merely cleansed once or twice daily, and nothing else done. Contrariwise, if the individual was of a nervous disposition, and could not tolerate the occasional appearance of a streak of pus from the nose, he then explained the nature of the operation, its chances of success, the possibility of a small scar, etc., and left the patient himself to settle which course he would pursue.

Sir FELIX SEMON said Dr. Tilley had raised a very grave and important question, which he was very glad had been brought forward. The question was, when ought one to perform a radical operation in these cases? Belonging to the seniors, he did not wish to be considered as opposing the progress of the times. It was a great achievement that they could diagnose these cases better, and so treat them more successfully than in the past by these big radical operations; but, on the other hand, he looked back over a period of twenty-five years, which had been devoted to special practice, and within that period he had seen plenty of these cases, and, so far as he knew, very few of them had come to grief prior to the discovery of these modern forms of treatment. No doubt there were a *few* cases in which threatening symptoms, such as severe headache, coma, meningeal troubles, and other complications, had arisen from a misunderstanding of their original cause, and from want of radical treatment; but how few were and are such cases! Looking at the question from another point of view, he asked whether a really complete and lasting cure could be promised in every one of these cases after a so-called radical operation? He had seen a good many of Dr. Tilley's cases, and most heartily congratulated him on the results, but he had also seen other cases—and he was not the only one who had—in which after the performance of a radical operation suppuration still continued; further operations had become necessary, and the patient finally was not much better off than before. This fact had been brought forward before in the Society. He was particularly anxious not to be thought incapable of seeing anything good in things new, but really, in his opinion, it was a matter deserving very great consideration as to whether the discovery of a little pus coming from the frontal sinus demanded radical operation in every case. He thought the surgeon was bound to tell the patient that the big operation occasionally left some deformity.

Dr. FITZGERALD POWELL had been much interested in this discussion, which to a certain extent had somewhat relieved his mind, as it appeared to him that the tendency of late was to rush to the performance of this rather serious operation as soon as pus was seen in the nose. He had at the present time a case in his hands, in which it had occurred to him that the radical operation should be done. The patient was a young woman who had suffered from all the signs of "frontal sinusitus" in a marked degree. He suggested to her the radical operation, also putting before her the possibility of deformity. As she was about to be married, she decided not to undergo the operation. At several sittings he removed as much as possible of the middle turbinate and freed the infundibulum, afterwards washing out the sinus. The patient was now perfectly free from pain and

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frontal headache. She used a nasal douche, and was quite comfortable. Every now and then a small quantity of pus appeared in the nose, which caused little or no inconvenience. This case fully illustrated the safety and propriety of leaving the radical operation alone.

Dr. DONELAN asked Dr. Lack what proportion of these cases underwent spontaneous cure. He had a case under his care about a year ago, in which a young man aged twenty-four had distinct suppuration of the right frontal sinus, and arrangements were made to operate. Before it could take place the discharge came away. He washed out the nose, and the patient had remained perfectly well since.

Dr. VINRACE wished to know how long would Dr. Lack wait, after freeing the nostrils from polypi, before proceeding to undertake one of these terrible operations.

Dr. LACK, in reply, said he thought Dr. Thomson a little hypercritical. He saw no reason for continuing treatment, as the patient was practically well and had ceased attending him for nearly a year. The indications for external operation on the frontal sinus were rather indefinite. He recommended operation whenever the disease caused symptoms producing serious inconvenience. When the only symptom was slight purulent discharge he thought the cases best left alone. He always in the first instance adopted intra-nasal methods to the extent of removing the middle turbinate, opening the anterior ethmoidal cells, etc., and thoroughly clearing the approach to the infundibulum, so as to allow the sinus to drain freely into the nose. If this failed to give relief he operated externally, and always endeavoured to obliterate the sinus, as he believed it the only certain method of obtaining a cure. Personally he did not believe in the possibility of making a definite diagnosis except by opening the sinus, and thought many of the cases cured by intra-nasal operations, such as opening up the anterior ethmoidal cells, were really cases of ethmoidal cell disease, but this was only an additional argument for carrying out thorough intra-nasal methods before adopting external operation.

PAPILLOMATA REMOVED FROM LARYNX BY ENDOLARYNGEAL METHOD.

Shown by Dr. HERBERT TILLEY. The patient was a lad æt. 4½ years, who was brought on account of difficulty of respiration and hoarseness. The former was so marked that the night previous to operation the patient was nearly asphyxiated. It was deemed advisable on account of the dyspnœa to perform a preliminary tracheotomy. Four days after this the endolaryngeal operation was carried out. The patient was chloroformed by Dr. Hewitt, and held in a sitting attitude; it was then quite

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easy to remove a few growths before the returning laryngeal reflex and acts of swallowing rendered a further deepening of the anæsthesia necessary.

By this means the growths were removed, and the voice returned for six months, when increasing hoarseness necessitated a second operation. On this occasion only a few growths were present, and were easily removed.

The speaker emphasised the ease with which the operation could be performed when the anæsthetic was skilfully given in the sitting position.

Case of Epithelioma of Tonsil with Extensive Glandular Involvement in a Middle-aged Man.

Shown by Dr. Dundas Grant. The typical epitheliomatous ulcer extended over from the tonsil on to the soft palate and anterior pillars, involving also the adjacent portion of the base of the tongue. There is also a large hard mass of glands in the neck. Dr. Grant presumed that the members of the Society would agree that the case was beyond operation. A coloured drawing by Dr. Mackintosh showed the characters and extent of the ulcer most perfectly when first seen. Since then a mass out of the centre of the growth had sloughed away, giving the patient very great relief.

Sir **Felix Semon** remarked that, in his opinion, it was not a case for operative interference.

Microscopical Portion of Vocal Cord removed by Means of Jurasz's Punch Forceps from the Vocal Cord of a Gentleman Æt. 61.

Shown by Dr. Dundas Grant. The patient was the subject of huskiness of the voice which commenced with influenza between seven and eight months before he was seen, gradually increasing in severity. On laryngoscopical examination there was seen in the middle third of the left vocal cord a granular outgrowth of a reddish-pink colour, internal to which was an excavation, the floor of

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which was moist and of a yellowish colour. The larynx was otherwise normal, and there was no impairment of mobility of the vocal cord. There was a history of primary specific inoculation in youth, and of a consolidation of the apex of the right lung in early middle age, the pulmonary trouble having apparently completely subsided. An examination of the morning sputum was made by a skilled bacteriologist, who in the first film found two bacilli which stained like those of tuberclc; numerous subsequent examinations of the sputum were in that respect entirely negative, and the bacteriologist came to the conclusion that there was not sufficient evidence on which to found a diagnosis of tubercle. Mercurial inunction and iodide of potassium were without the slightest effect, and the great probability was, therefore, that the disease was epitheliomatous, although the appearance was not absolutely typical. A highly skilled *confrère* considered that the evidence pointed also in this direction, and that the removal of a portion by endolaryngeal methods or the opening of the larynx was called for. Dr. Grant removed a large portion by means of Jurasz's forceps, but in none of the sections removed was there any appearance in the least suggestive of epithelioma. The growth seems, therefore, to have been entirely composed of inflammatory tissue, and the patient at present suffers only from the interference with his voice, which is due as much to the use of the forceps as to the disease itself. He is rapidly improving.

Case of Glottic Spasm in a Young Woman Æt. 24.

Shown by Dr. Dundas Grant and Mr. Mackintosh. Mr. Mackintosh was called to see the patient on account of a suffocative attack, the onset of which had been quite sudden; there was no previous hoarseness, but the patient had experienced uncomfortable choking sensations in the throat; there was a harsh brassy cough, the voice was husky, and there was occasionally stridulous inspiration. The suffocative attack rapidly and completely subsided, but the slight huskiness of the voice persisted. On laryngoscopic examination there was no œdema of the framework of the larynx; the vocal cords were slightly

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congested; the most marked feature was swelling of the lingual tonsil, in which there were numerous patches of exudation; there was also a distinct enlargement of the thyroid gland. Next day Drs. Grant and Mackintosh examined the patient together at the Central London Throat and Ear Hospital. The larynx was then free from any sign of inflammation; the swelling of the lingual tonsil had considerably subsided, and there were elicited such stigmata of hysteria as comparative hemianæsthesia of the right side, and diminution of pharyngeal and nasal reflex. The treatment ordered was bromide of potassium. The case was, therefore, considered one of hysterical glottic spasm, the acute lingual tonsillitis being a factor in the exciting causation.

Mr. Mackintosh called attention to the defective condition of the teeth, the whole of the upper set being represented by a row of foul blackened stumps which, in view of recent investigations, he thought might act as a producing factor.

Sir Felix Semon was not convinced that the local cause excited the spasm. He asked whether the lingual tonsil could be responsible for hemianæsthesia and paralysis. From the symptoms he personally would have great doubts as to the local cause.

Dr. Herbert Tilley related a case of glottic spasm in a particularly healthy-looking man (a butcher) aged forty-two. During the speaker's examination of the patient's throat a sudden suffocative attack ensued, the patient fell from his chair, and seemed in imminent peril of asphyxiation. A long-drawn inspiration terminated the attack, and the patient was quite well again. It seemed probable that the great irritability of the pharynx and larynx was due to excessive cigar smoking, because while avoiding tobacco for two months he had no attack. At the end of this period he had a similar attack ten minutes after smoking his first cigar.

Case of Innocent Growth on the Right Vocal Cord.

Shown by Dr. Wm. Hill. The patient was a woman æt. 48, with a small red, innocent growth, springing from the upper surface of the right vocal cord near its anterior extremity, and slightly projecting into the glottic space, thereby causing hoarseness; this symptom had lasted about one year. The larynx at present was extremely intolerant to intra-laryngeal instrumentation. Unfortunately the patient was from the country, and occupying a bed in hospital which should be placed

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at the disposal of a more serious case; under the circumstances, he wished to know the opinion of members as to whether he could, with any confidence, send the patient back to her doctor in the country (who was a skilled laryngoscopist), with the suggestion that the growth should and could be eradicated by applications of salicylic acid (5 per cent. in alcohol). He had no personal experience of the treatment, and hearsay evidence as to its value had been conflicting.

Dr. DUNDAS GRANT thought it a pediculated growth which habitually lay underneath the vocal cord. During the action of phonation it was forced up between the cords by the expiratory blast, and it seemed to him that as soon as the patient drew a breath it entirely disappeared. He thought that to apply salicylic acid or any other chemical would be a waste of time. The growth could be most easily removed by operation.

Dr. LACK said he had never seen any good result from the use of salicylic acid.

Dr. BRONNER thought formalin much more efficacious than salicylic acid, but in the present case the forceps should be used.

Dr. FITZGERALD POWELL said, in view of the intolerance of this patient's larynx to operative measures, he would recommend swabbing the larynx with a solution of perchloride of iron as likely to cause the disappearance of the growth, which was a very small one, and appeared to him to grow from the upper surface of the cord, and not from below. He had not infrequently seen these small growths disappear under the systematic employment of this treatment.

Dr. VINRACE asked Dr. Hill if he thought it would be advisable to nip the growth off.

Dr. HILL, in reply, was glad to get an expression of opinion on the salicylic treatment. When the larynx had been educated to tolerance the growth could be removed easily enough with forceps, but that would take a long time, he feared, in this instance.

A LARYNGEAL CASE FOR DIAGNOSIS.

Shown by Mr. ATWOOD THORNE. The patient, a man æt. 43, came to St. Mary's Hospital, on January 19th, in a very excited condition, complaining that while drinking a cup of cocoa he felt great pain in the throat, and he thought he must have swallowed some broken china or something.

Owing to the patient's excitement the house surgeon was unable to get a good view of the larynx, but finding a slight wound on the tip of the epiglottis was inclined to believe that

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some sharp substance had been swallowed, or had entered the larynx.

When seen on the 21st the cricoid cartilage was found to be swollen, the left ventricular band much crumpled, and in the arytænoid space was found a collection of muco-pus, and on removing this a gaping scar, as of a burst abscess, was visible.

There is no indication of tuberculosis in the lungs, but there is a history of syphilis dating back twenty-two years.

The wound of the epiglottis may have been due to an over-enthusiastic dresser passing a probang.

Dr. DUNDAS GRANT said the man had occasional loss of voice. Both vocal cords moved perfectly well, but there was an extraordinary swelling of the left ventricular band. It was one of those cases in which at times the swelling either acts as a damper by pressing on the vocal cord, or interferes with the production of tone by getting between the cords. If the trouble was sufficiently serious to justify the introduction into the larynx of a cautery, he would recommend cauterisation of the ventricular band.

Mr. ATWOOD THORNE said, in reply, that the ventricular band was certainly much swollen. The interest of the case, however, lay in the fact that the man had a pain in the throat directly after drinking a cup of cocoa, and thought he had swallowed a piece of china, and on examination two days after a recent scar was seen in the inter-arytænoid space.

CASE OF SUPPOSED EPITHELIOMA OF THE LARYNX.

Shown by Drs. DUNDAS GRANT and WYATT WINGRAVE. J. C—, male æt. 53, a piano-maker, was first seen on December 11th, 1900, complaining of loss of voice of twelve months' duration, commencing with slight huskiness and gradually becoming more marked; there had been no pain except on vocal effort; deglutition was normal; there was no cough, but lately occasional dyspnœa, especially on exertion, accompanied by inspiratory stridor. He had lost two stone within twelve months. There was no personal history of syphilis or tuberculosis. His wife is tubercular, and he has lost two children with phthisis. The sputum is scanty, and no tubercle bacilli could be found, the chest, beyond a slight emphysema, appearing to be normal. In the larynx there was seen a granular fringe along the whole length of the right vocal cord, and to a slighter extent below

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the most anterior portion of the left cord. The right half of the larynx was completely fixed, and some thickening was felt over the right ala of the thyroid. The opinion of the exhibitors was that it was a case of epithelioma, and they were desirous of having opinions as to whether a portion of the growth should be removed for examination, or the exploration effected by thyrotomy; they hesitated about removing a portion without receiving the patient's consent to a partial or complete extirpation of the larynx, should the diagnosis be confirmed.

Sir FELIX SEMON was not firmly convinced of its malignancy. Exactly the same appearance might be produced by either syphilitic or tuberculous infiltration. He certainly had seen malignant cases where there was very little more evidence than in this case, but he did not think the appearance absolutely typical. He would not feel justified in removing the larynx, but he thought an exploratory thyrotomy quite justifiable.

Dr. DUNDAS GRANT said there was no evidence of tuberculosis in the chest and sputum. The man had not been put upon iodide of potassium, but there was no history of syphilis. Was it a case in which one should remove a piece for examination, or do an exploratory thyrotomy? If it was malignant, and any operation was to be done, the sooner the better. That was the position of the case.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

SIXTY-FOURTH ORDINARY MEETING, *March 8th*, 1901.

E. CRESSWELL BABER, M.B., President, in the Chair.

ERNEST WAGGETT, M.B.,
CHARLES A. PARKER, F.R.C.S.(Ed.), } Secretaries.

Present—30 members and 4 visitors.

The minutes of the preceding meeting were read and confirmed.

The following gentleman was nominated for election at the next meeting of the Society:

Wilfred Glegg, M.D., M.R.C.P.(Edin.), Throat Hospital, Golden Square, W.

The following cases and specimens were shown:

A CASE OF MALIGNANT DISEASE OF THE LARYNX IN A MAN ÆT. 47, TREATED BY THYROTOMY AND REMOVAL OF THE DISEASED AREA, SHOWN SEVEN MONTHS AFTER OPERATION.

Shown by Sir FELIX SEMON. Mr. F. J. B—, æt. 47, was sent to me on July 4th, 1900, by Dr. Maguire, of Stoney Stratford. He had been suffering from hoarseness for several months past. This was the only symptom.

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On examination the right vocal cord was found to be much tumefied in the middle part and ulcerated in front, the ulceration extended into the subglottic cavity, and the mobility of the cord was much affected; the left side was quite free. Iodide of potassium failed to exercise any effect, and thyrotomy was performed on July 16th, 1900. When the larynx had been opened, it was found that the new growth was a good deal more extensive than it had appeared from laryngoscopic examination. It not only occupied the whole right half of the larynx, completely destroying the right vocal cord, but also extended below the anterior commissure to the front part of the subglottic cavity, and attacked the front part of the lower surface of the left vocal cord. On the other hand, it was well circumscribed. When the growth was removed it was found that it deeply infiltrated the thyroid cartilage, both on the right side of the subglottic cavity and on the left side of the anterior commissure. It was removed together with an area of apparently healthy tissue, and the parts were very energetically scraped, so that everywhere healthy cartilage was visible. Considering the condition just described, the chances with regard to recurrence appeared rather doubtful. The parts removed were examined by Mr. Shattock, who reported that the growth was a typical squamous-celled carcinoma. The patient made an uninterrupted recovery, and returned home on July 26th, ten days after operation.

Four months later Mr. Cecil Powell, of Stoney Stratford, reported for Dr. Maguire that the patient was getting on very satisfactorily, his general health had much improved, he had gained in weight, and the voice, which had been quite aphonic, had slightly increased in strength.

When I saw him on February 11th, *i. e.* seven months after operation, he was, as he is now, in excellent health, there being not the least trace of recurrence, and the voice, although still hoarse, had gained a good deal in strength since the operation. On phonation the remnant of the left vocal cord somewhat crossed the middle line, but only in front reached the cicatricial ridge which replaces the removed right vocal cord.

The President, on behalf of the Society, congratulated Sir Felix

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Semon on the success of his case; the result was most satisfactory, and the patient had a wonderfully good voice.

Mr. P. de Santi asked Sir Felix Semon the percentage of absolute recoveries in the cases on which he had operated. He knew the general percentage, but it would be interesting to hear what were his individual figures.

Sir Felix Semon hoped the voice would continue to improve. His experience was that the improvement continued up to the end of the first year, and even after that in some cases. In reply to Mr. de Santi, he said his last cases, namely those of the past eighteen months, had not been tabulated, but excluding these his permanent cures were 83·3 per cent.

Specimen of Retention Cysts of the Lymphoid Follicles of the Vallecula.

Shown by Mr. H. Betham Robinson. This specimen was removed from a healthy man æt. 25, who complained of a lump in his throat and occasional pain in the neck.

On examination, both by means of the tongue depressor and the laryngeal mirror, some whitish *lumps* were seen at the base of the tongue, standing out above the level of the mucous membrane, and situated about the outer margin of the vallecula; on the right side was a single large one, the size of a sixpence, and on the left side were three smaller ones.

Under cocaine they were removed with scissors and forceps.

The histological examination of these growths corroborates the clinical diagnosis. They consist of tonsillar tissue with retained products in the follicles.

The specimen seemed to him worth bringing to the notice of the Society, as he could not find any record of this condition.

Case of Chronic Laryngitis with Thickening over the Cricoid posteriorly.

Shown by Mr. H. Betham Robinson. The patient, a man æt. 44, complained of aching pain at the back of the neck and some pain on swallowing. There was no history of tubercle or syphilis; no cough, and no loss of flesh. His voice was husky and weak. There was general chronic laryngeal catarrh, with

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marked thickening of soft parts in the middle line posteriorly, and also definite subglottic thickening of the true cords.

Under the application of chloride of zinc all the symptoms and signs of catarrh had disappeared, with the exception of the posterior thickening.

Two Cases of Recent Perforations of the Septal Cartilage.

Shown by Mr. H. Betham Robinson. The first case was of tuberculous origin, and occurred in a lad æt. 20, who first noticed both his nostrils blocked in January, 1899. After a little while there was discharge from the right nostril, and later from the left. There was no pain except when the nostrils were completely blocked by crusts.

At the beginning of February, 1901, he was found to have a circular perforation in the septal cartilage, with thickened margins covered by grey watery exuberant granulations. These were curetted away, and lactic acid, 20 per cent., rubbed in, after which iodoform ointment was applied. He had very much improved under this treatment.

The second case occurred in an engine-driver, æt. 43, who complained of discharge from right nostril.

When first seen there were black crusts on either side of the cartilaginous septum, but no evidence of a perforation could be discovered by means of a probe. On the left side there was a small angular spur.

Over the right temple was a small indurated spot, and there was enlargement of the pre-auricular and cervical glands, probably secondary to the spot.

There was no history of tubercle, but a definite one of syphilis eighteen years before.

When next seen, sixteen days later, there was an oval perforation in the cartilage only, without any thickening of the edges, and the glands in the neck were breaking down.

The question here was whether the perforation, limited as it was to the cartilage, was induced by the trauma (picking), or whether syphilis played any part in its production.

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The PRESIDENT said that the first case was undoubtedly tubercular, and that the other might be either a syphilitic lesion or a simple perforation. The bone was not exposed, and the perforation was entirely in the cartilage, which was in favour of its being of a simple character.

Dr. DUNDAS GRANT asked if Mr. Robinson had seen the case at the stage of the gumma.

Mr. BETHAM ROBINSON said the patient referred to when first seen had simply a black mass where the perforation was now situated, which looked very much like necrosed cartilage. There was no hole then, but when he next saw the case he found the perforation in its present position. The septum broke down very rapidly. The softening glands in the neck might possibly be of syphilitic origin.

A CASE OF (?) SARCOMA OF TONGUE AND FAUCES.

Shown by Mr. H. BETHAM ROBINSON. The patient, a married woman æt. 49, was first seen on February 20th last, and then gave the following history. She had noticed no symptoms before a month ago. Her throat then felt ulcerated, and something seemed to burst; there was slight bleeding, but no matter. The bleeding had not been repeated, and there was no pain or dyspnœa, but with the increase in size of the tumour eating and drinking had become difficult. Her appearance corresponded with her acknowledged good health. There was no history of syphilis or tubercle.

On examination over the left posterior half of the tongue there was a somewhat circular swelling, the edge of which was raised fully one eighth of an inch above the surface of the tongue. It extended backwards and downwards, involving the left tonsillar region by the side of the epiglottis. The tongue movements were remarkably free, and the growth, though extensive superficially, evidently did not penetrate to any depth into the substance of the tongue. The surface of the swelling did not seem ulcerated, and (on February 20th) there was only one slightly enlarged gland at the angle of the jaw.

Since the patient was first seen the glands on the left side have become considerably enlarged and matted; this might be explained by an attack of influenza during the past few days.

The pathologist considered the tumour to be a mixed sarcoma, but Mr. Robinson thought that syphiloma was by no means improbable. This view was to some extent borne out by the

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following points :—the age of patient, her good health, the rapid growth, the absence of pain, and the tardy involvement of glands. On this supposition, iodide of potash had been given for the past week with some improvement.

The PRESIDENT remarked on the interesting nature of the case. Its character was doubtful. Antisyphilitic treatment ought to be tried.

Mr. SPENCER thought from the clinical appearance and from the microscopical specimen that the case was one of gumma.

Sir FELIX SEMON asked if the painlessness was not in favour of syphilis as against malignancy.

Mr. BETHAM ROBINSON, in reply, said the growth was called "sarcoma" because this was the opinion expressed in the pathologist's report. He favoured syphilis himself.

CASE OF A MALE ÆT. 26 WITH THE LEFT VOCAL CORD IN THE CADAVERIC POSITION, RIGHT FACIAL PALSY, AND PARALYSIS OF THE RIGHT GENIO-HYOGLOSSUS AND THE LEFT HALF OF THE SOFT PALATE.

Shown by Dr. HAVILLAND HALL. T. I—, æt. 26, corporal 6th Lancers. Has had five and a half years' service in India. Has since been in South Africa. Has not had fever. Acute rheumatism in July, 1900. Admits gonorrhœa but no history of syphilis.

Patient was on active service in the recent South African campaign. Two days after embarking for England from Cape Town patient first noticed a difficulty in swallowing. This steadily increased, and reached its maximum in fifteen days. Two days after landing at Southampton he first noticed a difficulty in speech, which is now so pronounced. This also gradually increased, and became stationary in about nine days. This period was also marked by the first appearance of the hacking, brassy cough, which was very distressing on admission into hospital. Patient had not noticed the right facial paralysis or the weakness on the right side until they were pointed out to him in the hospital.

There is no history of headache, fits, or vesical or rectal trouble during the development of the present illness, and it is remarkable that the patient has never had to lie up, or been in

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any way incapacitated from going about while the symptoms have been manifesting themselves.

Condition on Admission.—No headache, vomiting, or optic neuritis; intellect clear; no aphasia; speech markedly affected. Difficulty with labials and linguals to some extent, but great hoarseness also.

Eyes react to light and accommodation; no ophthalmoplegia of any kind; no nystagmus; paralysis of whole of right seventh, and deafness of right ear. Paralysis of right genio-hyoglossus. Tongue cannot be deflected to left side. Palsy of left side of soft palate; left vocal cord in cadaveric position.

Both sterno-mastoids and trapezii act equally well. Marked weakness on right side of body (both limbs). Both knee-jerks abolished; no ankle-clonus; plantar reflexes normal.

No sensory disturbance of any kind in body or limbs; some blunting of sensation in fauces, palate, and posterior pharyngeal wall.

A disseminated subacute polio-encephalitis is suggested as the probable cause of the condition.

The patient has had iodide and mercury in full doses, but without any apparent amelioration of his symptoms.

Case of Extreme Deflection of Septum to Right Side, causing almost Complete Unilateral Obstruction, in a Male Æt. 20.

Shown by Dr. Pegler. In this case there was considerable deviation of the right nasal bone with discoloration and thickening. The patient sought advice more for the disfigurement than for the obstruction to breathing or deadness of his voice. There was a history of a fall at age of three. The case was shown to elicit from members whether in such an extreme case as this there seemed a prospect of a good result from a sawing operation, or whether one of the methods of fracturing and forcible straightening of the septum appeared preferable.

Dr. Herbert Tilley thought the best treatment would be to saw off the projection in the right nostril. It was not a suitable case for Asch's operation, because the space in the left nasal cavity was already none too large for breathing purposes, and the result of Asch's

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operation would be to still further occlude the left side without making much difference on the right. The great thickening of the nasal bone on the right side was interesting. According to the patient this had been present since the fall which caused the septal deflection. It would seem to be one of those cases of traumatic periostitis of the bone, examples of which had already been shown to the Society at previous meetings.

Dr. PEGLER, in reply, thanked the members for their suggestions. He should try the saw as suggested in the first instance, as he had had on the whole better successes in these cases by that means than by performing an Asch or one of its modifications. The careful use of splints or adhesion preventers would be an important part of the after treatment.

CASE OF MALIGNANT DISEASE (EXTRINSIC) OF THE LEFT SIDE OF THE LARYNX IN A MALE ÆT. 56.

Shown by Dr. PEGLER. In this case there was also a malignant involvement of some glands on the same side of the neck. The case was shown to ascertain the feeling of members as to question of performing complete extirpation, the patient being willing to submit to any operation proposed for his relief. The history only extended back four months; voice not affected.

Mr. P. DE SANTI was strongly of opinion that the case should be left severely alone. The man had a large mass of glands on the left side, which were very hard and fixed. There were sure to be other glands deeper down, and it would be impossible to remove these, and therefore impossible to remove the whole disease.

CASE OF MALIGNANT DISEASE OF THE TONSIL.

Shown by Dr. JOBSON HORNE. The patient, a man æt. 60, states that the symptoms of the throat affection from which he is suffering are of not more than five months' duration. At first he experienced a soreness on the right side, more painful on swallowing; this steadily increased, and now deglutition is most difficult and painful.

There is considerable glandular enlargement on the right and also on the left side, and obvious swelling about the angle of the jaw, and under the chin there is a discharging sinus.

The jaw can be only partially opened, and the tongue cannot

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be protruded. The right tonsil is enlarged, extending across middle line, on the surface of which is an ulcer with thickened edges. The ulceration is extending on to the soft palate.

Recently he has experienced pain in the region of the left tonsil. There is no history of syphilis obtainable. He abstains from spirits, and only smokes half an ounce of tobacco a week in a clean pipe. Since February 26th he has taken thirty grains of Pot. Iod. a day, and has experienced relief.

The case is shown in the hope of eliciting suggestions as to ætiology, and for affording relief by either medicinal or operative measures.

Case of Total Extirpation of the Larynx.

Shown by Dr. Glegg for Mr. Harvey. When admitted to hospital this patient, a man æt. 48, was not in good general condition.

On examination a sessile growth the size of a large bean was seen situated on an infiltrated base just below the right arytæno-epiglottidean fold, and running obliquely down over ventricular band and hiding the anterior two thirds of vocal cord. The right side of larynx was fixed, and the posterior third of the vocal cord, which was alone visible, was seen to be motionless and white. The left side of the larynx and the vocal cord moved freely. There was an indefinite thickening on right side of neck opposite the level of thyroid cartilage (enlarged gland ?). The respiration was comfortable although there did not seem to be very much room. The voice was hoarse. The patient could only take fluids owing to obstruction to passage of solids, but had no pain.

History.—Until six months before operation the patient never had any trouble with the throat. About that time he had a little difficulty in swallowing and a feeling of gurgling in the throat. About two months before operation had pneumonia, temperature reaching 105°, and suffered from great dyspnœa, so much so that tracheotomy was contemplated. During the next two months he was hoarse on and off, gradually getting worse ; there was increased difficulty in swallowing, the cough was often

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severe, and there was much phlegm in throat, and occasional slight earache. He could swallow solids until two days before admission. Had been a heavy smoker and also drank freely. He had suffered from winter cough, and lately some wasting. There was a history of syphilis twenty-five years ago; he had been taking iodide of potassium without any benefit. A piece of the growth was removed and examined microscopically, and the diagnosis of epithelioma was confirmed.

On July 25th, 1900, the operation of total extirpation of the larynx was performed by Mr. Harvey, and it was then found that on the right side, at the level of the inferior cornu of thyroid, the growth had perforated into the neck through the posterior part of the crico-thyroid membrane.

The patient's health remained good, and the local condition satisfactory up to December, 1900, when he presented himself for examination, and a large, hard, irregular gland was found and removed from the sheath of the jugular above the level of the great cornu of the hyoid on the right side. He has now a Gluck's artificial larynx, whereby a loud whisper can be produced and conversation can readily be carried on, and his health appears to be quite satisfactory.

Case of Extreme Elongation of Uvula.

Shown by Dr. H. J. Davis. This patient, a male æt. 52, is the subject of left hemiplegia and old nasal and laryngeal trouble. He sought relief for stridor and dyspnœa associated with complete abductor paralysis of right cord.

The cords now move well, and there is no stridor, and I am simply showing him as a curiosity for another reason. He has the longest uvula I have ever seen. It hangs like a pigtail from his fauces, and when he protrudes his tongue—which organ is also of unusual length—you can see without the help of a spatula the uvula lolling on to the epiglottis.

Dr. Davis, in answer to a question, said the man had a slight cough, but the physical signs in the chest accounted for it. The patient did not wish to be operated upon; there was slight anæsthesia of the pharynx.

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Sir **Felix Semon** said he thought the scarring would account for the anæsthesia of the pharynx.

Specimens of Post-nasal Growths removed "en Masse" with a Curette.

Shown by Dr. H. J. Davis. These specimens, besides demonstrating the size to which such growths may develop, show—

(1) Two lateral masses attached to median raphe.

(2) Another specimen of the same in which the growth is studded with white specks, similar to that observed in follicular tonsillitis.

(3) A mass at free border of which is an ulcerated area containing pus and calcareous matter. This was removed from a child æt. 7, with enlarged cervical glands and probably tubercular.

(4) A central mass with a largish vessel entering upper surface.

They have been preserved in spirit since last June, and are therefore much shrunken, but the sulci and convolutions are very well marked.

A Case of Submucous Hæmorrhage of Soft Palate.

Shown by Mr. de Santi. This occurred in a man and was the size of a walnut. It had appeared suddenly whilst eating some crusts of bread, and was in all probability due to bruising therefrom. He had had two similar attacks, once on the back of the tongue and once underneath the tongue in the floor of the mouth.

When first seen by Mr. de Santi there was an ulcer in the right glosso-epiglottic fossa, on both sides of which there were enlarged veins. The hæmorrhage from the back of the tongue had probably come from the right glosso-epiglottic fossa.

The man was not a "bleeder."

Unfortunately all traces of the hæmatoma had by now disappeared, and also the ulcer already referred to.

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Drawing of Congenital Fenestration of the Faucial Pillars.

Shown by Dr. Watson Williams. This was shown in reference to the cases and drawings brought forward at the previous meetings of the Society. It depicted another case of probable congenital malformation.

Case of Fixation of the Left Vocal Cord and Empyema of Right Maxillary Antrum.

Shown by Dr. Dundas Grant. Frances T—, æt. 44, married, came under my observation on February 14th, 1901, complaining of hoarseness and dyspnœa on exertion, and a frequent catch in the breathing. The hoarseness had been present to a slight degree for from eighteen to twenty years, and had been gradually getting worse. On examination the left vocal cord was found to be absolutely fixed in the median position, its edge being markedly concave. Both cords had lost their lustre, and were distinctly congested. There appeared to be an abnormal degree of fulness round the base of the arytænoid cartilage in the left hyoid fossa. There was slight movement of the left cornicula. The movement of the right vocal cord was not quite complete. There appeared to be a rounded fulness under the left vocal cord, but this proved to be due to a shadow cast by a very dark greenish pellet of inspissated muco-pus adhering to the lower surface of the right vocal cord. On inspection of the naso-pharynx there was found to be a small collection of muco-pus in the neighbourhood of the right middle turbinated body, and on anterior inspection there was found a polypoid enlargement of the middle turbinated body. On transillumination the right antrum showed comparative opacity, and when it was punctured a considerable amount of fœtid muco-pus was washed out. The frontal sinuses were perfectly translucent. There is a slight flattening of the bridge of the nose, attributed to compression at birth.

She is the twelfth of a family of fourteen, of whom only two others survive. The brother, two years older than herself, died

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at fourteen of scarlet fever. Her father lived to very old age; her mother died at forty-four of dropsy, probably from heart disease. There are believed to have been several miscarriages. The patient has had seven children, of whom two have died; no miscarriages. She is somewhat anæmic, the palate is paretic, the pupils contract to light, and the knee-jerks are normal. The expulsion of the inspissated muco-purulent crusts in the larynx has been greatly facilitated by the inhalation of turpentine in warm water, and by the occasisnal injection of 10 per cent. menthol in olive oil into the trachea, the voice having become much clearer and the breathing much freer. She has been washing out the nasal passages, and it is proposed to puncture the antrum without delay. There is no evidence of abnormality in the thorax, and the laryngeal affection is probably maintained by the nasal suppuration.

Dr. DE HAVILLAND HALL thought it was an affection of the joint rather than a paralytic one. There certainly seemed to be on comparison with the right cord a difference in the shape, the left arytænoid being more round and full.

Dr. DUNDAS GRANT was glad to hear Dr. Hall's confirmation of his own opinion. The swelling was extremely small, and consequently left room for a considerable difference of opinion.

CASE OF TUMOUR OF THE VOCAL CORD IN A BOY.

Shown by W. G. SPENCER. This boy, æt. 12, has a tumour obscuring the right vocal cord, also a swelling in the right leg groin.

Huskiness in speech was first noticed a year ago, which has increased, until now he is very hoarse.

The swelling in the right leg began five years ago, after a blow from a stone. It disappeared, to return six months ago. The patient presents no other evidences of inherited syphilis. In the larynx there is nothing abnormal except a tumour, which obscures the right vocal cord. The swelling is red in colour, has a smooth glistening surface, and shows no sign of ulceration or hæmorrhage. When the glottis closes it seems to come in contact with, and then to pass somewhat over, the left vocal cord. But the right vocal cord vibrates freely during vocalisa-

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tion, as shown by the fact that the vocal fremitus to be felt in the crico-thyroid space seems to be equal on the two sides.

The swelling in the leg involves the upper and inner surface of the tibia; the skin is discoloured; two apparently periosteal nodes are to be felt on the tibia, from which extend backwards to the popliteal space an induration of the skin and subcutaneous tissue. The swelling is tender, and there is pain, especially at night. The femoral glands below and the iliac glands above Poupart's ligament are a little enlarged, but soft and discrete.

Dr. de Havilland Hall asked if any one would have suggested that the laryngeal condition was of syphilitic origin from the local appearances without reference to the tumour in the leg. To his mind the cord gave no suggestion of a specific lesion. He thought that it was a tumefaction rather than a distinct tumour, and he should have had no idea of suspecting syphilis unless he had seen the leg.

Dr. Lambert Lack thought that some members might remember a similar case shown to the Society by Dr. W. H. Kelson. In this case also there were no definite signs of inherited syphilis. The indefinite outline of the swelling on the ventricular band and the fixation of the cord pointed to its being of an inflammatory origin.

Dr. StClair Thomson said there was nothing in the appearance of the laryngeal condition indicative of a specific lesion. It agreed with what was commonly described as prolapse of the ventricle, but which was really inflammatory hypertrophy of the ventricle of Morgagni. Perhaps the case might be treated first with antispecific remedies to see what the result would be before resorting to surgical or other treatment.

Dr. Bond did not think it was specific, and he doubted whether the leg was, for there was a distinct history of injury at the beginning.

Mr. Spencer, in reply, said the cord was not fixed; vocal fremitus was obtained equally on both sides. He thanked Dr. Lack for recalling the case of Dr. Kelson to his mind. This might be a gummatous infiltration. With regard to Dr. Bond's remarks to the effect that the tumour in the leg might be due to the stone which injured the boy five years ago, it was rather a long time for a traumatic osteitis to be gradually going on. The injury might have localised the gumma in that particular position. He would treat the case with Pot. Iod., and show it again in a month's time.

A Laryngeal Case for Diagnosis.

Shown by Dr. Permewan. The patient, a man æt. 55, was sent to him four weeks ago suffering from dysphagia.

On examination a small circular white tumour about the size

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of a sixpence, low down on the back of the pharynx, could be seen on depression of the tongue. Laryngoscopically there was swelling of both arytæno-epiglottic folds, and behind the right arytænoid cartilage there was a whitish, granular-looking polypoid swelling. The left side of the larynx and left vocal cord were quite immobile, there being apparently fixation of the cord very near the median line.

The small growth was removed with a snare, and on examination was pronounced by a pathologist to be "inflammatory." The patient was ordered iodide of potassium. Three weeks afterwards the patient was seen again, and there was some apparent recurrence of the pharyngeal growth, but otherwise the appearances were unchanged. Dr. Permewan desired the opinions of the Society on the nature, prognosis and treatment of this case.

Sir Felix Semon would not commit himself definitely, but he was inclined to think that the various projections in the pharynx on the left and right side originated from one and the same general infiltration, which also caused the fixation of the left half of the larynx. He thought the whole thing was malignant.

Mr. Spencer thought that it might be syphilitic, but if not that it was most likely malignant. He had shown a large number of cases to Dr. de Havilland Hall at the Westminster Hospital, in which malignant disease of the lower part of the pharynx had gone unnoticed for a long time. The primary growth in that situation was exceedingly small. In this connection he instanced the case of a man who had a growth for a long time not quite as large as a threepenny piece, and indurated glands on each side of the neck. He had seen six cases in two years of malignant growth of the lower portion of the pharynx, and in one or two there were indurated glands in the neck, these latter having been sent to him with the request to take away the glands; in none could he see any chance of doing good by surgery.

Dr. Dundas Grant brought before the Society about a year ago a man with an extremely small growth in the wall of the pharynx, similar to that seen on the left side in Dr. Permewan's patient. His case was made easier in diagnosis by the involvement of the glands. There was room for some doubt as to whether or not it was malignant so far as its appearance was concerned, but the extreme hardness on palpation made it pretty evident what the real nature of the case was. Eventually the man died in the Cancer Hospital of malignant disease. He was disposed to think the present case one of malignant disease. It was certainly singular to have a large growth on one side and the cord fixed on the other.

Dr. Bond was disposed to think it malignant, though one might be

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led astray by the pathological report on the piece removed, which was reported to be of an inflammatory nature. Evidently there was extensive mischief. It was very uncommon to see two separate patches of apparently malignant growth, but the intervening tissue was no doubt quite infiltrated. Commonly, when one examined masses of this nature with the fingers, one made out very evident hardness and induration of the growth and surrounding parts. In this case the growth was quite soft. He showed such a case some three years ago. He thought this case a similar one, and that it was malignant.

Dr. FITZGERALD POWELL remarked that, with all due deference to the distinguished opinions which had been given, he could not help having a strong suspicion that the case might prove to be specific in character; he had elicited the fact that the man's wife had had three miscarriages, and he certainly thought that he should be treated by antispecific remedies.

Dr. PERMEWAN, in reply, agreed on the probable malignant character of the case. He would, however, give iodide of potassium freely, and report the result to the Society. He thanked Dr. Bond for the suggestion as to palpating these growths as well as examining them laryngoscopically.

A LARYNGEAL CASE FOR DIAGNOSIS.

Shown by Dr. BENNETT. P—, male æt. 31, a teacher, was first seen in September, 1900, on account of hoarseness of one month's duration. Examination of the larynx revealed the presence of what appeared to be a small granulating surface immediately below the anterior commissure of the cords, and involving to a very slight degree the anterior inner margin of the left vocal cord. On two or three occasions this surface was curetted and a small amount of granulation tissue removed. Nothing had been done to it for the last three months. The voice is now better, though not clear. There is still a small swelling visible, and the opinion of members of the Society is invited as to the nature of the condition.

Dr. STCLAIR THOMSON had perhaps not listened attentively to Dr. Bennett's description of his case, but he had obtained a very complete view of the whole length of the cords, and on phonation no thickening was visible in the anterior commissure. On phonation a slight thickening was seen in the anterior subglottic region. This was not an uncommon condition; it did not interfere with the action of the cords, and he therefore thought that the cause of any impairment of voice must be sought for elsewhere.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

SIXTY-FIFTH ORDINARY MEETING, *April 12th*, 1901.

E. CRESSWELL BABER, M.B., President, in the Chair.

ERNEST WAGGETT, M.B.,
CHARLES A. PARKER, F.R.C.S.(Ed.), } Secretaries.

Present—31 members and 4 visitors.

The minutes of the preceding meeting were read and con firmed.

The ballot was taken for the following gentleman, who was elected a member of the Society:

Wilfred Glegg, M.D., M.R.C.P.(Edin.), Throat Hospital, Golden Square, W.

The following cases and specimens were shown:

CASE OF TUMOUR OF RIGHT VOCAL CORD WITH A SWELLING ON THE LEG IN A BOY.

Shown by Mr. SPENCER. This case was shown at the last meeting. Since then the patient had taken 15 grs. of iodide of potassium daily, and Ung. Hydrargyri had been applied to the leg every night.

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Both swellings had largely subsided, tending to show that both had origin from the same cause, namely, inherited syphilis.

Mr. Spencer proposed to increase the dose of iodide of potassium, in order to obtain their entire disappearance.

Man Æt. 33 with Chronic Laryngitis and an Ulcer on one Vocal Cord.

Shown by Dr. StClair Thomson. The patient presented himself for hoarseness, and a constant desire to clear the throat, which had commenced about six months ago. When he was first examined there was general subacute laryngitis, the cords were congested, irregularly thickened and rounded. On the anterior third of the left vocal cord there was an oval, boat-shaped ulcer, covered with a greyish slough. A thickening on the opposite cord appeared to fit into this ulcerated depression on phonation.

His temperature was 98·8°, pulse 86; there were no symptoms suggestive of tuberculosis, and nothing was found in his chest. There was no definite history of lues, but he was put on 10 grs of iodide of potassium three times a day. On a subsequent occasion I examined his nose, and found each middle meatus covered with dirty greenish crusts. He was given a cleansing lotion, and at his last visit no crusts were visible; his left nose was clear, but there was some pus in the right middle meatus and in the right choana. In spite of the improvement in his nose the hoarseness was worse. This was a fortnight ago, and I have not seen him since, but show him to-day, before further treatment is carried out, to see if members agree that the chronic laryngitis and ulcer are both due to infection from the nose.

Sir Felix Semon thought it was a simple case of chronic laryngitis, and was not tubercular or specific.

The President said he was not sure of the presence of ulceration in this case.

Dr. StClair Thomson, in reply, said that at first the idea of tubercle had occurred to his mind whilst diagnosing the case; but the temperature was normal, the pulse not hurried, and though repeated examinations of the chest were made, no signs of pulmonary tuber-

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culosis were detected. There was no history of syphilis. Iodide of potassium was given, but this did not improve the patient, in fact the drug made him much worse. There was nothing definite about the nose, but there was a good deal of catarrh. He decided in favour of chronic laryngitis, possibly of nasal infection.

Case of Infiltration of Right Cord of Three Months' Duration in a Man æt. 40.

Shown by Dr. StClair Thomson. This man has been hoarse since early in January. It will be seen that the posterior two thirds of the right cord is represented by an even, red infiltration. The cord moves freely. There is some general hypertrophic laryngitis. The cavum is clear; some polypi have been removed from each nostril. He has had some treatment with iodide of potassium, although there is no history of lues. Rest to the voice and abstinence from tobacco and spirits do not appear to have improved him.

Dr. Jobson Horne considered that the changes to be seen in the larynx suggested *pachydermia diffusa.*

Dr. StClair Thomson, in reply, agreed with the remarks put forward by Dr. Jobson Horne, and thought the case more like one of pachydermia diffusa. The patient had been watched for some time. He was suspected of being addicted to alcohol.

Case of Infiltration of the Right Vocal Cord of Six Months' Duration in a Man æt. 56.

Shown by Dr. StClair Thomson. This patient has been hoarse since September, 1900. The central portion of the right cord is rounded, red, and infiltrated. As to the movement of the affected cord I have been considerably puzzled. At times it has appeared to move freely, but on other occasions I have felt convinced that it was slow and partially tethered in its excursions. The rest of the larynx is normal. He presents no changes in nose, pharynx, or chest. There is no history or suspicion of lues, but he has been given iodide of potassium up to 15 grs., three times a day, without any result. His weight is 12 st. 9½ lbs., and does not vary. Feeling that the appearances were uncertain and suspicious, I asked Sir Felix Semon to see the patient, which he kindly did about four

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months ago, and his conclusion was that there was not then sufficient evidence to justify a diagnosis of malignancy. Two months ago the patient was seen by Mr. Butlin, who wrote to me as follows:—"I do not think it is a new growth. It is too smooth, and there is too free movement of the cord. Also, his voice is not so badly affected as I should expect it to be with a malignant tumour of that size and character. On the other hand, I do not think that so definite and limited a swelling of the cord is likely to be due to any ordinary chronic inflammation. It is not like tubercle, not quite like syphilis, not like any of the 'infective' group of tumours. I have twice opened the larynx for somewhat similar tumours, under the impression that, if the disease was not malignant, it was too suspicious to be left. In one case I found in the centre of the rounded swelling a little mass of what appeared to be coagulated blood, in the other something of the same kind, but not so dark-coloured. One of the patients was a clergyman, the other a commercial traveller, therefore they both used their cords a good deal. I cannot help suspecting that this may be a case of a similar kind, in an agent who talks a good deal. In both my cases there was the same redness of the affected cord. I do not know whether you can get rid of the tumour without incising it or carefully cutting it away, taking the greatest care not to injure the cord itself in doing so. To do this may necessitate the opening of the larynx from the neck."

Both my patients are voice users; this one is a commercial traveller, while the former one is a shop assistant.

One of Mr. Butlin's cases is described by Sir Felix Semon in an article on "Blood-clots simulating Neoplasms in the Larynx,"* and the description there given certainly suggests a similarity to the present case.

Case of Laryngeal Neoplasm occurring on the Posterior Wall, and accompanied by Paresis of Left Vocal Cord in a Man æt. 49. For Diagnosis.

Shown by Dr. Scanes Spicer. The only symptom had been hoarseness of gradual onset, commencing over four years ago.

* 'Annales des maladies de l'Oreille,' etc., xxv, 1899, No. 8.

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The growth was sessile, and attached to the posterior wall. A portion was curetted off, and reported by a pathological expert to be tubercular. Six weeks later a further portion was removed, and was deemed, after examination by the same expert, to be malignant. There had been no pain, hæmorrhage, or emaciation, and there are no enlarged glands; no purulent infection from sinuses or nasal stenosis. There are no history or signs of syphilis or tuberculosis, and nothing to suggest excessive or perverted use of voice, or special exposure to dust in occupation. The patient had been on potassium iodide (gr. v, t. d. s.) for two months with no effect on his condition. Dr. Spicer inquired whether the Society considered that the clinical appearances were so suggestive of malignancy as to demand laryngo-fissure.

Sir Felix Semon feared the growth was malignant. Seeing that it was so very small, he advised an exploratory thyrotomy to aid the diagnosis, which was certainly difficult.

In reply, Dr. Scanes Spicer said that, as there was a conflict between the evidence of the histologist and that of the history of the case, and as the clinical appearances were equivocal, he welcomed the remarks that had fallen from Sir Felix Semon. He had not seen the section himself, but clinically he doubted the malignant theory.

A Case of Laryngitis with Marked Subglottic Hyperplasia occurring below the Anterior Commissure in a Man æt. 36. For Diagnosis.

Shown by Dr. Scanes Spicer. The illness commenced with hoarseness four months ago. The patient is anæmic, but there is no evidence of tuberculosis, there being no emaciation, night sweats, hæmoptysis, or cough, and there is no history of any other disease. The treatment for the last month had been a spray of chloride of zinc and small doses of iodide of potassium. Dr. Spicer thought the case was not at all plain, and seeing that the patient was a corn dealer, he inquired whether it was possible that a husk had become imbedded in the larynx. Occasionally the epiglottis and aryepiglottic folds became œdematous.

Dr. Dundas Grant thought it was a case of tuberculosis.

Dr. Pegler said, had not the evidence against tubercular disease of the lungs been confirmed, he would have regarded the laryngeal

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disease as tuberculous, to judge from a casual inspection. In testimony of how deceptive appearances sometimes were, he would mention a case very recently under his care, which was brought to his mind by a remark of Dr. Spicer's, that the œdema in this case might have been caused by the irritation of a husk swallowed by the patient. A middle-aged woman came to the hospital stating that she had swallowed a fish bone a week previously, and still felt it sticking in her throat. Examination of the larynx failed to reveal the bone, but a very marked œdematous swelling was seen occupying the left arytenoid region, and obscuring the glottis and both vocal cords, except quite the anterior portion of the right one. As this œdema might be due to one of several sources of irritation, a portion of tissue was removed for examination by Mr. Lake, who saw the case with the speaker. No bone was found, but the swelling began to subside, and a week later the patient brought a comparatively large plaice bone to the hospital, which she had hawked up. After this the œdema rapidly disappeared.

Mr. Lake felt very much inclined to recommend the use of mercury in some form.

A Specimen of a Larynx from a Case of Primary Laryngeal Diphtheria.

Shown by Dr. Logan Turner. The case was of interest from the fact that the disease was confined entirely to the larynx, that it occurred in a strong vigorous adult, and that it ran a rapidly fatal course. Frequent attacks of severe dyspnœa necessitated tracheotomy. *Post-mortem* examination showed the mucous membrane of the larynx to be covered with diphtheritic membrane, which extended from the apex of the epiglottis to the cricoid cartilage. Bacteriological examination demonstrated the presence of the Klebs-Löffler bacillus and streptococci.

A Specimen of a Larynx for Diagnosis.

Shown by Dr. Logan Turner. The larynx was removed from a boy æt. 8 years, who had died suddenly during the night from asphyxia, resulting from the drawing of vomited matter into the larynx and bronchi. All the organs of the body were healthy.

The mucous membrane of the larynx and upper part of the trachea was studded with a number of small white points, varying in size from a half to one millimetre or more in diameter

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and resembling small miliary tubercles. The posterior surface of the epiglottis was almost completely covered by a large white patch of a similar kind. There was no evidence of ulceration or swelling.

The microscope showed that each patch appeared to consist of a small area of lymphoid tissue, lying beneath the epithelial layer, and infiltrating between the glands of the submucous layer. There was a small communication with the surface. There were no giant-cells or other evidence of a tuberculous condition.

Dr. JOBSON HORNE said he had examined the larynx, and also the microscopic section; he did not consider the minute nodules to which attention had been directed had any pathological significance. By the epithelium having been destroyed, the underlying structure had become more obvious.

A CASE OF DESTRUCTION OF THE NOSE CAUSED BY A FERRET.

Shown by Mr. WALSHAM. The patient is now 24 years of age. At the age of three months a ferret was found gnawing her face. The whole of the nose, part of the skin of the forehead, and a large part of the middle of the upper lip were destroyed. She has had eighteen plastic operations, the most successful being done by Sir Thomas Smith in 1887, when the skin was taken from the arm, the arm then bound to the face for three weeks to fashion the nostrils, and the lip was repaired. The lip was very successful, and the left nostril fairly so. She has had the Indian operation done also, but it was a failure.

Right nostril was open, but closed up after last operation in 1899.

The PRESIDENT said that he agreed with Mr. Walsham that nothing further should be done. He added that he understood from Mr. Walsham that the introduction of cartilage in this case had been tried without success.

A CASE OF EPITHELIOMA OF THE LARYNX.

Shown by Dr. JOBSON HORNE. The patient, a man æt. 69, stated that in August, 1899, he had "influenza" which was followed by some impairment of voice, and which had gradually

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increased; he had experienced no pain or discomfort, and had not troubled about medical advice. Excepting an occasional cold, he considered his general health had been good.

The growth occupied the anterior two thirds of the right vocal cord, and appeared to be confined to this region. The greater part of the growth was a papillomatous mass filling the anterior third of the glottis. Being partly concealed under the ventricular band of the opposite side it could only be fully brought into view on deep inspiration. The right vocal cord was motionless. The left was not affected. There was some general congestion of the larynx, but this was not more marked on the right than left. No glandular enlargement had been made out.

Thirty grains of iodide of potassium had been taken daily during the previous fortnight without any material change being noted. The case was shown to ascertain opinions as to diagnosis.

The PRESIDENT said it looked like malignant disease. There was want of action on the right side of the larynx.

Sir FELIX SEMON was of opinion that there could hardly be any doubt as to the malignancy. There should be no hesitation in performing thyrotomy and removing the growth.

Dr. FITZGERALD POWELL said he had seen the patient in January last, and had advised operation, thinking there was no doubt as to the malignancy of the growth. The patient had declined operation, and he had not seen him again until now. Though still thinking it malignant, he was struck by the fact that the tumour had not grown or altered very much since January.

Dr. JOBSON HORNE, in reply, expressed his thanks for the opinions that had been given, which he also shared.

CASE OF TUBERCLE OF THE LARYNX IN A MAN ÆT. 18.

Shown by Dr. FITZGERALD POWELL. The patient states that he has suffered from gradually increasing hoarseness and difficulty of breathing for the last four years, accompanied by cough and attacks of suffocation at night. Five years ago he had erysipelas of the face and head, and twelve months ago the eruption, now apparent, on his nose and face appeared. He complains of pain in swallowing.

On examination the epiglottis, arytænoids, ventricular bands and as much of the larynx as can be seen are found to be pale

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and much swollen, and there appears to be very little room for respiration. The swelling in parts is covered by superficial erosions.

He had applied a 5 per cent. ointment of salicylic acid to the nose and face, which had caused some improvement, and he proposed curetting the larynx and applying lactic acid.

Specimens from Recent Cases illustrating the Two Chief Classes of Intra-nasal Papillomata.

Shown by Dr. Wyatt Wingrave. 1. The squamous variety regionally belonging to the vestibule, and histologically identical with an ordinary cutaneous wart. 2. The columnar or cylindrical variety only growing on mucous membrane, and therefore never found in front of the lumen vestibuli.

This latter may grow from the septum, floor, or turbinals, and is often referred to as a "moriform growth." Histologically it presents digitations of myxœdematous tissue covered with columnar or "palisade" epithelium, ciliated and smooth, resting upon a hyaloid basal border.

Warts on the mucous membrane may, however, be covered with squamous epithelium, a heterologous feature which is due to irritation causing retrograde changes, as seen in atrophic rhinitis, and often in slowly growing polypi.

One specimen is that of a "bleeding tumour." It is a squamous papilloma, which grew from the septum about half an inch behind the lumen vestibuli and above the floor. The "core" consists of numerous blood-vessels with very thin walls, which run into the digitations. Nests are found, but not of the "horny" variety so characteristic of the vestibular and cutaneous variety. The surface epithelial laminæ are also thinner.

Bleeding tumours other than malignant and granulomatous most frequently are of one of these two types of papillomata.

Drawings of (1) Cyst in the Floor of the Nose; (2) Pachydermia Laryngis (Tubercular).

Shown by Mr. Richard Lake.

The President congratulated Mr. Lake on the excellent drawings he had shown to the Society.

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A Case of Pharyngo-mycosis in a Female.

Shown by Mr. Attwood Thorne.

Dr. Scanes Spicer said the question to be considered was whether these cases should be actively treated or not. When the patients were worried by symptoms such as a sensation of a foreign body, scraping, discomfort, sourness of breath, unpleasant taste, and flatulent dyspepsia, he would recommend active treatment, such as the free and regular use of alkaline antiseptic washes, the application of perchloride of mercury solution to the crypts, or the insertion of the galvano-caustic point into three, or four, or six of these at a time. He usually found that these cases were very obstinate, and that even long holidays, alternating with periods of active treatment, by no means guaranteed freedom from recurrence. Patients suffering from mycosis were not as a rule content to be left alone.

Dr. Pegler inquired whether a bad taste in the mouth was complained of, as in a case of his own at present under treatment this was the principal symptom, and it was one to which some text-books gave prominence.

Dr. FitzGerald Powell advised scraping with a sharp curette once or twice a week, and the application of a solution of nitrate of silver, twenty to thirty grains to the ounce.

Dr. Wyatt Wingrave emphasised the importance of differential diagnosis between true leptothricia and keratosis of the tonsils. The latter appeared as hard papillary projections from the lacunæ, not easily removable, and showing under the microscope typical horny epithelium with few or no leptothrices. He had found a saturated solution of salicylic acid (well rubbed in) the best treatment for keratosis, while true pharyngo-mycosis yielded to sulphurous acid and antiseptics.

Mr. Parker thought that the most important point to be remembered in the treatment of cases of mycosis was that in the early stages of the trouble the fungus was very firmly adherent and very difficult to remove or destroy, but that if it was left alone for a few months—some placebo being given to the patient in the meanwhile—the fungus growth generally became quite loose, and it could then be easily wiped away. He therefore recommended that such cases should be left until the growth became loose.

Sir Felix Semon said that in discussing the treatment of pharyngo-mycosis, the Society was going over old ground, as the same subject had only recently been discussed by the members. At the former discussion every one who spoke recommended this or that remedy as giving excellent results, and there was, altogether, a great variance of opinions. Personally, he found that these cases, whether of the leptothricial type, or a true keratosis, always occurred in people very much below par, and if they were ordered change of air, tonics,

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rest, open-air exercise, etc., they would, in his opinion, get well without any other treatment, medicinal or operative. In his experience a bad taste was not at all usually present in the mouth.

Mr. ATTWOOD THORNE, in reply, said that the patient complained of no bad taste in the mouth. Personally, he was inclined to avoid any active treatment.

CASE OF ANTRAL SUPPURATION WITH MARKED DISTENSION OF THE INNER ANTRAL WALL.

Shown by Dr. HERBERT TILLEY. The patient is a boy æt. 16, who came under treatment for inability to breathe through the right nostril and a purulent nasal discharge, associated with feelings of languor and general depression.

Examination of the right nasal cavity showed a large swelling of the inner antral wall, which touched the septum opposite. On pressing it outwards with a probe a crackling sensation and noise were produced. A ridge of bone traversed the swelling from above downwards, and at first sight the appearance closely resembled that of a swollen middle turbinal, but the latter bone could be seen in its normal position above.

The bony ridge referred to was undoubtedly the uncinate process of the ethmoid, and immediately in front of this the soft bulging could be easily penetrated by an ordinary surgical probe.

The right second upper bicuspid, which was carious, was removed, and for three months the patient had been irrigating the antrum twice daily with various antiseptic washes. As long as these were continued the discharge practically ceased, but if the irrigation was interrupted for two or three days, then the discharge reappeared. The question arose as to whether any radical operation, such as removal of the bulging inner wall, or even a more radical procedure, should be adopted. The patient's father was very averse to any operation unless it was absolutely necessary for the cure of the case.

The PRESIDENT said that Dr. Tilley's motive in showing the case was to receive suggestions for treatment. It seemed as if the inner wall of the antrum was very much bulged, but, to make certain of this, examination of the parts with a fine probe was necessary. He would not advise a radical operation being done at present. The

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opening had only been made in January last, and the discharge, according to the patient, was slight in quantity, therefore he thought syringing should be continued for a time.

Dr. FitzGerald Powell said that if it was a fact, as he understood was the case, that there was no discharge at all, he did not think it was necessary to do a radical operation on the chance of discovering polypi.

Dr. Scanes Spicer saw no objection to waiting a little longer before resorting to further operative measures, but in his opinion something more radical would have to be done, either through the nose or through the canine fossa, for the reason that the discharge through the ostium maxillæ was an irritating one, and was keeping up ethmoiditis and inflammation of the uncinate body, producing the appearance which had been described as "cleavage."

Case of Cyst of the Thyroid.

Shown by Dr. Pegler. The patient was an elderly woman under the care of Dr. Frederick Spicer, for whom the exhibitor had offered to show her to the Society. An operation was contemplated next day, and Dr. Spicer would be glad of suggestions.

The swelling was the size of an orange, tense, fluctuating, and having a history of about eighteen months' duration. There were pressure symptoms, which had increased latterly, and the larynx was considerably displaced.

The President said that he was always doubtful as regards the cystic nature of these growths. He had had a large experience of them, and he was of opinion that without puncturing it was not possible to say whether they were cystic or not. This, he believed, had not been done in this case; probably not one, but several cysts would be found. With regard to treatment, the shelling out of these cysts could usually be accomplished without much difficulty; but in those cases where it could not be done, he had adopted the plan of opening the cysts and sewing the wall to the edge of the skin, allowing the cavity to granulate up. It took a longer time, but gave good results. He had been in the habit of puncturing goitres for exploratory purposes for many years, but had had an unusual experience lately. Immediately after puncturing a moderate sized goitre in a woman aged 25, and evacuating only a few drops of blood, the gland swelled up slightly, and a few days afterwards he heard from the medical man that an extensive ecchymosis had come out, extending down to the nipples. This soon subsided, and the gland returned to its previous size. Some tachycardia was present in this case, but no exophthalmos.

Dr. Dundas Grant asked if other members of the Society had had

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good results from tapping and then injecting perchloride of iron, as formulated by Sir Morell Mackenzie. He had several cases in which this procedure answered well. He was guided beforehand by the degree of collapse that the cyst underwent after tapping, and previous to injecting with iron.

Sir FELIX SEMON could answer Dr. Grant's question. Some fifteen or twenty years ago he had a very lively controversy in the 'British Medical Journal' on the injection treatment of goitres. He then quoted a number of cases showing that the injection of iodine occasionally was very dangerous. Since then he knew of another case in which injection of iron after puncturing a cyst had been followed by inflammation of the gland, sepsis, and death. In former years he himself had used injections a good deal in his cases, and had never personally had any bad result, but he had now completely given up this method of treatment. The surgery of the thyroid gland had made such advance that one ought not to have recourse to such expedients as injections now, when one could remove the whole thing more simply and surgically.

The PRESIDENT agreed with Sir Felix Semon that the injection of iron was not satisfactory. It might produce an abscess, and give rise to a great deal of trouble.

Dr. STCLAIR THOMSON thought that in modern surgery the method of tapping and injecting cysts had gone out of practice. It was simply done in the pre-antiseptic days from fear of opening these cavities, but now they might be opened perfectly harmlessly.

Dr. FITZGERALD POWELL said he thought the best treatment was removal of the tumour. He considered that there was a good deal more danger in tapping and injecting these cysts than in shelling them out. He referred to a case in which he witnessed a well-known surgeon introduce needles for treatment by electrolysis. The patient died within half an hour.

CASE OF RHINOLITH ? IN A CHILD.

Shown by Mr. R. CHARSLEY.

Mr. ATTWOOD THORNE considered that the case was one of foreign body, and expressed a wish that a further report of the case be made at the next meeting.

The PRESIDENT would prefer to call it a case of foreign body rather than rhinolith; he had used a probe, but could feel no solid body. There was either a growth or a foreign body obstructing the nostril.

Dr. CHARSLEY could obtain no information of any foreign body having been put in the nostril. The body was white, hard, and very moveable, but he was puzzled to know exactly what it was. He saw the patient for the first time on the previous day.

N.B.—The day after the meeting the boy was anæsthetised, and a block of white india-rubber, one inch long by half an inch broad, was removed from the nostril.

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Case of Unusual Tumour on the Posterior Wall of the Larynx.

Shown by Dr. Lambert Lack. The patient is a female, married, æt. 39, who for fifteen years has had occasional difficulty in swallowing. This has been worse for the last three months, and the voice has been weak. The patient is thin, but not wasting, and there are no enlarged glands in the neck. On laryngoscopic examination a large, nodular, pale tumour is seen projecting from the posterior surface of the arytænoids on the right side. It is soft to touch, and grows apparently from the posterior surface of the cricoid cartilage. The growth is almost certainly not epithelioma, and appears to be either simple or possibly sarcomatous. Suggestions as to diagnosis and treatment are asked for, since as far as the exhibitor's experience goes the case is quite unique.

Sir Felix Semon considered it a very interesting and rare case. Of one thing he felt sure, and that was that it was not carcinomatous, and he was very strongly of opinion that it was not a sarcoma. If it were a malignant growth, there would be by now secondary infection of the lymphatics, and there would also be deficiency of movement of the vocal cord on the affected side, from myopathic disability of the posterior crico-arytænoid muscle. Both these signs being absent here, he was convinced of the innocent nature of the growth. He advised that the growth should be removed by the snare internally, and should be submitted to microscopical examination, and he would be guided in the future treatment of the case by the result of that examination.

Dr. StClair Thomson thought it should be described as an œsophageal growth. It seemed to him to be a simple growth, and he agreed with Sir Felix Semon's remarks. Sir Felix and he had seen a similar case in consultation together. The patient was a lady from the Cape, who had a suspicious-looking growth behind the larynx, and they had come to the conclusion that there was an abscess in connection with it, which of course there was not in Dr. Lack's case; but the tumour was like the one in the present case. His own patient returned to the Cape two or three years ago, and he had since heard that she had remained perfectly well. She was an elderly woman; the glands were not enlarged. No operative treatment was carried out.

Dr. Jobson Horne, referring to the remarks made by the previous speaker, said he thought the growth sprang primarily and mainly from the arytænoid region, and he regarded t as a laryngeal and not as an œsophageal growth.

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Cases of Lupus of the Septum and Widening of the Dorsum of the Nose in a Young Girl.

Shown by Dr. Dundas Grant.

Case of Pachydermia of the Vocal Processes in a Middle-aged Man.

Shown by Dr. Dundas Grant. The patient, whose employment necessitated the use of his voice in directing the work at a large railway station, had for one year been becoming gradually more and more hoarse. On the vocal processes there were found extremely typical pachydermic swellings. He was being treated by means of weekly applications of salicylic acid, and was improved as regards voice, although no change in the pachydermic swellings was obvious.

Case of Specific Perforation of the Palate and Ulceration of the Larynx of Tuberculous Appearance in a Middle-aged Woman.

Shown by Dr. Dundas Grant. The perforation of the palate was typical of tertiary syphilis, and there was indirect evidence (miscarriages, etc.) of specific infection. In the larynx the epiglottis was thickened and ulcerated all over in a manner resembling tuberculosis, but without any increase of secretion. Dr. Grant asked whether this appearance had been met with by other members in pure cases of syphilis; he was himself of the opinion that the process in the larynx was of tuberculous nature, and that, in fact, the case was one of mixed tuberculosis and syphilis. (Coloured drawings of the appearances in the pharynx and larynx by Dr. Mackintosh were exhibited.)

Dr. Scanes Spicer said that this case had been under his care some time ago. He regarded the present condition of the epiglottis as a tubercular one, for the appearances differed from all the syphilitic ulcerations he had seen. The epiglottis was really very similar to that in Dr. FitzGerald Powell's case. When he had the case there was no laryngeal involvement at all, but the palate presented the typical perforation and distortion of tertiary syphilis—just as seen now.

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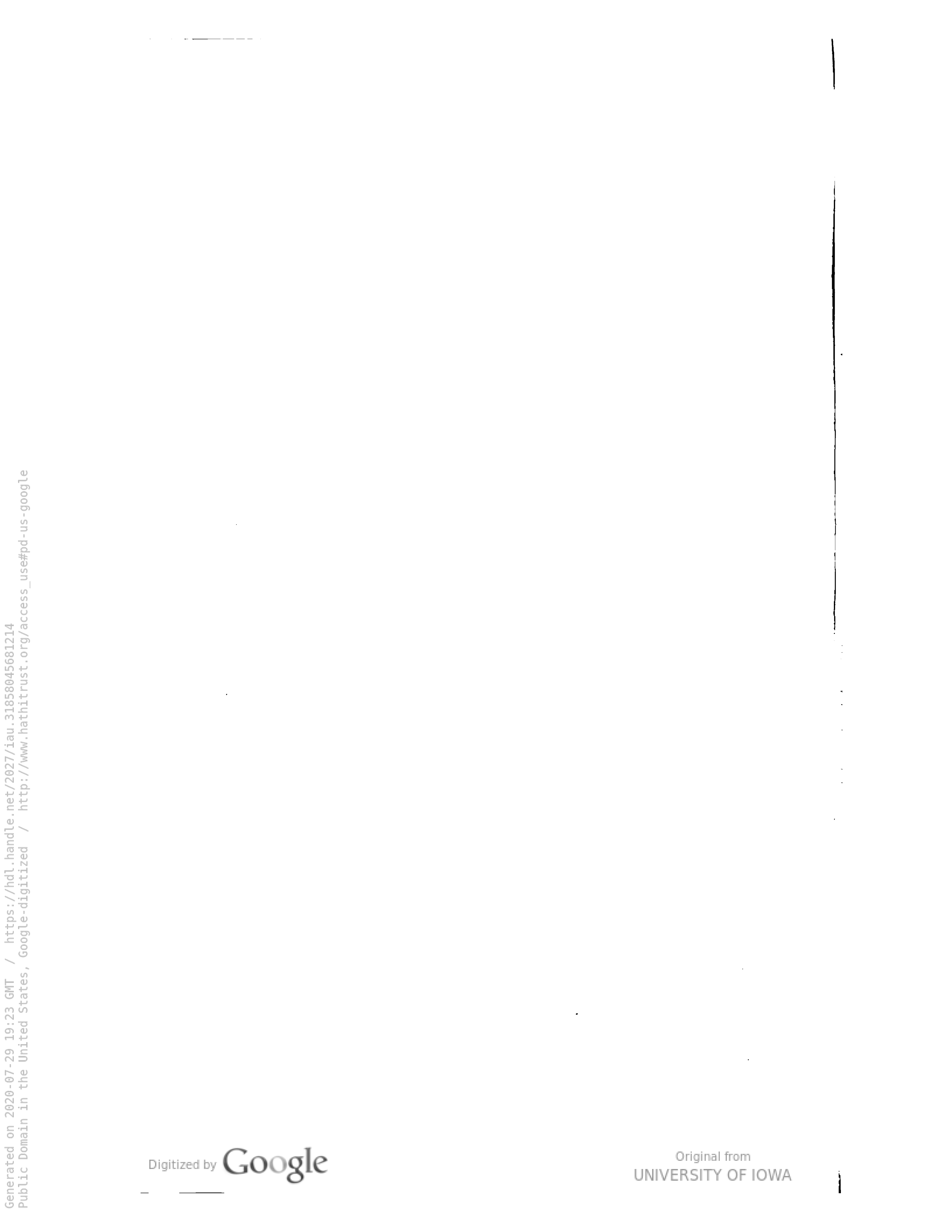

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

SIXTY-SIXTH ORDINARY MEETING, *May 3rd*, 1901.

E. CRESSWELL BABER, M.B., President, in the Chair.

ERNEST WAGGETT, M.B., } Secretaries.
CHARLES A. PARKER, F.R.C.S.(Ed.), }

Present—30 members.

The minutes of the preceding meeting were read and confirmed.

The following cases and specimens were shown:

CASE OF LARGE LARYNGEAL GROWTH SHOWN AT A PREVIOUS MEETING.

Shown by Dr. BARCLAY BARON. There was, on the previous occasion, some difference of opinion as to the nature of the growth, but it was generally agreed that it was attached by some sort of pedicle, and that its removal through the mouth would be easy. At the operation it was found quite impossible to remove it in this way, as the growth was a widely infiltrating epithelioma with no pedicle at all, the epiglottis and other structures of the larynx being implicated.

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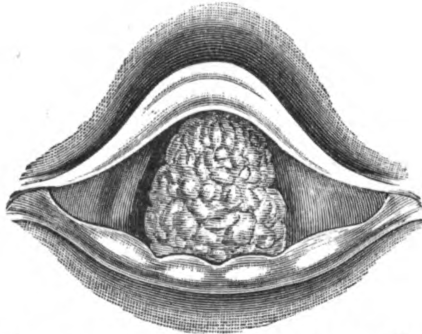
The patient is still living, the glandular infection being very considerable; he has declined to submit to a total extirpation of the larynx, which would be necessary to eradicate the tumour.

A Man æt. 61, from whose Left Vocal Cord a Large Epithelioma was removed by Endo-laryngeal Operation in 1886 and again in 1887, since which there has been no Recurrence.

Shown by Mr. Mark Hovell. R. P—, æt. 46, a stoker at some gas-works, came to the Throat Hospital, Golden Square, on March 17th, 1886, suffering from severe dyspnœa, caused by a large growth of a whitish colour, which almost filled the larynx. He looked pale and anxious, and perspired freely on the least exertion.

On March 20th, after a solution of cocaine had been sprayed into the larynx, nearly the whole of the growth was removed



The growth as seen before operation.

through the mouth with cutting forceps. Free hæmorrhage occurred, but it quickly subsided. The growth came away easily, and after its removal was found to have been attached to the inner border and under surface of the left vocal cord for almost its whole length. Subsequently two or three small pieces were removed as before with cutting forceps, and when the patient left the hospital, on April 5th, not a trace of the growth remained.

After the operation the patient gave the following history:

In the summer of 1884, whilst making up the fire, he suddenly experienced, for the first time, difficulty in breathing. The subsequent attacks of dyspnœa, which as time went on became

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more severe, used to come on suddenly and last for a few minutes. They came at irregular intervals, sometimes two or more in a day, and at other times only one or two during the week. In consequence of the attacks increasing in frequency and severity, he went to the Westminster Hospital at the beginning of 1885, and there saw Dr. de Havilland Hall, who wished him to become an in-patient; but he refused to do so, and did not consent to this proposal until April, by which time the difficulty in breathing had considerably increased. He remained in the hospital three months, during which time some pieces of growth were removed by Dr. Hall. He was taken by Dr. de Havilland Hall to see Dr. Felix Semon at St. Thomas's Hospital, who attempted to remove the remaining portion of the growth. He left the hospital, but was subsequently taken by Dr. Hall to see Dr. Semon again, who then recommended the removal of the portion of the larynx to which the growth was attached. To this treatment the patient refused to submit.

He returned home and resumed work, and remained at it for three weeks or a month. The difficulty of breathing then became so great that he was obliged to seek further advice, and he went to St. George's Hospital, with the hope that relief could be obtained there without an operation being performed. He saw Dr. Whipham, and was made an in-patient. When he had been in the hospital about a week, he learnt that it was proposed to perform tracheotomy before an attempt was made to remove the growth through the mouth. He declined to have tracheotomy performed, and left the hospital. He then again returned to work, and remained at it until the end of 1885, when his breath was too short to enable him to continue at it any longer.

On March 17th, 1886, he came to the Throat Hospital as before mentioned.

After leaving the Throat Hospital the patient was not seen again until May 2nd, 1887, on which date he returned, and was found to be in a condition similar to that which existed when admitted the previous year. On examining his larynx a growth was visible almost identical in appearance, as regards size, colour, and macroscopic texture, to that previously removed. Subsequent to the second operation he told me that on leaving the hospital on April 5th, 1886, he resumed work, and felt no

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discomfort until about January, 1887, when his breathing became a little short. The dyspnœa steadily increased, and about the middle of April he was obliged to discontinue work.

As the patient still refused to allow any extra-laryngeal operation, it was decided to again remove the growth with forceps. A solution of cocaine having been sprayed into the larynx, the growth was removed as before with cutting forceps. It was tougher than that of the previous year, and had a much larger base, being attached not only to the under surface and inner edge of the left vocal cord, but also to its upper surface and to the left ventricular band. At the first operation, on May 9th, although the hæmorrhage was greater than it had been on the former occasions, sufficient growth was removed to enable the patient to breathe with comfort. Another piece was removed on May 17th, and the patient left the hospital on May 20th. The last piece was removed on June 15th, after which no trace of the growth was visible, and the surfaces from which it had been removed soon healed. The long intervals between the operations were made to suit Mr. Hovell's convenience, and were not caused by any unfavourable symptoms having occurred. On June 30th slight congestion of the larynx still remained; the left vocal cord moved but little, but the movement of the right cord was normal. His voice was strong and distinct, but slightly husky in consequence of the congestion.

The patient was examined on August 13th, 1887, and there was no trace of the growth. The movement of the left vocal cord was impaired, but with the exception of slight general congestion of the larynx, and slight thickening of the interarytænoid fold, the result of chronic laryngitis, no abnormal condition was visible. The patient's voice was clear and strong, and there was no dyspnœa. The patient had been employed at the gas works for twenty-one years, and the dusty work during this period would account for the chronic laryngitis.

The following microscopical report of the growth removed in 1886 was kindly made by my colleague, Mr. Frederic Eve:

"The growth removed in 1886 was an epithelioma with a markedly papillary surface. The papillæ were very long and filiform. The base of the growth, under the microscope, showed prolongations downwards of the surface epithelium. These were

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cylindrical, and terminated in a well-defined rounded or subdivided end. In some parts the growth of epithelium was more confused, and composed of tortuous columns or cylinders, which here contained numerous cell-nests; but these also existed in smaller numbers in other parts of the growth. The submucous tissue was nowhere present in the parts removed, but the epithelial columns forming the growth were so well defined that I do not suppose there was any diffuse infiltration of the mucosa with young epithelial cells.

"The growth removed in 1887 differed from that of the previous year in that it contained very few cell-nests, and these of small size. The epithelial columns were more confused, and their margins less well defined. Some shreds of mucosa were attached to its base. These were composed of small spindle-cells and fibrous tissue, containing elongated nuclei, and many small round or 'indifferent' cells. Looking at the matter solely from a histological point of view, I have no hesitation in expressing my opinion that the growth was an epithelioma. This is based on the extensive and characteristic ingrowth of epithelium, the presence of cell-nests, and the general appearances of the neoplasm.

"*P.S.*—I have formed an impression that epitheliomata are less highly malignant if distinctly warty or papillary on the surface; whilst, when the opposite condition exists and the surface is flat or ulcerated, the infiltration below is wider and more diffused, and the growth more malignant. As examples of comparatively lowly malignant warty epitheliomata, I may mention chimney-sweep's cancer of the scrotum, and the epithelioma following ichthyosis of the tongue. This may account in some measure for the successful issue of your case."

Mr. Hovell, in conclusion, said that, although the attempt to remove an epithelioma from the larynx by means of forceps was not a procedure which in an ordinary case would be entertained, or, if undertaken, would in the large majority of cases have any chance of success, yet exceptional cases must be dealt with in an unusual manner.

In the present case the man was fortunate to have got rid of the disease by the measures adopted; but, although in his case a cure had been effected, it was to be hoped that other patients

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would not persistently refuse to have the affected region exposed and efficiently dealt with, or decline to have even a preliminary tracheotomy.

Mr. DE SANTI said that he was extremely interested in the history, the line of treatment, and the result of this case. What one had to consider in the matter was, firstly, the microscopic appearances of the sections submitted to the meeting; and secondly, the clinical features presented by the history given. Mr. de Santi had very carefully examined the microscopic sections, and must state that he could not find in their appearance anything whatever pointing to epithelioma. The drawing shown was a very artistic one of a perfect epithelial cell-nest, but in no part of the sections could he find anything even like an imperfect cell-nest. Moreover, cell-nests might occur in growths that were not epitheliomatous. He felt certain that as regards the microscopic appearances the diagnosis of epithelioma must be considered non-proven. Again, looking to the clinical aspect of the case, the time over which it had extended, together with the great size of the growth, as shown by the drawing, was quite unlike any epithelioma he had ever seen or heard of. If the growth had been malignant and had existed as long as stated, there must have been extensive infiltration at its base, and no endo-laryngeal operation could possibly have eradicated the disease as the disease had been eradicated in this instance. Neither, therefore, did the clinical features or the microscopic appearances warrant the diagnosis of epithelioma, and in Mr. de Santi's opinion this conclusion was more than supported by the result obtained by the removal of the growth by endo-laryngeal forceps. In his opinion the growth had been of an innocent nature throughout.

Sir FELIX SEMON declared his entire agreement with the remarks of Mr. de Santi. It would not be expected of him, after the lapse of fifteen years, that he should recollect the case, and indeed he frankly confessed that he had no recollection whatever of it. What he was going to say would be based only on the drawing which Mr. Hovell had shown to the Society, on the microscopical appearances, on the clinical features of the case, and finally on the present appearance of the patient's larynx. From all these points of view he could not help confessing that the case was a mystery to him. To begin with, he could not reconcile the idea of malignancy with the clinical appearance as now presented. We were taught—and his own experience corroborated it,—that the difference between a benign growth and a malignant growth was that a non-malignant growth sprouted from the *surface*, while the malignant infiltrated the *tissues*. How then could an infiltrating growth be removed so thoroughly that no recurrence had taken place, whilst the larynx, as at present seen, showed not the least trace of any operation having ever been performed? He did not wish to be misunderstood, and he wished to say distinctly that he did not deny the *possibility* of removing a malignant growth from the larynx by endo-laryngeal operation. Quite a number of cases of that sort were now on record. Perhaps some of the older

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members of the Society might remember a letter which he had written to the 'British Medical Journal' on June 4th, 1887, in reference to the case of the then German Crown Prince, for the purpose of warning laryngologists against subordinating clinical apprehensions to the report of the microscopical examination. But in that letter he himself had described a case on which involuntarily he had performed a radical intra-laryngeal operation. It was the case of an old gentleman, aged seventy-five, who had a suspicious-looking wart on one vocal cord. He had only wished to remove a piece for microscopical examination. However, as every laryngologist of experience knew, intra-laryngeal operations were after all more or less of a fortuitous character, and by an exceptional piece of luck he found he had removed the *whole* growth. Mr. Shattock made transverse sections through the whole growth and its base, and it in part bore the characters of a typical cornifying epithelioma. The patient in question was now alive, although more than ninety years of age, and about six weeks ago he actually preached at a wedding! It was well known to the Society that his friend, Professor Fraenkel, of Berlin, had made himself the champion of the intra-laryngeal method of removing a malignant growth in suitable cases, and there were now, as he had said before, a number of well-authenticated cases on record in which the proceeding had been successful. But he could not understand, in spite of this, how after removing an infiltrating growth from the larynx, particularly of the size of the one shown in Mr. Hovell's drawing, it came about that one could not detect the slightest evidence of its former presence and of its removal. Now there was no sign whatever in the larynx of Mr. Hovell's patient to show that a large epithelioma had been removed. If he were asked at the present moment in a court of law to state on oath from which vocal cord the growth had been removed, he would have to confess his inability to tell, and he would have to say it looked as if nothing had been removed. So clinically he must confess the case beat him altogether. Further, he had seen a good many cases in which there was for some time a considerable arrest in the progress of a malignant growth, but for this to happen for *several years*, during which there was practically no progress observed in the size of the growth, surely was most unusual. He was not one who did not believe in things for the mere reason that he himself had not seen them; but he found it difficult to understand an arrest of this kind. Again, from a careful examination of Mr. Hovell's own drawing of the growth, it looked to him much more like a large papilloma springing from the anterior commissure of the vocal cords than like a growth, benign or otherwise, springing from one of the vocal cords. If this surmise of his should be correct, then they would have a perfectly natural explanation of the present appearance of the case. He had once himself removed a very large papilloma looking exactly like the growth shown in Mr. Hovell's drawing from the anterior commissure of the vocal cords of a lady aged forty-eight. The specimen was at present in the museum of St. Thomas's Hospital. With regard to the microscopical appearance, he had looked very carefully, but could not see anything in the specimen typical of epithelioma. He willingly admitted that it was an old

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specimen, and therefore it might not be so characteristic as it originally had been. He had asked Mr. Hovell if he would consent to more pieces being examined by the Morbid Growths Committee. He hoped it would be the general opinion of the Society that such an unusual case should be submitted to this examination. In conclusion, he wished to say that nothing had pleased him more than Mr. Hovell's final observations to the effect that this was an unusual case, and therefore had to be dealt with in an unusual manner. If the man absolutely refused to have the growth removed in the way which was in accord with the progress of modern scientific surgery, *i. e.* by external operation, then under such circumstances an intra-laryngeal operation was permissible; but he strongly hoped that a case of this sort would not be made the starting-point for further intra-laryngeal operations in cases of suspected or proved malignancy. These remarks were analogous to those he had made at the last meeting in the discussion of the value of injections of iodine or iron in cases of goitre. At a time when one had not a better, such methods were both valuable and permissible, but the operator should keep pace with the progress of surgery; and so he was particularly delighted to hear Mr. Hovell say that under normal circumstances he would recommend the extra-aryngeal operation. With this sentiment he entirely agreed.

The PRESIDENT, in commenting upon this interesting case, thought Sir Felix Semon's proposal of re-examination of the tumour by the Morbid Growths Committee was a valuable one, and ascertained from the meeting that it would be its wish to adopt it. He said the larynx at the present moment showed so little change that it was difficult to imagine that any malignant growth had been removed.

Mr. VINRACE wished to asked Mr. Hovell whether from first to last he had observed any lymphatic enlargement in connection with this growth?

Mr. MARK HOVELL, in reply, said he had not troubled the Society with the full notes of the case, and therefore had not mentioned the attachments of the growth at the time of the first and second operations. At the first operation the growth was attached to the inner border and under surface of the left vocal cord along its whole length. At the second operation the growth was much tougher, and it had a much larger base, being attached to the whole length of the under and upper surface, and inner edge of the left vocal cord, and to the left ventricular band. As regards the portions of the growth which he exhibited, he should be very happy for the Morbid Growths Committee to have a portion of each for further examination. He reminded the meeting that Mr. Eve, who had made his own sections, had definitely stated that the growth was an epithelioma. With regard to the mobility of the left vocal cord, the movement was impaired after the first operation, and had remained so since. In reply to Mr. Vinrace, he did not recollect any lymphatics being enlarged.

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Female Æt. 15, with Absorption of the Cartilaginous Septum due to Pressure from Nasal Polypi.

Shown by Dr. Frederick Spicer. The patient came under observation some months ago with both nostrils completely obstructed with polypi, on the removal of which the cartilaginous septum was found to have been absorbed, and the nose disfigured, but there was no perforation.

The case was shown in order to obtain the opinion of others as to its causation; but Mr. Spicer ventured to describe it as above, firstly, because he believed the usually recognised sources from which this trouble arises have been eliminated; secondly, on account of the history; and thirdly, because of the totally blocked condition of the nose when first seen.

There was no family history of syphilis, and none of scrofula; nor was there a history of any injury.

The first indication of anything wrong was the appearance four years ago of what she called "a pimple" upon the bridge of the nose, from which matter came; this was accompanied by a discharge of pus from the nostrils, and was of sufficient import to require the assistance of a doctor. It only lasted a few days.

The President understood that this case had been brought forward with a view to eliciting an opinion as to whether the absorption was really due to pressure from the nasal polypi. It was evidently a case of nasal polypus with disease of the ethmoidal, and possibly of other, sinuses. He should hardly say that absorption of the cartilaginous septum was due to pressure, but more likely to some abscess in the septum, and he would like to ask Dr. Spicer whether he had observed at any time in this case an abscess in this position.

Dr. FitzGerald Powell had seen a case under treatment very similar to Dr. Spicer's, in which there had been an abscess of the septum, which pointed, and was opened at the anterior margin of the septum. The cartilage had entirely fallen away from the nasal bone. There was considerable thickening or broadening of the latter, the result of ethmoiditis. The exciting cause was said to be traumatism. The case was improving, and if possible, and agreeable, he would show the patient at a future meeting as an interesting comparison with the present case.

Mr. Nourse thought that an interesting point in this case was the actual cause of the falling in of the nose; was it due to the absorption of the septal cartilage or to some further injury? He recollected a case he saw at the hospital a short time ago, where the only remain-

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ing vestige of the division between the two nostrils was the little columella; the septum, bony and cartilaginous, having entirely disappeared, and yet the nose was perfectly straight and without deformity externally. It struck him in this case that possibly, although there had been disappearance of the triangular cartilage, the falling in was due to the absorption of the lateral cartilages, with consequent breaking of the cartilaginous arch.

Dr. SCANES SPICER thought that this was a case of old septal abscess in which the upper lateral cartilages had been destroyed by the suppuration, and that the deformity was characteristic of that condition. In his experience, traumatism and syphilis were the commonest forerunners of these septal abscesses.

Dr. STCLAIR THOMSON thought that Mr. Nourse's explanation might read entirely the other way. He agreed with the President that the broadening was due to starting ethmoiditis, and that the most likely explanation was that the patient had had an abscess of the septum. He had made reference on a previous occasion to a case in which an abscess in the septum—not traumatic—occurred in the course of suppurative disease of the antrum. Of course they all knew of cases like that mentioned by Mr. Nourse, where the whole cartilage might be absent, and yet there was no falling in. But if the cartilage was absent through an abscess, the consequent contraction of the cicatricial tissue explained the dragging down of the bridge and the deformity of the nose. In this patient, if the nose was grasped from side to side and compared with one's own nose, it became very evident that there was a large defect of the quadrilateral cartilage of the nose.

The PRESIDENT thought Dr. Thomson's explanation the correct one, *i. e.* the occurrence of contraction of the cicatrix after absorption of the cartilage.

Dr. F. SPICER thanked the various speakers for their remarks. He had nothing more to add. He thought he must agree that the absorption was due to abscess, and considered the abscess was secondary to polypi and ethmoidal trouble.

CASE OF UNUSUAL LARYNGO-PHARYNGEAL TUMOUR IN A WOMAN, WITH MICROSCOPIC SPECIMEN OF GROWTH REMOVED.

Shown by Dr. LAMBERT LACK. This patient was shown at the last meeting of the Society (see page 116). The advice given on that occasion had been very carefully considered, but after some hesitation the exhibitor had preferred to perform an external operation, so as to thoroughly examine the growth and its attachments, and to see exactly what steps were necessary to completely extirpate it. An incision some four inches long was accordingly made in the anterior triangle of the neck, the sterno-mastoid muscle and the large vessels drawn outwards, and the

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lateral pharyngeal wall exposed. A linear incision was then made into the pharynx, and the larynx hooked forward so as to thoroughly expose its posterior wall. The growth was soft and nodular, about the size of a pigeon's egg, and attached by a broad base to the mucous membrane over the cricoid cartilage. The mucous membrane was divided all round the growth, and it was then dissected off the larynx. The wound in the mucous membrane of the larynx was closed with a few catgut sutures. The wound in the pharynx was then closed by a row of closely placed fine sutures uniting the edges of the mucous membrane, and the pharyngeal aponeurosis was also carefully stitched up. A large drainage-tube was inserted into the wound in the neck, and the skin wound closed by silk-worm gut sutures. Just before opening the pharynx, a laryngotomy was performed as a precautionary measure, but it was really not needed, and the tube was removed next day. The after history was uneventful. The patient swallowed easily the day after the operation, and five days later could take solids more easily than before operation. The wounds, except where the drainage-tube had been, healed by first attention, and the patient is now able to attend the meeting, on the sixteenth day after the operation. Examination with the laryngoscope shows nothing abnormal.

Dr. Jobson Horne has made sections of the growth, which he reports to be a mixed-cell sarcoma.

Sir Felix Semon suggested that this specimen should be submitted to the Morbid Growths Committee. He did not pretend to be a great histologist, but to him the section of the tumour looked more like a fibroma than a sarcoma, and he would like to have the opinion of the Morbid Growths Committee. Under all circumstances, Dr. Lack must be congratulated on his most successful operation.

Dr. StClair Thomson asked if Dr. Lack intended publishing the case in full in the 'Proceedings;' if not he would like to have a few particulars as to whether it was necessary to put temporary ligatures round any of the arteries; as to whether he had experienced any difficulty with bleeding or breathing, and as to what steps were necessary in turning round the larynx.

Dr. Lambert Lack said there was no difficulty with bleeding, as the large wound exposed the whole field of operation to view. Consequently there was no necessity to put temporary ligatures round any of the large vessels. Such a proceeding was only necessary when operating in the pharynx through the mouth, where it would be impossible to pick up any large vessel which might be cut.

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The PRESIDENT having obtained from the Society an expression of its desire that a specimen of the growth should be submitted to the Morbid Growths Committee, Dr. Lack said he should be very pleased to supply a portion of the growth for examination.

SPECIMEN OF BONY OCCLUSION OF ONE NOSTRIL.

Shown by Dr. LAMBERT LACK. The specimen showed a complete occlusion of one nostril at about its centre by a bony septum. The nose was otherwise normal. The specimen was obtained whilst dissecting, and no history was obtainable.

SPECIMEN OF MULTIPLE PAPILLOMA OF LARYNX.

Shown by Mr. H. W. CARSON. The specimen was removed post mortem from a female child æt. 2½ years, who had died suddenly of asphyxia. There was a history of orthopnœa and dysphonia from birth. The specimen showed well-marked papillomatous growths in the region of the vocal cords, and a subglottic extension on the anterior wall. There was some œdema in the arytænoid region.

Mr. Carson wished to ascertain the views of members of the Society on the question of prognosis, more especially as regards recurrence after thyrotomy.

The PRESIDENT said this subject had been under discussion at the Society on previous occasions. They knew that recurrence often did take place. There was the celebrated case in which thyrotomy was performed seventeen times.

CASE OF PACHYDERMIA LARYNGIS.

Shown by Mr. CHARLES A. PARKER. This patient had been shown to the Society about two years ago, when it was thought by some to be of a tuberculous nature. Since then the chest had been frequently auscultated, and the sputum examined from time to time, but no evidences of tubercle had been discovered. The local condition was practically unchanged, in spite of various

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methods of treatment, both at Mr. Parker's hands and at the hands of others, for the patient had sought relief at other hospitals. Mr. Parker would be glad to know if anything further could be done for the patient.

The PRESIDENT said he understood that the condition had existed for three or four years without much improvement.

Dr. JOBSON HORNE considered the condition was typical of pachydermia laryngis verrucosa, and agreed with Mr Parker that tuberculosis was not a factor in its causation. Dr. Horne was not in favour of any local treatment of a surgical nature.

Mr. DE SANTI was of opinion that in this case the line of treatment now should be to leave the man quite alone.

Mr. PARKER, in reply, said he showed the case chiefly because on the former occasion it was thought by some members to be tubercular, and he was then asked to bring it forward again. He did not think there had ever been any evidence of tubercular disease. For the last nine months no treatment had been attempted.

A CASE OF TUMOUR OF THE BASE OF THE TONGUE IN A YOUNG FEMALE.

Shown by Dr. DUNDAS GRANT. This case was shown with the object of gaining from the members of the Society opinions as regards both diagnosis and treatment.

Mr. DE SANTI considered this case to be one of extensive sarcoma of the base of the tongue. The feel of the tumour, its irregular surface, the absence of ulceration, the age of the patient, and the history, all pointed strongly to its malignant nature. Moreover, a large piece of the growth had been removed a year ago (unfortunately he understood this piece had been lost, and therefore not submitted to microscopic examination), and had been followed by a rapid and considerable extension of the tumour. The patient he noticed had enlargement of the submaxillary glands, and this was far from uncommon in sarcomata of this neighbourhood. A piece of the growth should be removed and submitted to a skilled pathologist for microscopic examination, and the case dealt with surgically.

Dr. LAMBERT LACK had under his care at the present time, a young girl æt. 19, presenting some features very much like this case. The tumour was a smooth one with large vessels coursing over it, and he was under the impression that the growth was a thyroid tumour. He would not, however, like to give that diagnosis in the present case, unless some of the ulceration seen was due to the removal of pieces by Dr. Grant.

The PRESIDENT said with regard to thyroid tumours at the base of

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the tongue, he had had one case which he had shown to the Society, but this case presented a different appearance. It was more irregular and more like a malignant growth.

Dr. FitzGerald Powell said that the tumour looked like a carcinoma to him, though the woman's age was against its being so; anyhow a portion should be removed and examined microscopically before anything further was done.

A Case of Ulceration of the Tip of the Tongue in a Man æt. 52. For Diagnosis.

Shown by Mr. Attwood Thorne. The patient had complained of some pain for the last year. Mr. Thorne only saw the patient ten days ago, and he then at once put him on iodide of potassium, grs. 10 three times a day. There was, if anything, a slight improvement. Hs asked whether it was epithelioma, syphilis, or tubercle? The tongue was slightly fixed.

The President advised that the iodide of potassium be pushed.

Mr. Mark Hovell suggested that a piece should be removed and submitted to the microscope.

Dr. StClair Thomson said syphilitic disease was certain, and malignant possible. In all cases where there was any doubt it was the rule to treat the case on anti-syphilitic lines. He had once had a patient who was condemned to have his tongue removed by a leading authority on syphilis. That patient was afterwards shown as having been cured of cancer by Mattei's remedies. Mr. Thorne would be well advised to take no further measures until inunctions of mercury had been given a good month's trial.

Mr. de Santi considered this case to be epitheliomatous rather than syphilitic. There was marked induration at the base of the ulcer; the ulcer itself was raised and warty, not depressed and punched out, and it rubbed distinctly over the lower incisor teeth. There was a little limitation of movement, and some slight fulness in the submaxillary region. It was an uncommon situation for a gumma, but not so uncommon for epithelioma.

Dr. Lambert Lack said that Dr. Thomson had exactly stated his views when he said it was certainly syphilis and quite likely epithelioma, but he disagreed entirely with his suggestions as to the course to be pursued. Dr. Lack thought it was very wrong to put a case of suspected epithelioma in such an accessible region on a course of iodide of potassium, and more especially to give him a month's course of treatment by mercurial inunction, when the diagnosis could be immediately made by removing a small piece of growth for microscopical examination. Should the case be malignant, the danger of such a long delay was obvious.

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Mr. VINRACE wished to ask whether Mr. Thorne had noticed any fixation in the tongue. He thought the patient had considerable difficulty in putting it out, and its movement was impaired. He asked if there were any infiltrations, other than those of a malignant nature, which impaired the movements of the tongue.

Mr. THORNE, in reply, said that he would remove a small portion for examination, and would order mercurial inunctions, and hoped to report on the case at a future meeting.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

Sixty-seventh Ordinary Meeting, *June 7th*, 1901.

E. Cresswell Baber, M.B., President, in the Chair.

Ernest Waggett, M.B., } Secretaries.
Charles A. Parker, F.R.C.S.(Ed.), }

Present—32 members and 3 visitors.

The minutes of the preceding meeting were read and confirmed.

The following cases, specimens, and instruments were shown:

Case of Ulceration of the Larynx (? Tuberculous) in a Male æt. 48.

Shown by Dr. de Havilland Hall. The patient was first seen on April 30th, 1901, when he complained of hoarseness. He was in the army thirteen years, and has been in India, Canada, Egypt, and South Africa. The only previous illness he has had was enteric fever in 1882. No history of any venereal disease can be obtained. The patient lost his voice twelve months ago, but he had no treatment until last April. He has had a cough and some expectoration, but no hæmoptysis. He has lost weight,

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There has been thickening and ulceration of both vocal cords and interarytenoid commissure. There has also been some ulceration on the laryngeal aspect of the epiglottis. There are physical signs of consolidation with râles at both apices, and a few tubercle bacilli have been found in the sputum.

Under the inunction of blue ointment and the administration of potassium iodide—20 grains three times a day—there has been considerable subjective improvement, but very little objective alteration in the larynx.

Dr. StClair Thomson was of opinion, from an inspection only of the larynx, that it was a case of tuberculous ulceration in a syphilitic subject, who had probably had pachydermia, and had now contracted tuberculosis of the larynx.

Dr. de Havilland Hall said this was precisely the view he took of the case when it was in hospital, though he was unable to obtain any history of syphilis. In spite of inunctions of mercury and iodide of potassium internally, there had been very little alteration in the appearance of the larynx as seen by the laryngoscope. At the present time, however, the patient breathed much more comfortably than he did when first seen.

Case of Malignant Laryngeal Growth in a Man Æt. 52.

Shown by Dr. StClair Thomson. This patient complains of hoarseness coming on slowly for the last two and a half months. He attributes it to repeated colds since January, so that we may take it that the laryngeal affection dates from at least five months ago.

His voice is now reduced to a hoarse whisper. The anterior four-fifths of the right cord is occupied by an oblong growth with an irregular mammillated surface ; the tips of some of these excrescences present the white snow-like surface which has been referred to at previous meetings of the Society in connection with the question of malignant disease. The anterior third of the left cord is also infiltrated, and shows one or two of these white-tipped mammillæ. The posterior part of the same cord appears as if indented by the larger growth on the right cord. Both cords move, but while the left moves freely, the right is decidedly limited in its excursions.

There is nothing in the patient's history to arouse a suspicion

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of lues. He has no cough, expectoration, or hæmoptysis. The temperature is normal, the pulse is not hurried, and the chest sounds are normal. He has taken 5 grains of Iodide of Potassium with some Liquor Hydrargyri Perchloridi since May 25th without any apparent effect.

Dr. Thomson inquired whether the condition was due to malignant disease, whether the diagnosis could be made with sufficient certainty without recourse to removing a portion for microscopic examination, and whether the case was suitable for operation by laryngo-fissure ?

Mr. SPENCER thought it was malignant and now bilateral owing to infection from the opposite side. In his opinion it required early and extensive operation.

Mr. WAGGETT asked Dr. StClair Thomson if he contemplated performing thyrotomy, and if so, would he bring the case before the Society when he had done so. He presumed thyrotomy should be undertaken as an exploratory measure.

Dr. STCLAIR THOMSON said he thought of performing a thyrotomy, and he wished to know whether members present thought the diagnosis could be positively made without recourse to the excision of a piece of the growth. He himself thought removal of a portion was unnecessary, for if the examination was negative it would not alter their present opinion. Before proceeding to a thyrotomy he should like to know how freely one might remove the parts when both cords were affected ? Of course, one might scoop out very freely the whole of one side of the interior of the larynx. Could one be as free on the other side without fear of stenosis ? He had had one case in which the whole of one of the cords right up to the arytenoid was removed, and the anterior fourth of the opposite cord as well, but in the present case it seemed to him that not only the whole cord originally affected, but two thirds of the opposite cord required removal ; if at the exploratory operation he found this was so, would it be safe to carry it out ?

Sir FELIX SEMON said that he had several times found it necessary to excise both vocal cords, and that no subsequent stenosis had resulted. He did not think that such an event was to be feared. He quite agreed with Mr. Spencer that in all probability there was secondary disease of the left vocal cord, owing to auto-infection. Probably, however, it would be found sufficient to simply excise the left vocal cord, if this suspicion should turn out to be justified, with curved scissors.

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A Case of Frontal-Sinus Suppuration Fourteen Months after External Operation,

Shown by Dr. StClair Thomson,

and

Three Cases Demonstrating the Results of External Operation on the Frontal Sinus,

Shown by Dr. Herbert Tilley.

Dr. Thomson's Case. This case was shown to illustrate the completeness and permanence of the cure of nasal suppuration, due to frontal sinusitis, and also to demonstrate that the external scar was trifling and had not increased with time.

The ordinary external operation was performed on April 10th, 1900. A photograph was shown of the scar three months later, and by comparison with the patient's actual condition, it would be seen that this had not increased.

The patient still has suppuration in the antrum, which is drained through a tooth socket. She had, however, been instructed not to syringe this out for forty-eight hours, and as she had not had occasion to wash her nose out since the date of operation on the frontal sinus it would be allowed that the freedom of the nose from all trace of pus was both genuine and complete. She now never requires more than one handkerchief a day, and states, that were it not for æsthetic reasons, two a week would suffice.

Dr. Herbert Tilley's Cases. These cases were shown to demonstrate that if the radical operation was effectually carried out, there was no reason why a recurrence of the discharge should take place with lapse of time, as he understood Dr. McBride to have suggested at one of the recent meetings of the Society, and that there was nothing terrible about the operation. These cases had been operated on fourteen months, nine months, and six months ago respectively, and there was still no trace of purulent discharge into the nostrils. Two of the cases also illustrated how slight a deformity is caused by a somewhat radical operation.

Dr. Vinrace confessed to having used the word *terrible* in connection with these operations, as he considered them both formidable and

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of a serious nature. He laid stress on the importance of freeing the inferior meatus or breathing channel of the nose from all obstruction, and of giving that a fair trial before proceeding to the radical operation. He gathered from the patients that this had not been done in the cases before them. He also considered that it seemed more rational to enlarge *per nares* the natural communication between the frontal sinus and the nose, namely the infundibulum, than to perform an external operation.

Dr. FITZGERALD POWELL asked the exhibitors to give the Society some detailed information as to the methods adopted in the operative treatment of these cases. He would like to know firstly what amount of bone was removed, whether the whole of the anterior wall of the sinus or only a portion of it. Also, if the opening from the nose to the sinus was enlarged and kept open by a tube, either solid or hollow, for purposes of drainage; and secondly, as to the method of packing, and general treatment. They seemed to him to be very excellent results, upon which the operators should be congratulated.

Mr. SPENCER asked Dr. Tilley to give some information with regard to the comparative frequency of unilateral and bilateral affection of the frontal sinuses. Dr. Tilley seemed to meet with unilateral cases chiefly; was it that these cases were more frequent? At one time, very nearly fifty per cent. of cases of frontal-sinus empyema were found to be bilateral, but he had noticed Dr. Tilley showed fewer bilateral than unilateral cases. Was this due to the fact that by doing the radical operation on one side early he prevented the empyema from becoming bilateral?

Dr. McKENZIE JOHNSTON said that, generally speaking, he thought the antrum of Highmore a much simpler thing to treat than a frontal sinus. In several of these cases, however, the antrum had been opened, and from the fact of the patients still wearing a tube, he presumed that in these cases, as far as the antrum was concerned, the termination of the case was not yet reached. He would like to know when it was proposed to remove the tubes, and whether the "cure" was considered complete before the antrum was in a satisfactory condition.

Dr. FURNISS POTTER asked Dr. Tilley what symptoms he considered necessitated the operation. Would he do the operation in every case in which he had reason to suppose that pus came from the frontal sinuses?

Dr. PEGLER said it was just worth remarking with regard to Mr. Vinrace's remarks that there was much difference of opinion as to which really was the "breathing channel" of the nose.

The PRESIDENT said the main point of interest was what should be the exact radical operation undertaken. The treatment should be as short as possible, and leave as little scar as possible. On these two points the Society would be glad to hear the remarks of Dr. StClair Thomson and Dr. Tilley. He thought it was clearly settled, as had been mentioned by Dr. Tilley, that before operating on the frontal sinus it should if possible be washed out from the nasal cavity. It was usually also necessary to first remove the anterior end of the middle turbinated body.

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Dr. StClair Thomson said that with regard to the severity of the operation, the temperature chart showed this not to be the case. His patient was out of bed on the fourth day after the operation, and on the seventh was up for the whole day, and in about a fortnight left the hospital. So at any rate it was not such a "terrible" operation as regards the time the patient had to remain in bed. This woman had the operation done because the discharge was such that she averaged six to eight handkerchiefs a day, and sometimes in the twenty-four hours she might require eighteen. The symptoms were pain over the left eye and neuralgia. She had had discharge for ten months. The disease was evidently brought to a head by an attack of influenza, which made her frontal-sinus condition much worse. There was plenty of room in her nose to admit of proper breathing when it was not obstructed by pus. When the frontal sinus was opened it was found full of pus, and entirely lined with degenerated polypoid mucous membrane. The anterior end of the middle turbinate was removed sixteen days before the operation, which evidently had given sufficient room for drainage, since for some two months after the operation the patient was able to blow air from the hole in the forehead. Even now, if one put the hand on the forehead when the patient distended her nose, one could feel the scar bulge. Several members had noticed this. With reference to the suggestion of treating the frontal sinuses from within the nose, the matter had been considered by the Society on a previous occasion. In this patient, knowing that unsatisfactory results had been obtained, and that fatal cases had been put on record, he determined to keep the wound open for a long time. He operated on April 10th, and did not allow it to close till June 30th. This was one of the factors in the treatment of his case. Another was that he cleared out the fronto-nasal duct, but left no drain into the nose. His patient had, as Dr. Johnston mentioned, still empyema of the antrum. He had thought it might simply be a reservoir for the frontal sinus, and so he left it alone, hoping it would spontaneously heal when it ceased to be filled from above. But the antrum was still secreting pus, though in very small amount. At some future time he intended operating on the maxillary sinus.

Dr. Tilley, in answer to Dr. Vinrace, observed that removal of nasa polypi was a purely temporary measure, and did not relieve the headaches for which the operation had been performed in the cases exhibited. One of his patients had been having his polypi periodically removed for seventeen years at different hospitals. He also pointed out that other questions raised by Dr. Vinrace and Dr. Potter would be found answered in the Proceedings of the Society for February, 1901, p. 78. In reply to Mr. Spencer, Dr. Tilley said that in twenty-three cases of frontal-sinus empyema with which he had had to deal, ten cases had been bilateral.

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Two Cases of Thyrotomy for Malignant Disease of Vocal Cords.

Shown by Dr. Herbert Tilley. In these two cases the operation had been performed five and three and a half years ago respectively. The patients had enjoyed perfect health since, and in the second case the voice was quite good. In the first case the left vocal cord and arytænoid cartilage had been removed, and a few weeks after the operation a large granulation appeared in the anterior commissure, which was still present in a cicatrised form. Had this not been carefully watched it might have been regarded as a recurrence. Sir Felix Semon had confirmed the opinion of the nature of the case before it was operated on. Full details of both cases may be found in the 'British Medical Journal,' October 22nd, 1898.

Mr. Waggett had seen Dr. Tilley do the operation in one case. He remembered that a fortnight after the operation they found some large suspicious-looking granulations in the anterior commissure. These, however, disappeared without treatment.

Case of Infiltration on Left Cord in a Man Æt. 28.

Shown by Dr. Furniss Potter. This patient, a railway porter, whose duties entailed very considerable use of the voice, had recently come under observation complaining of huskiness and a feeling of irritation in the throat, which had troubled him for the last six months.

On examination the uvula appeared to be somewhat elongated, and the left cord was seen to be reddened and infiltrated in its whole length, and it presented an uneven granular appearance. Its mobility was not impaired. The arytenoid region was unduly red, but otherwise the larynx was in normal condition.

The chest had been carefully examined, but no sign of pulmonary mischief had been detected. There was no cough or expectoration, and no loss of flesh or strength, the patient stating that he felt perfectly well, and able to do his work. There was no history of syphilis, and the family history was free from evidence of tuberculous taint.

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The President thought the case might be tubercular, but he understood there was no evidence of tubercle in the lungs. There was no want of movement of the cords.

Dr. Furniss Potter thought it was tubercular.

Specimen from a Case of Sarcoma of the Tonsil, with Microscopic Slide.

Shown by Dr. McKenzie Johnston (Edinburgh). L—, male, æt. 28 years, a farm servant from Shetland, was sent to me at the Royal Infirmary about the beginning of December, 1900, on account of a tumour in his throat. He stated that he had only been aware of its presence for about six weeks, but on inquiry it was found that his friends had noticed for about three months that his speech was thicker than usual. He had no pain or discomfort, and had nothing to complain of except the fact that he felt a lump in his throat, although, latterly, he noticed that when swallowing liquids they were occasionally regurgitated through the nose.

On inspecting the throat, the left tonsil was seen to be enormously enlarged, extending inwards for some half inch beyond the middle line, and also well down into the pharynx. In colour and appearance it appeared much like an hypertrophied tonsil, only somewhat softer and more vascular. Nothing else abnormal could be seen. Several friends to whom I showed it were inclined to think that the condition was a simple inflammatory swelling. I ordered a course of iodide of potassium, but it was soon evident that in spite of this the growth was rapidly increasing, and that glands underlying it were also enlarging. I then removed the greater part of the projecting mass with the electro-cautery, and Dr. Gulland, who kindly examined it for me, pronounced it to be a rapidly-growing round-celled sarcoma. It was therefore evident that if it was to be removed the operation should be undertaken as soon as possible.

On January 3rd, 1901, my friend Mr. David Wallace operated, and I am further indebted to him for the following notes of the steps of the operation. The remains of the tonsil and tissue between the pillars of the fauces and the pillars themselves

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were removed, together with two enlarged glands situated posteriorly and below the angle of the lower jaw. An incision corresponding to the posterior part of Kocker's normal incision was made behind and below the angle of the jaw, the enlarged glands removed, and a ligature placed on the external carotid artery. The jaw was exposed in front of the masseter muscle and divided obliquely, in a line from above downwards and forwards, and the two portions widely separated. This, after opening the mouth, exposed the region of the tonsil very freely, and allowed excision of the diseased tissues to be readily carried out. There was practically no bleeding. The jaw was united by silver suture, a drainage-tube inserted through the opening into the mouth, and the posterior part of the wound completely closed. The patient made an excellent recovery, and at the present date remains perfectly well.

The President said this was a very interesting case, and the Society was much indebted to Dr. **McKenzie Johnston** for coming so great a distance to show this specimen.

Specimen of a Cheesy Mass found in an Adenoid Growth after Removal.

Shown by Dr. McKenzie Johnston. The cyst appeared to be about size of half an almond, and was filled with a cheesy material.

Dr. StClair Thomson did not think these cases were very rare. One often saw them in acute adenitis of Luschka's tonsil, but in the chronic cases they were more rarely visible in the mirror. He had had a case sent to him at the Throat Hospital for recurrent attacks of laryngitis, tracheitis, and bronchitis. The patient had adenoid remains, which were removed, and all present were struck by the sickening smell of the caseous matter in the adenoid growths. It was quite possible that from time to time it gave rise to infection, spreading downwards. He did not think Dr. Johnston looked upon this condition as being of rare occurrence, but showed his specimen as being a good example of these cases. They occurred more often than was suspected.

Dr. Johnston agreed with Dr. Thomson's remarks. He did not think the case extremely rare, but he had not met with such a good specimen before, nor one in which the secretion was so deeply situated;

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the specimen, of course, did not exemplify the condition so well as when it was at first removed. Small, somewhat seedlike, masses were often seen, but such a cyst he did not remember to have seen before in this situation.

Sketch of an Aneurism of the Aorta in which Paralysis of the Left Vocal Cord was the only Physical Sign during Life.

Shown by Dr. Donelan. This patient, an Italian man æt. 39, was admitted into the Italian Hospital on February 14th, complaining of loss of voice, slight dyspnœa, and some numbness and pain in the left arm. He had become slightly hoarse two months before, and had complete aphonia for fifteen days before admission.

There was no history of syphilis. No physical signs could be elicited by the stethoscope. On the 15th, at the request of Cavaliere Naumann, under whose care he was, I made a laryngoscopic examination, and found the usual evidences of paralysis of the left recurrent nerve.

The diagnosis made was paralysis of left recurrent from intrathoracic tumour, probably an aneurism.

On the following morning the patient was suddenly seized with symptoms resembling those seen in angina pectoris, became rapidly collapsed, and died within two hours of the seizure.

The post mortem showed a healthy state of all the organs with the important exception of the aortic arch, where a small oval aneurism was situated on the postero-superior aspect, and immediately outside the origin of the left subclavian. The tumour overlapped and compressed the left recurrent nerve in the manner shown in the rough sketch exhibited.

Case of Separation of the Upper Lateral Cartilage of the Nose in a Male Æt. 25.

Shown by Dr. Fitzgerald Powell. On May 1st of this year this patient consulted me, complaining of considerable nasal obstruction, discharge, and deformity of his nose. He stated

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that on June 15th, 1900, he received a blow on the nose, which was followed by bleeding.

In November, 1900, he had an attack of influenza, which left him with much nasal obstruction, and in December he consulted a specialist, who did not find much the matter in his nose.

In January, 1901, a swelling suddenly appeared on his septum, which was opened, and contained pus; a drainage-tube was put in. From this time his nose began to sink and broaden.

When I saw him last May his nose had sunk in at the junction of the cartilages and the bones. The nasal bones were thickened, and the nose widened. The septum was deflected to the left, was swollen, and had an opening of a sinus, which was discharging. The upper lateral cartilages had become separated from the nasal bones.

At the present date he has much improved, the nose is more natural in shape, not so thick and wide, though the depression remains. The sinus is closed; there is no discharge, but he says he sometimes has attacks of epistaxis.

The PRESIDENT understood that portions of cartilage had come away, the result being that the cartilaginous arch had fallen in.

Dr. FITZGERALD POWELL said he showed this case as he thought it would be of interest as a comparison with a somewhat similar case shown by Dr. Frederick Spicer at the last meeting of the Society. Dr. Spicer thought that the condition in his case arose from the pressure of polypi, but the general opinion of the members was that it was due to abscess of septum, probably arising from traumatism. In the case now before them the man had received a blow on his nose on June 15th, and as late as seven months afterwards an abscess formed in his septum, which was opened and drained, and from that time the falling in of the nose took place from the separation of the cartilages. The sinus was discharging up to a month ago, but was now healed, some necrosed cartilage came away, but no bone was observed. The shape of the nose appeared to be improving.

A CASE OF CHRONIC ULCER OF THE SEPTUM (? TUBERCULOUS).

Shown by Mr. WALTER SPENCER. This occurred in a girl æt. 18, who worked with dusty woollen goods. The ulcer was situated on the left side of the septum, and had been present for a year, during which time there had been some healing at its

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lower part, but some extension upwards. There is now an ulcer about ½ cm. in diameter covered by granulations, which easily bleed. The cartilage is not exposed. She has a ringing cough, but there is no evidence of lung or laryngeal disease, nor have tubercle bacilli been found with sputa. The treatment applied has been simple, only alkaline douches and ointments.

Dr. McKenzie Johnston said from the view which he had obtained there seemed nothing to favour the idea of tuberculosis. He considered it of a simple nature, and recommended the application of chromic acid, and at the same time of some simple ointment to prevent the secretions from becoming too hard. He had no doubt it would heal in a short time.

Mr. Parker looked upon the case as one due to dry rhinitis. The ulcer was situated just at the spot where excoriation occurred from dust, etc., impinging on the septum. He did not think there was any evidence of tubercle.

The President thought there was an absence of evidence of tuberculosis in this case.

Mr. Spencer would apply some chromic acid, and recommend to the patient the use of a douche.

An Apparatus for Vibratory Massage.

Shown by Dr. A. Hudson. Dr. Hudson considered that this instrument afforded a useful method of applying vibratory massage by means of an electromotor. It could be so regulated that any kind of massage could be employed from the faintest stroking to the coarsest hammering. Many thousand vibrations could be obtained a minute, and consequently there was great power of penetration, as the exhibitor had proved by experiments with water enclosed in an india-rubber bag. He had obtained markedly beneficial results in diseases of the eye and ear, and suggested that it was equally suitable for nose and throat troubles, especially for bringing about absorption of inflammatory thickening, and for the stimulation of muscles in cases of paralysis. He had also found it useful for relieving pain and inducing sleep.

Dr. Vinrace asked if any motor power could be used to work the instrument.

Dr. Hudson replied that a continuous current was necessary.

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Three Cases of Bilateral Abductor Paralysis in Tabes Dorsalis.

Shown by Sir Felix Semon. (The notes of these cases were very kindly prepared for the demonstration by Dr. M. Douglas Singer, Senior House Physician to the National Hospital for Paralysis and Epilepsy, Queen Square, Bloomsbury, of which the three patients were then inmates.)

Case I.—G. B—, toy-maker, æt. 51 (under Sir William Gowers). Syphilis twenty-five years ago. No secondary symptoms.

Present illness began three or four years ago with pains and pins-and-needles in legs and feet, and some difficulty in walking. Quite from the beginning he had "choking attacks" at night. Stridor at night first noticed about three years ago, and during last three months has been present also in the daytime if he exerts himself at all. Has also had transient diplopia and a girdle sensation. Hesitant micturition for two years. No incontinence.

Status, April 26th, 1901.—Pupils R. > L., Argyll-Robertson type. Partial bilateral ptosis. All deep reflexes absent. Superficial reflexes brisk. Marked ataxia of legs. Well-marked Rombergism. Well-marked analgesia of trunk, ulnar borders of arms and legs.

Larynx, May 3rd.—Marked double abductor paralysis, almost complete. The left cord is a little better abducted than the right, but even then the maximum width of the glottis in inspiration is only 1½ to 2 mm. Subjective and objective dyspnœa is considerable.

4th.—Tracheotomy performed by Mr. Ballance.

31st.—The glottis is a little wider than it was four weeks ago during inspiration.

In remarking on this case, Sir Felix Semon said he wished to draw particular attention to the fact that since the performance of tracheotomy, the inspiratory inward movement of the vocal cords had ceased. This fact was held to be important in connection with the question whether such inspiratory inward movements were due to a purely mechanical cause, viz. to the

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rarefication of the air below the stenosis during inspiration—a view held by the older laryngologists, and by the speaker,—or whether it represented an active inward movement of the vocal cords due to the fact that during respiration both abductors and adductors were simultaneously innervated, and that the abductors having been paralysed, the innervation of the adductors alone prevailed. This view had been advocated by Rosenbach, Burger, and others. If it were correct, one would naturally expect the inspiratory movement to continue even after the performance of tracheotomy. The disappearance of the movement in the present case was held to point strongly in favour of the mechanical theory.

Case II.—C. L—, barman, æt. 32 (under Dr. Bastian). Syphilis fourteen years ago. Temperate in alcohol, non-smoker.

Present illness began three years ago with a heavy feeling in his feet and sudden giving way at the knees. Soon after he began to have lightning pains. Two years ago he was told that he snored very much at nights, a thing which previously he did not do; this snoring has continued ever since. Sixteen months ago began to have difficulty in walking, which has steadily increased. About five months ago first had choking attacks at night, and on one occasion lost consciousness in one of these attacks. No bladder trouble.

Status, May 13th.—Pupils small, R. > L., Argyll-Robertson type. Knee and Achilles jerks absent. Elbow and wrist jerks diminished. Superficial reflexes brisk. Marked ataxia of legs, with extreme Rombergism. Some analgesia of legs.

Larynx, May 31st.—The larynx shows abductor paralysis on both sides with paresis of the internal thyro-arytenoid and the inter-arytenoid muscles. The glottis in front on deep inspiration forms a small ellipse, the vocal processes of the arytenoid cartilages almost touch one another; behind them a comparatively large triangular gap remains.

Case III.—T. W—, smith's labourer, æt. 30 (under Dr. Bastian). Father of patient died of "religious mania." Syphilis fourteen years ago. No secondary symptoms.

Present illness began with gastric and rectal crises two and a

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half years ago, and have recurred at intervals ever since. Ten months ago began to have also difficulty in walking and lightning pains. About the same time first had choking attacks at night, and soon after noticed a change in his voice. Has had also girdle sensation and precipitate micturition.

Status, March 1st.—Pupils L. > R., Argyll-Robertson type. Double ptosis. Knee jerks absent. Slight ataxy and Rombergism. Analgesia of ulnar borders of arms and of lower part of trunk.

Larynx, March 8th.—Considerable bilateral and asymmetrical abductor paralysis with slight paresis of the internal tensors. On phonation the cords come promptly together, and only a very small elliptic gap remains in the middle part of the glottis. On deep quiet inspiration the cords are never separated more than about 2½ mm. in the broadest part of the glottis; their inner borders are slightly excavated, and a small triangular gap remains in the cartilaginous part of the glottis. The speaking voice has a slightly forced mournful character. Patient states that he has lost several notes in the upper register.

The President remarked on the great interest of these cases, but at such a late hour of the meeting he thought it would be impossible to enter upon a full discussion of the subject. The case in which tracheotomy had been performed was, he thought, of especial interest.

Dr. Fitzgerald Powell asked Sir Felix Semon when in his opinion it was necessary to perform tracheotomy in such cases.

Mr. Waggett asked what Sir Felix thought of the plan of early tracheotomy in such cases as these, the ordinary cannula being replaced by a solid plug. This measure would relieve the patient of danger from sudden and fatal dyspnœa, while at the same time avoiding the disadvantages of permanent respiration through a cannula.

Sir Felix Semon said that at this late hour it was impossible to fully enter upon the discussion of the points which had been raised by the various speakers. With regard to Dr. Fitzgerald Powell's question, he wished to say that this subject had been discussed quite recently in the Society, when he had stated the principles which now guided his action as to the performance of tracheotomy in cases of bilateral abductor paralysis in tabes. It was a very difficult question indeed, and the decision must be made dependent upon the degree of stenosis, and the question of serious choking fits supervening, whilst a full explanation of the situation ought to be given to the patient, and the decision in doubtful cases be left to him. The occurrence of paralysis of the interarytenoid muscle, which as a rule followed the original abductor paralysis somewhat later than the paralysis of the internal tensors, was a blessing in disguise to the patient, as the greater

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opening of the glottis resulting from this paralysis greatly diminished the danger of suffocation. As to the permanent wearing of a tube, he thought that the dangers and discomforts it was said to entail were more theoretical than real. He had a patient, a stockbroker, on whom he had performed tracheotomy twenty-one years ago for bilateral abductor paralysis, who was fully able, whilst still wearing his tube, to follow his occupation, and he had never suffered from bronchial or pulmonary affections.

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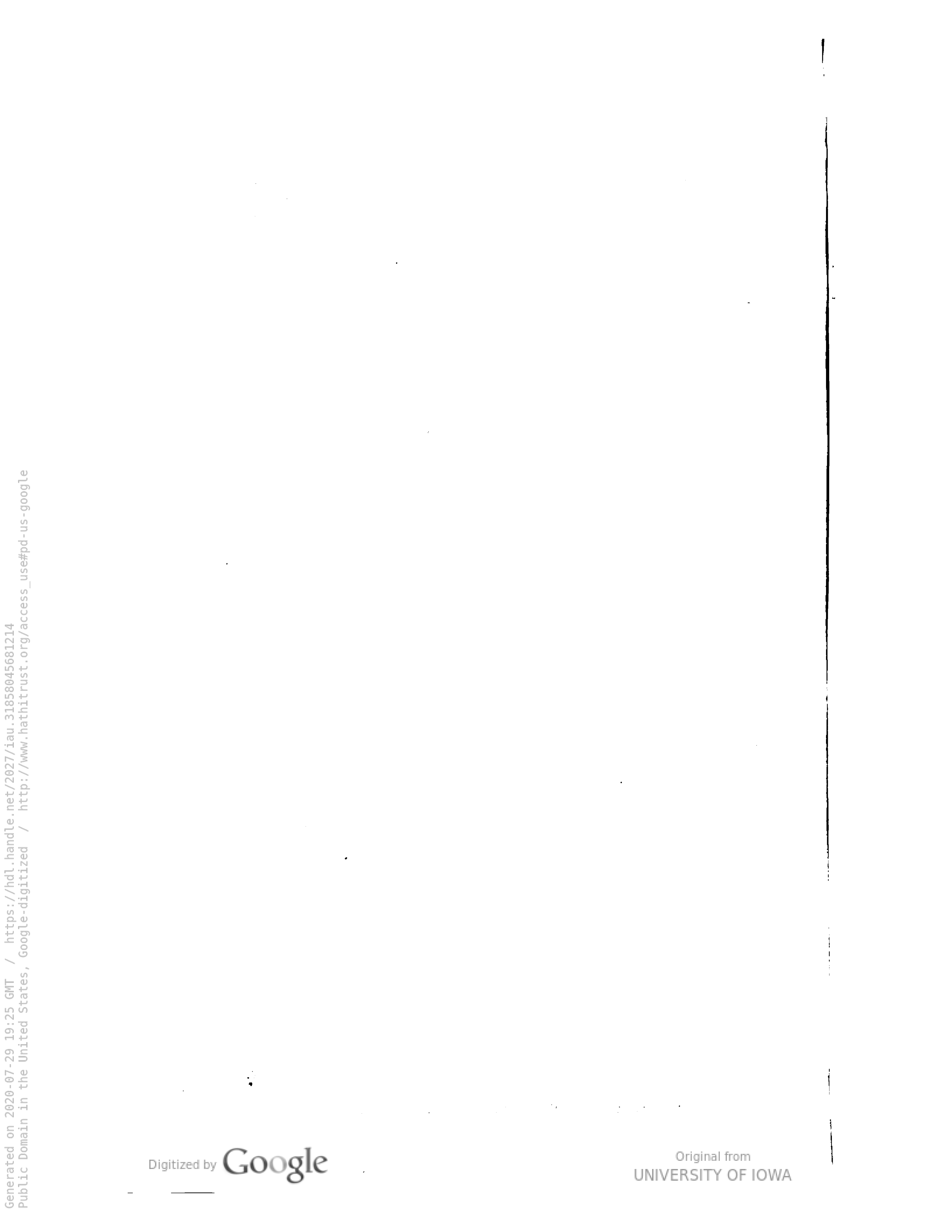
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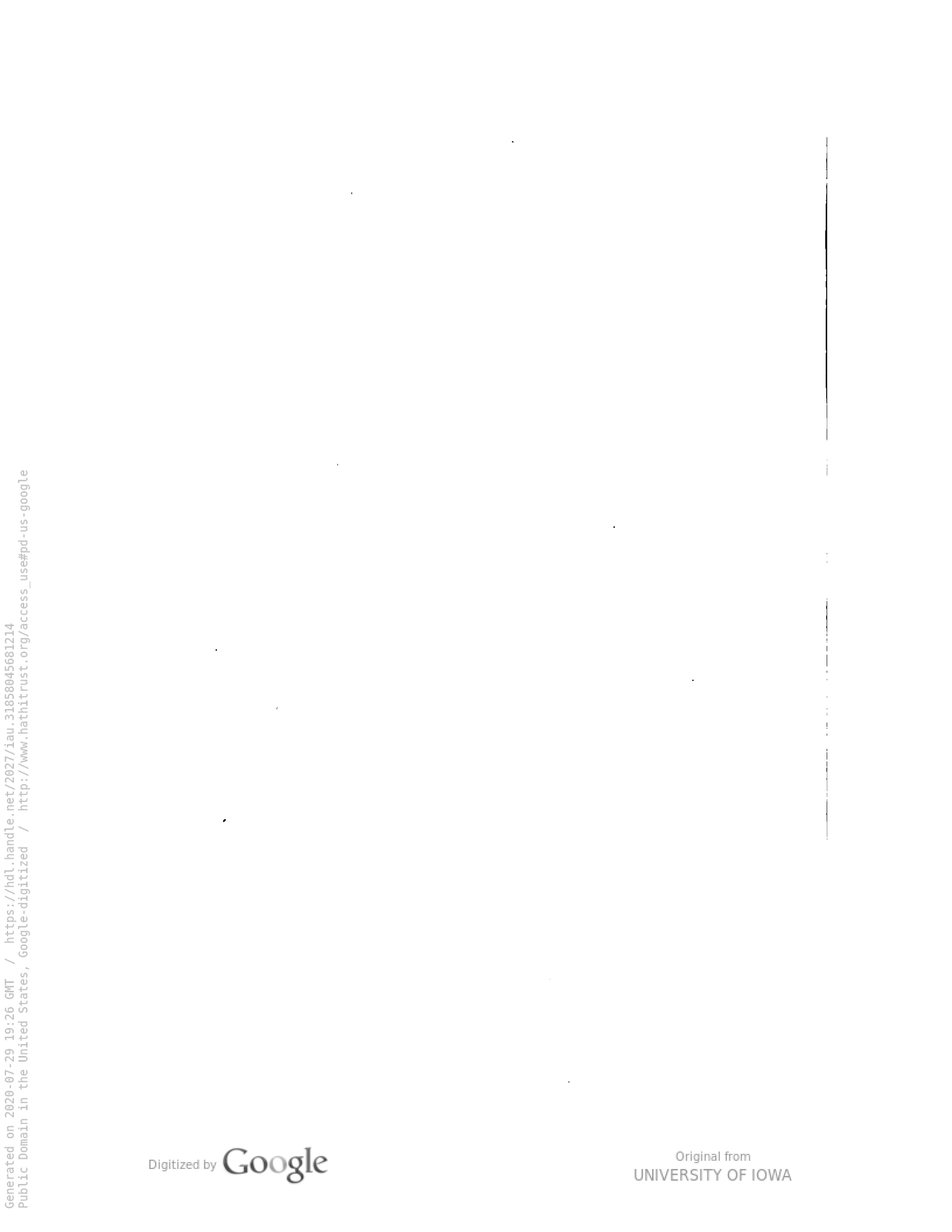

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OF THE

Laryngological Society of London

ELECTED AT

THE ANNUAL GENERAL MEETING,

JANUARY 10TH, 1902.

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(*From its Foundation.*)

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1893	SIR GEORGE JOHNSON, M.D., F.R.S.
1894-6	SIR FELIX SEMON, M.D., F.R.C.P.
1897-8	H. TRENTHAM BUTLIN, F.R.C.S.
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1901-2	E. CRESSWELL BABER, M.B.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

SIXTY-EIGHTH ORDINARY MEETING, *November 1st*, 1901.

E. CRESSWELL BABER, M.B., President, in the Chair.

ERNEST WAGGETT, M.B., CHARLES A. PARKER, F.R.C.S.(Ed.), } Secretaries.

Present—46 members and 2 visitors.

The minutes of the preceding meeting were read and confirmed.

The following report of the Morbid Growths Committee was read:

Mr. Lake's specimen of laryngeal growth (Slide No. 20), see 'Proceedings,' March, 1900, page 71. The section presented shows the structure of a glandular carcinoma.

Dr. Potter's case of growth in the region of the left tonsil (Slide No. 21), see 'Proceedings,' May, 1900, page 114. The section submitted for examination shows the structure of a large round-celled sarcoma.

Mr. Mark Hovell's case of laryngeal growth (Slides 22, 23, and 24), see 'Proceedings,' May, 1901, page 120. Fresh sections were cut by Dr. Horne from fragments removed in 1886 (Slides

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22 and 23) and 1887 (Slide 24). The Committee are of opinion that the histological structure of the specimens submitted to them is that of a benign papilloma.

Dr. Lambert Lack's case of laryngeal tumour (Slide 25), see 'Proceedings,' May, 1901, page 128. The Committee consider the case to be one of mixed cell sarcoma.

The following cases, specimens, and drawings were shown:

Case of Tertiary Syphilitic Laryngeal Stenosis treated by Laryngofissure without Tracheotomy (Re-exhibited).

Shown by Mr. W. G. Spencer. The patient, a potter, was operated upon in March, 1899, for severe dyspnœa, not relieved by large doses of iodide of potassium and mercury.

Tough, irregular masses of inflammatory sclerosed tissue covered the ventricular bands and partly the vocal cords, which, however, moved fairly, and the cartilaginous framework was not involved. Much of the obstructing tissue was excised, including part of the right vocal cord. The patient has remained well and at work, breathing freely as well by night as by day. He has a hoarse but thoroughly audible voice. The inflammatory hypertrophy of the cord on one side now crosses the middle line so as to meet the remaining portion of the excised cord. When exhibited, soon after recovery, the opinion of the meeting was strongly in favour of tracheotomy for such cases, and it was thought that this patient would soon require it (see vol. vii, page 62).

The case shows that tracheotomy is not always best, but that in selected cases, especially where the cartilages are not involved, success is to be obtained by thyrotomy and excision.

The President congratulated Mr. Spencer on the successful result obtained, for there was no contraction of the wound in this case. The man had a very fair amount of voice and was certainly more comfortable than he would have been if he had had tracheotomy performed.

Mr. P. de Santi said the case he had intended to show was of the same nature as Mr. Spencer's but was one where tracheotomy had been performed, and the man's life was a burden to him. He was unable to do any work, and ready to have any operation whatever

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done so long as he could get rid of the inconvenience caused by the tracheotomy tube. If tracheotomy could have been avoided with a result equally as good as in Mr. Spencer's case, it would have been a great advantage to the patient.

Dr. HERBERT TILLEY said that the case referred to by Mr. de Santi had recently been operated on by the speaker at the Golden Square Hospital. The patient was very anxious to dispense with the tube, and laryngoscopic appearances seemed to indicate that if the left ventricular band and vocal cord were removed sufficient room would be provided for natural respiration. Thyrotomy was performed, but it was found that the cicatricial tissue extended below the larynx and was particularly marked in the cricoid region. Hence little good could be expected from removal of the left vocal cord and ventricular band.

Mr. W. G. SPENCER said the Germans had been trying grafting skin and turning the flap in as a means of checking the stenosis. Perhaps Dr. Tilley and other members would try this flap method. It had apparently been attended with some success, especially as regards getting rid of the tracheotomy tube.

An account of some cases in which this operation had been performed would be found in the Centralblatt für Chirurgie.

A SERIES OF SPECIMENS, PHOTOGRAPHS, AND DRAWINGS, ILLUSTRATING THE INFLAMMATORY DISEASES OF THE NASAL FOSSÆ AND ACCESSORY CAVITIES.

Shown by Mr. F. WESTMACOTT. One dry preparation showed a marked frontal projection of the anterior ethmoidal cell. Another a very large sphenoidal cavity coming far forwards and with very thin walls.

Several photographs and drawings taken from specimens in Zuckerkandel's Museum in Vienna presented some abnormalities in size of Highmore's cavity and of the ethmoidal and frontal sinuses, and also hypertrophies of mucous membrane in the nasal fossæ.

TWO MOLAR TEETH SHOWING HEALTHY CROWNS, BUT EVIDENCES OF CARIES IN THE PALATAL ROOT—IN EACH CASE THERE EXISTED AN EMPYEMA OF THE CORRESPONDING ANTRUM.

Shown by Dr. HERBERT TILLEY, who pointed out that although the crown of a tooth might appear healthy it did not prove

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that the roots were not diseased and the cause of antral suppuration; hence in a given case of antral suppuration the healthy aspect of the corresponding molar teeth should not at once lead to the inference that such an empyema was due to intra-nasal causes. If the patient experienced pain or discomfort in a tooth, which was coincident with an increase of the antral symptoms, such a tooth should be regarded with suspicion, no matter how healthy its crown might appear.

In one of the cases referred to, the abscess around the palatal root had free access to the antrum; in the second, a small abscess was situated in the recess at the root of the fangs.

Mr. PARKER asked Dr. Tilley whether there were any signs of pyorrhœa alveolaris, because otherwise he did not see how caries and suppuration could occur at the roots of the teeth, unless it was secondary to the sinus disease. The only conditions which could account for it would be either ordinary caries proceeding from without inwards, or else pyorrhœa, and if there was no pyorrhœa in these cases he should look upon the caries of the fangs as being secondary to, rather than the cause of, the sinus suppuration.

Mr. WAGGETT wished to say in contradistinction to the previous speaker that Tomes, in his 'Dental Surgery' (Ed. iv, page 389), points out that one may meet with necrosis of the pulp without any external wound of the tooth whatever, an abscess forming from pus escaping through the apex of the fang.

Mr. NOURSE was of opinion that there was a small area of caries on the crown of one of the teeth.

Mr. WESTMACOTT said that this question of an apparently sound tooth with an abscess at the root had recently come under his consideration in the case of a doctor, who had, when he first saw him, antral suppuration on the right side. Apparently the set of teeth on that side was perfect. He noticed a symptom which to him was new, and he had not found any confirmation of it elsewhere. By trans-illumination with a strong lamp in the right side of the mouth, the first molar was opaque, the other teeth being perfectly transparent. From the experience of a previous case he came to the conclusion that the first molar was "dead," and advised its removal. An abscess was found at the apex of the palatine root leading into the antrum, and which was apparently the cause of the empyema. The same thing had, within the past month, been again brought to his notice in the case of a gentleman who applied to him with marked irritation at the front of the hard palate. Nothing could be found to account for this until, by means of trans-illumination, it was discovered that the right central incisor was opaque. On removing it, an abscess was found at the root of the tooth. After extraction all the symptoms disappeared.

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Dr. StClair Thomson said he had just been reading an old book—Spencer Watson's book on 'Diseases of the Nose,' and found the following on page 161: "It may happen that the teeth are all apparently sound, and yet one of them may be the cause of the purulent collection within the antrum in consequence of the death of the fang, the symptoms of which are not by any means easily detected. The skilful dentist, however, is sometimes able to get information on this point by striking the crowns of the teeth in succession with a metallic rod until one of them is found to be more sensitive than the rest, and he then proceeds to test the condition of the pulp cavity of the suspected tooth. . . . ." Dr. Thomson was sorry that they could not consult with dentists on this subject, because he had had cases in which the patients had insisted on having certain teeth extracted, which were found to have diseased fangs when there was nothing to be detected in the crown. He could not say whether in these cases the tooth was the cause, or whether it was secondarily infected. He believed he had read that the Röntgen rays were being used for the purpose of detecting diseased roots of teeth. He did not know if any member had come across this in the literature on the subject, or if anyone skilled in dentistry could tell them about the procedure.

Case of Laryngeal Syphilis with Fixation of Left Vocal Cord.

Shown by Dr. Donelan. The patient, a man æt. 52, had contracted syphilis sixteen years previously. Three weeks ago there was a large foul ulcer occupying the left side of the larynx and involving the left arytenoid, vocal cord, ary-epiglottic ligament, and extending past the middle line on the posterior surface of the epiglottis with several unhealthy granulations. There was complete fixation of the left vocal cord. There had been remarkable improvement under antisyphilitic treatment so far, but in view of the unilateral character of the affection, and the existing appearances, he desired the opinion of members as to whether there was not malignant disease as well.

Mr. Spencer thought the antisyphilitic treatment might be continued for some time, as it looked likely to be successful.

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MAN, ÆT. 33, SHOWN AT THE MEETING IN APRIL LAST (vide '*Proc.*,' p. 104) WITH CHRONIC LARYNGITIS AND AN ULCER ON ONE VOCAL CORD. NOW SEEN TO PRESENT MARKED LUPUS INFILTRATION AND ULCERATION OF THE EPIGLOTTIS.

Shown by Dr. STCLAIR THOMSON. This patient has now complained of hoarseness and a constant desire to clear his throat for about a year. When shown to the Society six months ago the author raised the question as to the ulcer on one cord and the general thickening and congestion of both cords being due to tubercle, but he abandoned it in the absence of any confirmatory signs, and also because some purulent rhinitis was thought to be a sufficient explanation of the condition. Several members expressed their opinion that it was only a case of simple laryngitis, and some even thought that the man's hoarseness was to a great extent functional.

On June 1st last it was noticed that no ulcer was visible on the cords, which were simply thickened, catarrhal, with granulations along their attached border. For the first time the epiglottis was then noticed to be red, velvety, and infiltrated with slight vertical fissures (? commencing ulceration) on its laryngeal surface. He did not come under observation again until October 20th, when the epiglottis presented the condition which may now be observed. It has lost much of its contour, being thickened, red, congested-looking, and with marked loss of substance and tubercular infiltration of the floor of the ulcers. There is no marked dysphagia. The voice remains hoarse and painful.

The PRESIDENT asked whether there were any symptoms or history of syphilis in this case, and also whether tubercle bacilli had been found.

Dr. JOBSON HORNE did not know why it should be regarded as a case of lupus. To him, it seemed a fairly straightforward case of tuberculous disease.

Dr. STCLAIR THOMSON said, in reply to the President, that there was no distinct history of syphilis in this case. He had been put on ten grains of iodide of potassium, but it had made him rather worse; this, of course, tended to confirm the suspicion of tuberculosis. There was a great clinical difference between tuberculosis and lupus in the larynx,

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a point which he had previously raised before the Society. He thought this distinction assumed its greatest importance in regard to the question of treatment, because if this was a case of lupus of the epiglottis, it was a form of disease most amenable to treatment; but if it was a tuberculous epiglottis, it was one of the most malignant of laryngeal affections.

Case of ? Congenital Fenestration of the Anterior Pillars of the Fauces.

Shown by Dr. E. Waggett. The case was a well-marked example, occurring in a woman æt. 43, of the condition of which several instances had been exhibited at meetings during the past year. History of ulceration was completely wanting, but the patient had scarlet fever at an early age.

Dr. Clifford Beale said that considerable interest was attached to this case, in association with cases previously shown to the Society, because the question was raised whether such fenestration could be due to scarlet fever. It struck him at the time that there was not very much evidence generally forthcoming to show that scarlet fever was followed by such fenestration. Since then he had looked up the literature of the subject and seen what the authorities had to say in this matter. The result was that he found several recent editions of present text-books had quoted from one another, and that finally the quotations came from one source—a paper by Goodall, in 1894, recording a short series of cases where there was definite fenestration after scarlet fever. No one else appeared to have brought forward such cases. He had the personal evidence of physicians at the fever hospitals to the effect that it is almost outside their experience to meet with palatal fenestration after scarlet fever. One physician had told him that he had come across one case where perforation had followed, but otherwise he had never seen it. That is to say, although ulcers of the soft palate follow scarlatina—they are, indeed, fairly common—they do not usually end in fenestration, but in recovery.

Dr. Donelan referred to the recent literature of this subject, particularly to the cases of Monro, of Glasgow, and Koenig, of Paris, as showing that perforations of this kind were liable to be due to so many varieties of infection that the question whether a given case was congenital or otherwise was attended by increasing difficulty. In Monro's case, which appeared in the October number of the 'Glasgow Medical Journal,' the bacteriological evidence appeared to show clearly that the erosive action was due to the pneumococcus.

Dr. FitzGerald Powell thought that there was very little doubt that this was a case of perforation resulting from ulceration. The openings, it would be observed, were certainly surrounded by

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bands of white cicatricial tissue, which showed that there had been ulceration, whether scarlatinal or not in origin he could not say.

Some time ago he showed a case of malformation of the fauces, which he thought was due to developmental causes, and which looked much more like it than the present case, but the general opinion was, on that occasion, that it was due to scarlatinal ulceration.

He thought Mr. Waggett had, on previous occasions, shown cases which confirmed this opinion.

Mr. WAGGETT, in answer, agreed with Dr. Powell in thinking that scarring was present, and that the condition was probably, in this case, due to ulceration.

A SERIES OF LIVING CULTURES OF THOSE BACILLI WHICH SIMULATE BACILLUS TUBERCULOSIS BY THEIR STAINING REACTION.

Shown by Mr. ST. GEORGE REID. Each culture was supplemented by a microscopical drawing of the organism. They included besides Koch's bacillus tuberculosis, the bacillus tuberculosis of fish, *Dubard,* by inoculation; and the following organisms isolated by Moeller: the bacillus tuberculosis from the blindworm, a bacillus from manure, the Timothy grass bacillus, and grass bacillus I and II—five different bacilli isolated from butter by Maria Tobler; those isolated from butter by Rabinowitsch and Grassberger; Korn's bacilli Nos. I and II, also from butter, and Marpmann acid fast bacillus from the urine.

Mr. St. George Reid explained that all the microscopical preparations from these cultures had stood a prolonged soaking in 15 per cent. acid solution, and in acid-alcohol without yielding up the carbol-fuchsin stain; but that the cultures themselves showed how extremely they differed in their manner of growth from that of Koch's bacillus. Under the microscope, while some organisms simulated exactly bacillus tuberculosis, others showed a very distinct variation from that bacillus, as shown when it was obtained from fairly recent cultures.

CASE OF GROWTH (PROBABLY PAPILLOMA) ON THE LEFT VOCAL CORD IN A MAN ÆT. 32, A PORTER BY OCCUPATION.

Shown by Dr. FITZGERALD POWELL. The patient stated that in February this year he began to suffer from hoarseness and difficulty in singing, which had gradually got worse. There had

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been no pain or dyspnœa. On examination, an irregular sessile growth is seen arising from the anterior three-fourths of the left vocal cord. It is nearly white in colour and shows slight papillary projections on the surface. The growth is most probably a papilloma, containing some fibrous tissue. It is interesting to note in these cases of benign neoplasms of the larynx arising from the cords, even when of considerable size, the slight amount of interference with the breathing in adults.

Dr. Clifford Beale asked whether a papilloma of such a very white colour was not very uncommon? He suggested that such an excellent case should be recorded by means of a coloured drawing.

Dr. Law wished to point out that the late Dr. Whistler showed a case to the Society some years ago in which the growth was even much whiter than the present one.

The President remarked on the whiteness of the growth.

Case of Epithelioma of the Epiglottis in a Man æt. 58.

Shown by Dr. Dundas Grant.

Mr. Butlin said he believed Dr. Grant did not so much raise the question of diagnosis as that of operative interference, and from that point of view he would not regard the case as a favourable one. He had never operated on a case in a similar condition to this, and he was doubtful as to which was the best way of exposing the growth. Seeing that the man had a gland on the right side and that the gland was movable, he thought it would be best to cut down on it and make an extensive incision on the right side, getting to the base of the tongue and epiglottis, and then to make a thorough examination. At Dr. Grant's request he had put his finger down onto the back of the tongue as far as the epiglottis, which was very hard. The base of the tongue was also indurated, but not to the extent he had anticipated, taking into consideration the visible thickening. There seemed to be little infiltration. Those cases that one saw, not very uncommonly, of malignant disease in front of the epiglottis spreading along the base of the tongue and backwards into the epiglottis, he had never yet ventured to attack by operation, the disease was so deep-seated and extensive; but he had often thought that he would expose the growth from the outside when a suitable case came before him, although he doubted whether it would be successful. Here he would expose the growth from the side and remove the glands at the same time, if he were going to operate from the outside.

Dr. Lambert Lack agreed that the case was quite unsuitable for

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operation. Not only the larynx but so much of the adjacent parts of the anterior wall of the pharynx and tongue would have to be removed that it would be quite impossible to close the wound. In early cases of epithelioma spreading from the tongue to the epiglottis, it was sometimes possible to remove the disease without removing the larynx, and in these cases he had seen very good results.

Case of Nasal Stenosis occurring in a Man Æt. 43, in which the Symptoms seemed to be chiefly Subjective.

Shown by Dr. Dundas Grant.

The President said it seemed to him that the patient had a good deal of objective inspiratory obstruction; in addition to the very irregular septum, the collapse of the alæ on inspiration made it difficult for the man to inspire.

Dr. Pegler noticed some constriction of the folds of the limen vestibuli which might contribute to the general stenosis. He hoped Dr. Grant would show the case again after the objective conditions had been treated.

Dr. FitzGerald Powell thought the symptoms were chiefly objective; there was also some superficial ulceration about the anterior nares which rather suggested a specific taint, and he would suggest putting the man on anti-specific treatment.

Case of ? Tubercular Disease of the Epiglottis.

Shown by Mr. H. M. Ramsay. The patient, a girl æt. 19, an envelope sorter, complains of cough and hoarseness. She states that she was quite well till eight months ago, when she noticed an alteration in her voice, and began to be troubled by a cough. On examination, she has extensive thickening and lumpiness of the epiglottis and ary-epiglottidean folds. It is difficult to see the cords, but they seem to be very little affected and to move freely. The patient has no pain. The chest is normal, and no tubercle bacilli have been found in the sputum. The case is shown with a view to diagnosis.

Dr. StClair Thomson thought this case was, clinically, a very typical example of lupus. There was the greatest difference between that and tuberculosis of the same extent in the larynx. If this girl had no mischief in her lungs, it was one of the most favourable cases

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for local treatment, and it was quite possible to make a cure of it. He had recently seen such a case, in which the disease, apparently quite as extensive as in this girl, was completely arrested by the use of the galvano-cautery in one of his colleague's hands. He mentioned this because he had heard in the Society many expressions of opinion against the use of the galvano-cautery in the larynx. The case he referred to was one of extensive lupus, not only of the epiglottis, but also of the ary-epiglottic folds, and treatment with the cautery resulted in complete arrest.

Mr. Butlin said that with regard to the use of the galvano-cautery in the larynx, a well-marked case of lupus was once handed over to him. The patient was in the hospital. He applied the cautery very freely indeed, and in the end succeeded in getting the disease cured. But he was bound to admit that on one occasion the patient nearly died, and certainly would have died had he not instantly performed tracheotomy in the ward. Anybody who was going to apply the cautery in the larynx in the case of lupus unaided should be prepared for such a contingency.

Case of Laryngeal Swelling.

Shown by Dr. Bond. The patient, a boy æt. 14, has had a peculiar voice since infancy. On the left side the cord is masked by a swelling, especially in front and low down, red in colour, slightly granular and moving with phonation. Occasionally a small portion of base of cord can be seen. The boy is unable to obtain work because of his peculiar voice. Suggestions as to treatment of the condition will be welcomed.

Dr. Law would suggest as a possible, but very improbable, explanation of the condition, the impaction of a foreign body. He remembered when he was House Surgeon at Golden Square a patient coming to the hospital for four or five months presenting a very similar appearance in the larynx to this patient. He heard a year or two afterwards that a piece of rabbit bone was one day extracted which had not been visible during the previous year's observation.

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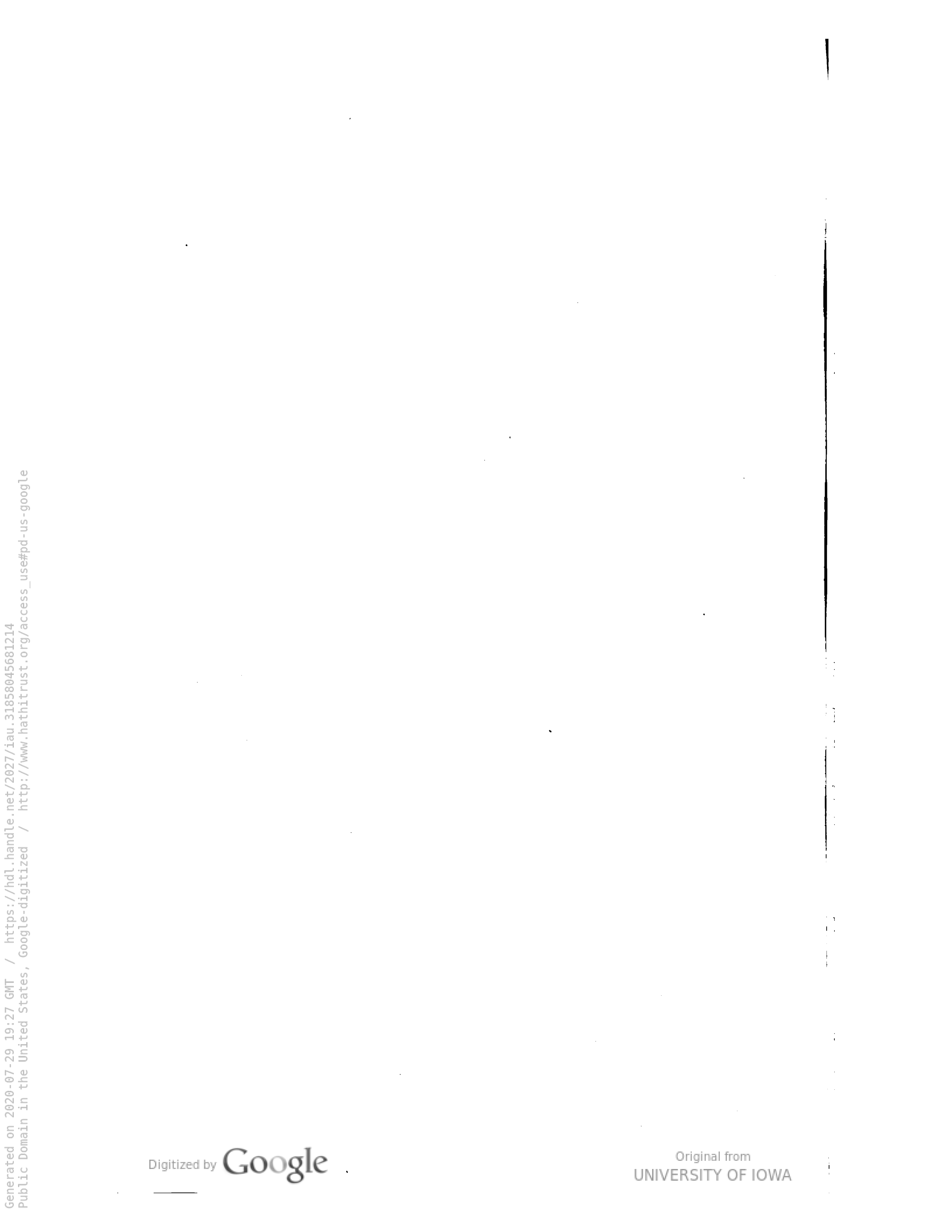
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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

SIXTY-NINTH ORDINARY MEETING, *December 6th*, 1901.

E. CRESSWELL BABER, M.B., President, in the Chair.

ERNEST WAGGETT, M.B., CHARLES A. PARKER, F.R.C.S.(Ed.), } Secretaries.

Present—35 members and 5 visitors.

The minutes of the preceding meeting were read and confirmed.

The following gentleman was nominated for election at the next meeting of the Society:

Arthur Stanley Green, M.B., B.S.Lond., 9, West Parade, Lincoln.

The following cases and specimens were shown:

PERFORATION OF LEFT FAUCIAL PILLAR.

Shown by Dr. FURNISS POTTER. This case was exhibited chiefly because it presented a considerable contrast to the case shown by Mr. Waggett at the last meeting of the Society, and

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also because of Dr. Clifford Beale's remarks on that occasion, who stated that from inquiry he had learned that perforation as the result of scarlet fever was almost outside the experience of physicians at the fever hospitals.

The patient, a single woman æt. 24 years, stated that she had scarlet fever when she was four years of age, at which time she had "a very bad throat and mouth." No history of syphilis was obtainable. On examination a slit-like opening about three quarters of an inch long was seen in the left anterior faucial pillar, through which a probe could easily be passed. In the right posterior pillar there was the appearance as of a perforation, but a probe could not be passed through. There was considerable cicatricial tissue in the pharynx, and the right posterior pillar was partially adherent to the pharyngeal wall. The angles of the mouth were scarred. There were no signs of tonsils. As a result of the scarring there was considerable deformity and interference with distinct articulation, the patient speaking in a manner somewhat resembling that of a case of cleft palate.

Dr. Clifford Beale said that on looking at the case one could not help having rather a doubt as to its causation. There were scars on the edges of the lips and elsewhere in the mouth, which were, in his opinion, most probably due to infantile syphilis. He thought it hardly fair to label the case as being definitely and entirely due to scarlet fever. If scarlatinal ulceration was a common cause of perforation more cases would have been noted, since scarlatinal patients were always kept under observation for some weeks after the cessation of the fever.

Sir Felix Semon did not quite know for what purpose the case had been shown. Was it merely to show the occurrence of perforations in the palate, or was it brought forward as a counterproof against the possibility of a *congenital* formation of such clefts in the palate? He thought the case was an excellent illustration of the fact that faucial webbing might be developmentally explained. He could not think of a better illustration showing the difference between a congenital defect and one of ulcerative agency, for in the congenital cases there was absolutely no trace of *cicatricial* tissue at the edges of the clefts, whereas in this case the cicatricial tissue was most marked.

Dr. F. de Havilland Hall suggested that possibly scarlet fever might have had something to do with the condition by depressing the patient's vitality, and allowing the poison of hereditary syphilis to act.

Dr. Furniss Potter said, in reply, that with regard to Dr. Clifford Beale's remarks as to syphilis acting as a cause, he had carefully

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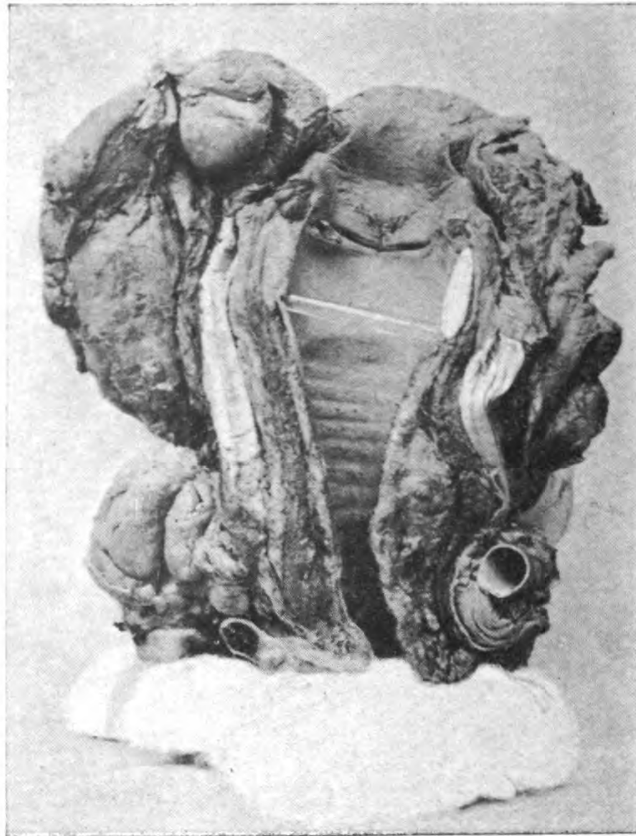

Process reproduction of a photograph of a larynx removed, July 18th, 1898, from a woman aged 23, a subject of Hodgkin's disease.

The larynx has been opened to show an ulcer on the posterior part of the left vocal cord; the adjacent lymphatic glands are considerably enlarged. No evidence of tuberculosis was found in the lungs.

To illustrate Dr. Jobson Horne's communication on a "Path of Infection in Hodgkin's Disease."

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questioned the girl, but could not elicit any history leading him to suppose that she or her family had been affected by syphilis. The patient stated that she suffered at the time of having scarlet fever from very severe ulceration of the throat and mouth, the ulceration, in fact, extending to the mucous membrane inside the cheeks, and to the lips. This would, he supposed, account for the scars at the angles of the mouth.

With regard to Sir Felix Semon's question, he showed the case because he thought it was in sharp contrast to the one shown by Mr. Waggett at the November meeting, and also because it would be of interest after Dr. Clifford Beale's remarks on that case in November.

Macroscopic and Microscopic Specimens of the Larynx from Cases of Lymphadenoma, Lympho-sarcoma, Tuberculous Lymphadenitis, etc.

Shown by Dr. Jobson Horne. Dr. Jobson Horne exhibited and demonstrated these preparations, and said that upon them he had based his opinion that the diseases generally grouped under the name of Hodgkin's disease were due to infection, and that one manner of entry of the infecting agent was through ulceration in the larynx. An account of the work he had done on this subject would be found in the 'Journal of Laryngology' for December, 1901. Dr. Horne mentioned that in one of the cases (microscopic sections of which were exhibited) he had found tubercle in a gland which presented the structure of lymphadenoma, and which was adjacent to the ulcer in the larynx; this, he considered, raised the question whether the ulcer in such a case and in the absence of tubercle in the lungs should be regarded as evidence of primary tuberculosis of the larynx.

Dr. FitzGerald Powell thought he understood Dr. Jobson Horne to say lymphadenoma was due to tubercular infection; he should like this explained.

In reply to Dr. FitzGerald Powell's question as to whether lymphadenoma and tuberculosis were to be regarded as one and the same disease, Dr. Horne said it was a point on which it was difficult to make himself clearly understood, for this reason: that tuberculosis was an entity, and lymphadenoma might also be one, but at present, no two people in discussing lymphadenoma seemed to be quite agreed upon what should be regarded as lymphadenoma. Dr. Horne said he recognised a distinct histological structure as characteristic of lymphadenoma; in that structure he had at times observed distinct

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histological tubercle with giant-cells and tubercle bacilli; whether the lymphadenoma structure had been developed through the presence of tubercle, or whether the tubercle had been added to the lymphadenoma, there was not sufficient evidence at present upon which to base an answer.

Case and Specimen of Tubercular Rhinitis in a Man Æt. 35, treated with Röntgen Rays.

Shown by Mr. L. Lawrence. The patient, a road surveyor, had been troubled with discharge from the nose for rather more than a twelvemonth. Some months ago he was treated with douches, first of boracic acid, and later of an alkaline lotion with some apparent benefit. Later the discharge returned, and on September 21st last the following condition was noted:—The whole septum, both sides and also both sets of turbinate bones were, as far as visible, greatly inflamed and covered here and there with yellow patches. The mucous membrane in many places was polypoid. In the floor of the nose on both sides the septum and inferior turbinals were pressing against each other. There was abundant offensive discharge from the nose. A piece of polypoid mucous membrane was removed for microscopic examination, and well-marked tubercle (exhibited) was shown. The man's general health had been good all along, but he had had severe supra-orbital neuralgia and some pain in the eyeballs. Treatment by exposure to Röntgen rays had been tried since September. The patient had had twenty-one applications, varying from seven to ten minutes each. His symptoms had considerably abated, and there was much less swelling in the nose than formerly. The pain also had gone from eyes and forehead, and the patient now expressed himself as feeling more comfortable.

Dr. Hugh Walsham explained the technique of the treatment of such cases with Röntgen rays.

Dr. Herbert Tilley wished to suggest in connection with this case that if after twenty-three applications of the Röntgen rays, administered by such an expert as they knew Dr. Hugh Walsham to be, the improvement was not more marked than it appeared to be in this case, it was high time to proceed to other and more drastic

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measures of treatment. He suggested thoroughly curetting the ulcerated surface under general anæsthesia, followed by the rubbing in of pure lactic acid. The application of the Röntgen rays was a very interesting form of treatment which one would like to see more often applied to difficult cases of lupus of the inside of the nose, especially in the earlier stages of the disease. He could conceive that it might produce good results, similar to those obtained in lupus of the skin. He did not know how bad this case was when it was first seen before the rays were applied, but it was obvious that it must have been an exceedingly bad one if the present condition of things was supposed to be one of great improvement.

Mr. DE SANTI had recently had two such cases under his care in the out-patient department; they were both tubercular affections of the nose. One was treated by the Röntgen rays and the other he was treating with urea (ten grains to the ounce of water). He was bound to admit that the latter treatment had been much more effective than the former. The urea was taken internally, and local treatment was also applied to the interior of the nose of the nature mentioned by Dr. Tilley (scraping, lactic acid, etc.). He had also had very satisfactory results in cases of tubercular glands of the neck treated by the internal administration of urea.

Dr. STCLAIR THOMSON suggested that as primary tuberculosis of the septum was very rare, Mr. de Santi should put his cases on record. There were only seven cases in British literature bearing on the subject. Six of these were reported by Mr. Steward, of Guy's Hospital,* and the seventh by himself.† His authority for this statement was Renshaw of Cambridge, who searched the literature in connection with some animal experiments in which tuberculous matter was inoculated into the nose ('Journal of Pathology,' vii, No. 2, 1901, p. 142). These seven cases did not include lupus. His own case was shown at the Clinical Society, and he had watched it for four years. The treatment had, to a great extent, been palliative, and its condition was now much better than the one they had just seen in the adjoining room. The treatment in his own case consisted of cleanliness, with a little curetting, the use of lactic acid, and general hygiene. The patient objected so strongly to the curette, and was so positive that she was better without it, that he had not pressed it. The same patient was treated by Dr. Watson Williams at the Bristol Infirmary with tuberculin, to which she reacted violently according both to her own account and that of Dr. Watson Williams, and she was no better for it. He had not seen the patient now for a year, but the progress of the disease was extremely slow, and at that time her condition was very comfortable.

Mr. DE SANTI, in reply to Dr. Thomson, said his cases were not primary tuberculosis of the nose, but cases of lupus, which he included in the designation "tubercular."

The PRESIDENT regarded the case as one of chronic tuberculosis of the nose; such cases were not uncommon. As regards the light

* 'Guy's Hosp. Rep.,' vol. liv.

† StClair Thomson, 'Clin. Soc. Trans.,' October, 1897, and February, 1900.

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treatment, he had had a case of this description which he saw in the spring, in which the patient received eighteen applications of Finsen's light treatment for spots of lupus outside the nose, and twenty applications of X rays. The former seemed to do some good. Of the X rays he could not speak so decidedly; if they had any effect at all in this case, which had been previously treated by curetting, lactic acid, etc., it was in making the parts look more glazed and drier. As regards the internal administration of urea, he mentioned that his colleague, Mr. Buck, had obtained good results from it in lupus of the skin. He himself had tried it in one case of tuberculosis of the nose, and had given it for about four months. The nasal mucous membrane had been previously curetted and treated with lactic acid, and the patient expressed herself as very satisfied with the urea treatment; at any rate, no re-growth had occurred, although there had been no scraping for some months, only applications of lactic acid. It was impossible, of course, to draw any conclusions from a single case of this character; a large number would require to be treated before an estimate of the value of urea given internally could be formed, and it should, if possible, be tried on cases that had not been submitted to local treatment. With regard to the case under discussion, he thought thorough curetting was necessary, or else a further course of the Röntgen rays. Personally he would advise the former, and then apply lactic acid in the usual way. The Society were much indebted to Mr. Lawrence for bringing forward such an interesting case, and also to Dr. Hugh Walsham for explaining the method and technique.

Mr. LAWRENCE said: "As regards the treatment of the case, of course the obvious thing at present would be to curette it and rub in some lactic acid. I think, looking to the fact that the Röntgen rays have done considerable good, and that there is really no great urgency in the case, and that it is improving slowly, it is worth while trying the rays for a little longer, especially as Dr. Walsham is willing to go on with the treatment to see how it answers. On a future occasion I will, if you will allow me, bring the patient before you again."

CASE OF COMPLETE LOSS OF INTERNAL FRAMEWORK OF THE NOSE IN A GIRL ÆT. 22.

Shown by Dr. CATHCART. The patient was quite healthy up to the age of thirteen. She then contracted scarlet fever, followed by inflammation in the nose, which resulted in complete loss of all the internal nasal structures. The bridge of the nose had fallen in, and Dr. Cathcart would like to have the opinion of any member who had had experience of the subcutaneous injection of paraffin as to whether this was a suitable case for such treatment.

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Dr. Scanes Spicer had had one case in which he had injected vaseline under the skin of the nose for a very similar deformity. The only disadvantage which followed was that some of the paraffin worked its way into the upper eyelid. He had shown the casts of the nose before and after treatment, and photographs at the meeting of the British Medical Association at Cheltenham this year. Within the last few weeks he had handed over the patient to the ophthalmic department to see if it were practicable to remove the paraffin from the subcutaneous tissue of the lid; but having made an incision, Mr. Keeling had not been able to improve matters, and so the puffiness of the lids remained. He hoped to show the photograph and the patient at the January meeting of the Society if possible. The technique for inserting the paraffin into the nose was rather troublesome. He used just such a small syringe as used to be used for tuberculin injections. He heated the paraffin in a water-bath, and had the patient standing near. Having sterilised the skin with alcohol and sublimate solution, he injected three or four syringefuls of the paraffin into the subcutaneous tissues over the middle of the nasal bridge, and moulded the mass up with the fingers to the shape of a normal nose. The point of injection was sealed with collodion. In future he would inject only a small amount at one time, and repeat as necessary, and he would press down the skin at root of nose on to the subjacent tissues, so that nothing could escape, at all events at time of injection. He thought Dr. Cathcart's case was a suitable one, because the skin was so freely moveable, and a bolster of paraffin between the skin and the bridge would make a presentable nose. The paraffin in his own case had now been *in situ* six or seven months, and it was really wonderful how well it filled up the depression which had previously existed in the bridge. Before commencing treatment the condition was quite as bad as that now seen in Dr. Cathcart's case, whereas now there was really quite a decent bridge, though the feature was not of an ideally refined type.

In reply to Dr. Tilley, Dr. Spicer stated that the paraffin used melted at 105° or 106° F., and was sterilised. It was a mixture of lard and soft paraffin, as first recommended by Dr. Gersuny of Vienna.

Dr. StClair Thomson asked if there were not some doubt as to this case being the result of scarlet fever. He saw the words used to describe the case were "after scarlet fever." Did the history point indubitably to this destruction being the result of scarlet fever? Perhaps members with a greater experience than he possessed would tell the Society whether it was ever a recorded occurrence for the bony framework of the nose, or even part of it, to be destroyed by scarlet fever.

Dr. S. Snell thought that the patient had been the subject of interstitial keratitis; there was also scarring at the right angle of the mouth, and he was therefore of opinion that this was a syphilitic lesion, perhaps lighted up by the scarlet fever.

Dr. Cathcart was much obliged to Dr. Scanes Spicer for the description of the technique he had given, and for the results of his experience, and if he decided to inject paraffin he would take advantage of the latter, and try and prevent the paraffin going into the lids.

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With regard to what Dr. StClair Thomson had said in reference to the ætiology, according to the description given him, the affection came on immediately after or during an attack of scarlet fever.

With reference to a specific origin, there was a small leucoma on the corneal periphery below, in the right eye, but it was confined to one eye and was not interstitial keratitis, but a leucoma following an ulcer.

Case of Mal-development of the First and Second Branchial Clefts.

Shown by Dr. Cathcart. The patient, a boy æt. 8, has mal-development of the first and second branchial clefts on the right side. There is a rudimentary auricle, slight facial paralysis, and a sinus halfway down the anterior border of the right sterno-mastoid. There is also marked hydrocephalus.

Case of Epithelioma of the Epiglottis in a Middle-aged Man.

Shown by Mr. E. Waggett. This was a case of slow-growing epithelioma involving the cervical glands. It was brought forward as one in which divergent opinions might be expressed as to the possibility of radical operation.

Sir Felix Semon did not think this a case suitable for operation. The disease was very extensive, and had infiltrated the pharyngeal wall on both sides; there were also large glands on both sides. Even if it were possible to remove the disease entirely, which he doubted, rapid recurrence would be unavoidable.

Mr. de Santi fully agreed with the remarks of Sir Felix Semon. He did not think in that particular case it would be possible to get away the whole of the disease. It should be left entirely alone.

Case of Cicatricial Stenosis of the Pharynx in a Young Woman, the Sequel of Cut Throat inflicted Eighteen Months previously.

Shown by Mr. Waggett. Deglutition and respiration were embarrassed by a firm web binding the epiglottis to the posterior wall of the pharynx. A cutting operation through the mouth had been followed by some dyspnœa, and it was now proposed to perform laryngofissure.

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Case of Paralysis of the Left Vocal Cord in a Woman Æt. 42, probably of Specific Origin.

Shown by Mr. de Santi. The patient had suffered from embarrassed breathing for from three to four months; she had also had a bad cough during the last six months. There were well-marked tertiary scars about both legs, and her last baby, born five years ago, had had snuffles, etc. Examination of the larynx showed well-marked paralysis of the left vocal cord, otherwise the larynx was normal. There was no swelling in the neck to be discovered, and examination physically of the chest had been negative. The case looked, however, like one of thoracic aneurysm with pressure on the left recurrent laryngeal nerve, and this would tally with the history of syphilis. (Subsequent to the meeting the thorax was examined by the rays, and a dilatation of the arch of the aorta easily made out.)

Case and Specimen of Fibroma of Nasal Vestibule.

Shown by Mr. W. H. Kelson. The patient, a man, came to hospital complaining of a tumour which blocked the left side of his nose and produced considerable deformity. He had noticed it for about ten years. It looked and felt like a cyst. An incision was made through the skin of the vestibule, where the growth appeared to take origin, and it was enucleated. The tumour, which was about the size of a small hen's egg, was solid, and microscopically was seen to be a fibroma. Patient had had one or two similar tumours removed from other parts of his body. The side of the nose previously blocked was now pervious, and the deformity had quite disappeared.

Case of Sublingual Dermoid Cyst in a Male Æt. 17.

Shown by Dr. Wyatt Wingrave. The symptoms were chiefly discomfort in deglutition and speech of about two months' duration. The swelling was visible on each side of the frænum

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linguæ of a somewhat purple colour. It projected below the mandible, fluctuated, and was painless.

It was opened nine days ago on the left side of the foramen, releasing at first a small quantity of clear thin fluid with a few white flakes. On digital pressure about two ounces of white pasty matter, resembling German yeast, was evacuated. This mass was not fœtid, and consisted microscopically of amorphous fat granules and epithelial squames.

Part of the capsule, which was deeply situated and very thick, was excised, and the cavity, which extended under the tongue between the genio-hyoglossal muscles, was scraped and swabbed out with pure phenol.

The foramen cæcum was not well marked, and although the cavity extended closely to it, no actual communication could be made out.

The contents conformed in every respect with cholesteatomatous cysts of the auricle.

A similar case was recently under his care in private, in the person of a young athlete æt. 22. The history, anatomy, and treatment were exactly like the present case, but it healed without suppuration, and had caused no further trouble, there being no signs of its existence eight months after operation.

Case of Tubercular Larynx with Fixation of the Left Cord.

Shown by Mr. C. A. Parker. The patient, a man æt. 29, complained chiefly of hoarseness. On examination there was found to be some general chronic laryngitis, but the more marked pathological changes were confined to the left side of the larynx. The left cord was infiltrated, ulcerated, and fixed, and there was a red fleshy swelling springing from the left ventricular band.

The patient had been losing flesh slightly, and there were signs of commencing phthisis at the left apex.

Just before coming to the meeting Mr. Parker had learned that the case had previously been brought before the Society by Dr. Furniss Potter in June last.* There were then no signs of phthisis, and the cord was freely moveable.

* See 'Proceedings,' vol. viii, p. 141.

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Dr. CLIFFORD BEALE stated that when he examined this case he certainly thought that the left cord moved as well as could be expected in a patient the subject of that amount of disease. He did not think it was fixed when he saw it. It quite fell into one's ordinary experience of unilateral tubercular disease in the larynx when comparatively acute. Sometimes in such conditions the cord worked well and sometimes not. Very often in consultation one had a little indecision in these cases as to whether the cord was fixed or not, but after observing it for a short time one generally came to the conclusion that the damaged cord moved very much like an arm when damaged, *i. e.* sometimes better than at other times, but at all times badly and stiffly. With regard to the question of fixation as the result of tubercular disease, he thought it would be better to exercise care in reporting and describing these cases if there was a doubt as to the absolute fixation. Such a case as the one under discussion, if so described, would make it appear that the Laryngological Society of London recognised fixation of the cord as one of the natural sequences of tubercular disease of the larynx. He ventured to say that the Society would not give their assent to that opinion. He had not yet seen any case put on record to prove that fixation of the crico-arytænoid joint did occur as a direct result of tubercular disease.

Mr. C. A. PARKER said in reply that he quite agreed with Dr. Clifford Beale that there was not absolute fixation of the cord; "impairment of movement" would have been a more correct description. At times, however, he thought the cord refused to act at all.

CASE OF RE-GROWTH OF MALIGNANT DISEASE IN A MAN ÆT. 52, AFTER PARTIAL REMOVAL BY LARYNGOFISSURE.

Shown by Dr. STCLAIR THOMSON. This patient was shown to the Society in June last (*vide* 'Proceedings,' vol. viii, p. 136), with a growth involving the anterior four fifths of the right cord, and the anterior third of the left. It was then generally agreed by members that the growth was malignant and suitable for thyrotomy. This operation was undertaken on June 18th, and as soon as the skin incision had been carried down to the front of the larynx it was seen that the disease was much more extensive than any one had suspected. The glands in front of and alongside the larynx were infiltrated and the muscles even were affected, while the thyroid cartilage itself had broken down in the middle line. It was noteworthy that no one who had seen the case beforehand had suspected this malignant perichondritis, though possibly it was indicated by a red fleshy

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granulation below the cords in the anterior commissure. (This was indicated in a drawing handed round, made by an artist the day before the operation.)

In spite of the extension of the disease beyond the confines of the cartilaginous voice box it was thought desirable to give the man any benefit of doubt, and all the soft parts inside of the thyroid cartilage were widely removed, the cartilage being left bare on each side and the cords removed right back to the arytænoids. The infiltrated parts of the cartilage in front were cut away.

One interesting point was to note how well the patient stood the operation. That evening his temperature was 100·8°, but the next day it was only 99·4°, and it never rose higher. He swallowed water on the evening of the operation. The next day he sat out of bed for four hours, and forty-eight hours after the operation he was swallowing solid food, such as eggs and bread and butter.

The neck wound healed well, and he gained a fair whispering rough voice from the development of cicatricial tissue in the larynx into pseudo-vocal cords. At the end of July he appeared fairly well.

He did not come under observation again until November 30th, when the growth was seen to have re-grown on the right side, where an enlarged gland is to be felt.

The growth removed was reported by the pathologist to be epithelioma.

The patient now weighed fifteen stone and had remained these six months in the enjoyment of good general health, and no local discomfort beyond the diminished voice power.

Sir Felix Semon would make a further attempt, for it seemed to be a pity that nothing more should be done. The disease still appeared to him limited enough, so that a second operation of the same sort might be more lastingly successful than the first one had been.

Mr. de Santi understood from Dr. StClair Thomson that when operating enlarged glands were found, and also some glands which were not usually described, namely, one or two in the front of the larynx—the prælaryngeal glands. It would be interesting to find out whether these glands, which were removed at the time of operation, were infiltrated with epitheliomatous disease. If so—and it was presumable they were involved—one would not get any really good results from a

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second operation, as recurrence would undoubtedly take place rapidly. Moreover the disease was very extensive, and it was a question whether its limits could be at all defined. In his opinion, therefore, it was not a suitable case for secondary operation.

Dr. LAMBERT LACK did not think further operation advisable. The growth had spread to the arytænoid and anterior wall of the pharynx. If operation were decided on, the case required total extirpation of the larynx and part of the pharynx as well.

Sir FELIX SEMON said he should like to know why extirpation of the whole larynx was recommended by the last speaker. There was no evidence of the return of the disease on the left side. In other respects the man was in a good state of health. If he personally was in this man's unfortunate position, he would rather undergo a second operation than go certainly downhill, as must otherwise be the case.

In reply to Sir Felix Semon, Dr. LACK said the chief point in favour of extirpating the whole larynx was that the mortality of cases in which half the larynx had been removed was very much greater than that of cases in which entire removal had been done. He further thought that total extirpation would give a better chance of freedom from recurrence.

Dr. STCLAIR THOMSON said he had not seen the patient since the end of last summer until a few days ago, but after some discussion of the case in the next room the history came back to his memory. He was speaking now without having recently looked up his notes. When he made the first incision at the operation, he came down at once, as Mr. de Santi had mentioned, upon some glands in the neck which were distinctly infiltrated. They were situated over the crico-thyroid membrane. The thyroid cartilage itself was also involved, and was ulcerated so much that he resected portions of it, and clipped away a lot of muscle which appeared to be infiltrated. The pathologist reported that the growth was epitheliomatous. The disease had spread very much more than was suspected before operation. He agreed with Dr. Lack that it seemed to him the disease had spread through the arytænoid, and very possibly to the side of the pharynx quite close to the tongue, and so he thought an operation of any sort was almost hopeless, especially when one bore in mind the extra-laryngeal conditions found at the laryngofissure six months ago.

CASE OF COMPLETE PARALYSIS OF THE RIGHT VOCAL CORD IN A MAN ÆT. 33.

Shown by Mr. E. W. ROUGHTON. The patient had well-marked physical signs of phthisis and a small deep-seated swelling in the right side of the neck, which Mr. Roughton thought was a mass of tuberculous glands involving the recurrent laryngeal nerve.

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Dr. Clifford Beale had some doubt as to the absolute paralysis of the right cord here, for he saw it move to a certain extent.

Dr. FitzGerald Powell said there did not appear to be any tubercular disease in the larynx, but he thought the cord was quite paralysed; it was suggested that this was a case of fixation or paralysis of the cord from enlarged tubercular glands in the neck pressing on the recurrent laryngeal nerves, and this he thought to be the case.

Dr. Scanes Spicer thought the condition one of immobility from paralysis of nerves rather than organic fixation. He could not detect any movement whatever in this case, whereas he agreed with Dr. Clifford Beale as to the previous case shown as paralysis of cord that there was now considerable movement.

In reply Mr. Roughton said he did not think there had been any tubercular disease of the larynx at all.

Case of Hoarseness in a Child æt. 1 year and 10 months.

Shown by Mr. E. W. Roughton. In this case Mr. Roughton had been unable to obtain a view of the larynx.

Dr. Scanes Spicer considered that this was a very suitable case for trying the method of general chloroform narcosis with simultaneous local application of cocaine. He continued to find this combined anæsthesia invaluable in a large number of cases of laryngeal trouble in children in which it was essential to examine or operate on the larynx.

The President would advise trial of an examination with cocaine, using a tongue depressor and small laryngeal mirror. During respiration a momentary view of the glottis might be obtained.

Dr. Lambert Lack thought it would be quite easy to examine the child with the aid of his tongue depressor without using either chloroform or cocaine.

The President said he knew Dr. Lack's method, but had not always found it successful.

Growth in Larynx in a Case of Syphilis (for Diagnosis).

Shown by Dr. H. Lambert Lack. This patient, a woman æt. 37, has been under treatment for a month with ulceration of the left vocal cord, fixation of the left side of the larynx, and a fleshy growth springing from the anterior commissure. There is extensive scarring of the palate attesting former syphilis. In spite of large doses of potassium iodide (gr. xxv ter die) the

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laryngeal growth is increasing rapidly. The case is shown for suggestions as to diagnosis and treatment.

Dr. StClair Thomson said that pieces of the growth had been punched out, and so it was impossible to say clinically what it might be. He would like to hear the microscopist's report, as it might be tubercle, syphilis, or almost anything. At present it was only an ulcerated thickening.

Case of Swelling of Left Side of Nose (for Diagnosis).

Shown by Dr. Furniss Potter. The patient was a woman æt. 49, who stated that the swelling in her nose had been developing for the last four years. She had had pain at times, and some discharge. There was no history of syphilis. On examination the left side of the nose was seen to be considerably swollen externally, the mucous membrane of the left nasal fossa was swollen, and bled very readily on being touched. The septum was much thickened and presented two perforations, one behind the other.

Dr. FitzGerald Powell said he thought that this was a case of breaking-down gumma or tubercular abscess, but the perforation of the septum led one to suspect a specific origin. On making firm pressure on the swelling outside, pus was distinctly seen coming from a sinus on the inside of the nose.

Dr. StClair Thomson thought the condition of the septum suggested tuberculosis much more than syphilis, and that a portion of the hypertrophy might be removed and examined microscopically. It was a sort of thickening that could not be easily described, and was similar to the tuberculous case he had referred to earlier. The patient under discussion had had for four years a thickening of the skin on the nose, and he did not think it likely that a node could remain *in statu quo* as long as that.

The President agreed with Dr. StClair Thomson in believing the swelling looked more like tuberculosis. A piece should be scraped off and examined under the microscope.

Dr. Furniss Potter would act on the suggestions made, and obtain a scraping from the nose and have it examined microscopically.

Case of Stenosis of the Pharynx.

Shown by Mr. C. A. Parker. The patient, a woman æt. 37, stated that when ten years old she had an abscess in the neck

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followed by trouble in the throat which caused her to talk thickly. She was then and for many years afterwards under the care of the late Sir Morell Mackenzie. There was no history of scarlet fever and there were no definite signs of hereditary syphilis.

On examination, the tonsils and posterior pillar of the pharynx were seen to be bound down to the posterior wall of the pharynx; lower down the epiglottis was adherent to the pharynx, leaving a small circular opening not much bigger than a threepenny piece. On strongly depressing the tongue the opening could be seen by direct vision as a narrow vertical chink about half an inch long and an eighth of an inch wide. The patient had no difficulty in respiration and but little in deglutition; she could swallow solids, but occasionally fluids "go the wrong way."

The PRESIDENT said this case reminded him of one he had shown some years ago at the Society—a young person with stenosis of the lower part of the pharynx (see 'Proceedings,' vol. i, p. 9).

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ANNUAL MEETING, *Friday, January* 10*th*, 1902.

E. CRESSWELL BABER, M.B., President, in the Chair.

Present—18 members.

The minutes of the last Annual Meeting were read and confirmed.

Drs. H. Sharman and Braine-Hartnell were appointed scrutineers of the ballot, and the following officers were appointed for the year:

President.—E. Cresswell Baber, M.B.
Vice-Presidents.—E. Clifford Beale, M.B., F.R.C.P., and F. W. Bennett, M.D., and Dundas Grant, M.D.
Treasurer.—William Stewart, F.R.C.S.Edin.
Librarian.—StClair Thomson, M.D., F.R.C.S.
Council.—F. de Havilland Hall, M.D., F.R.C.P.; Sir Felix Semon, M.D., F.R.C.P.; H. Lambert Lack, M.D., F.R.C.S.; Richard Lake, F.R.C.S.; Ernest Waggett, M.B., and J. Barclay Baron, M.B.
Secretaries.—Charles A. Parker, F.R.C.S.Edin., and James Donelan, M.B.

The report of the Council was then read and unanimously adopted.

REPORT OF COUNCIL.

The past year has been marked by the deep sorrow of the Society at the lamented death of Her late Majesty Queen Victoria, the respectful expression of which was graciously acknowledged by His Majesty King Edward.

The Council has the pleasure to report that the Society continues in all respects in a most prosperous condition.

At the last Annual Meeting the rules, as revised by the late Council, were unanimously adopted. These rules include special

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provisions with regard to the qualifications for membership of the Society, and in consequence only five new members have been elected during the year.

The meetings have been well attended and the clinical material has been both interesting and abundant. By the exclusion of academic matter from the first section of each meeting the transaction of business has been facilitated.

The following report of the Treasurer was read and adopted:

During the past year the Society's receipts from all sources amount to £143 17*s*. 10*d*. Several members have neglected to pay their subscriptions for 1901, but most of the outstanding subscriptions referred to in the Financial Report of last year have now been paid in.

The total expenses have amounted to £140 10*s*. 10*d*., thus leaving an excess of income over expenditure of £3 7*s*. for the year. To this has to be added the balance brought forward from last year, viz. £216 11*s*. 1*d*., making a total credit balance on January 1st, 1902, of £219 18*s*. 1*d*. Of this amount £200 has been placed on deposit with the Society's bankers during the past year.

The Balance Sheet, duly audited and found correct by the auditors, Dr. FitzGerald Powell and Mr. L. A. Lawrence, is appended.

BALANCE SHEET, 1901.

INCOME.

				£	s.	d.
7 Entrance Fees				7	7	0
113 Subscriptions				118	13	0
10 „ (1900)				10	10	0
1 „ (1899)				1	1	0
Sale of 'Proceedings,' Reading-cases, etc., per Hon. Librarian				2	2	0
Interest on Deposit				4	4	10
Cash on Deposit	£200	0	0			
Balance brought forward from 1900	16	11	1			
Balance Jan. 1st, 1901	3	7	0			
Total Credit Balance	219	18	1			
				£143	17	10

EXPENDITURE.

	£	s.	d.
Rent	31	10	0
Adlard—Printing	68	15	6
Reporting	16	16	0
Baker—Microscopes	1	18	0
Pulman—Binding	3	6	0
Annual Dinner	10	2	0
Clarke—Indexing	1	10	0
Mathew (porter)	2	0	0
Tongue-cloths	0	12	6
Carbolic acid, etc.	0	7	3
Hon. Secretaries' Expenses	1	6	6
Hon. Treasurer's Expenses and petty cash payments	1	4	6
Bank charges	1	2	7
Total Expenditure for 1901	140	10	10
Balance	3	7	0
	£143	17	10

Dec. 31*st*, 1901. Audited and found correct, { H. FITZGERALD POWELL. L. A. LAWRENCE.

E. CLIFFORD BEALE, *Treasurer*.

The Librarian's report was then read and adopted.

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The following "Exchanges" have been regularly received during 1901:

Journal of Laryngology.
The Laryngoscope.
Revue Hebdomadaire de Laryngologie, d'Otologie, et de Rhinologie.
Annales des Maladies de l'Oreille, du Larynx, du Nez, et du Pharynx.
Monatsschrift für Ohrenheilkunde.
Archiv für Laryngologie.
Archives Internationales de Laryngologie, d'Otologie, et de Rhinologie.
Archivii Italiani di Laryngologia.
Bollettino delle Malattie-dell' Orecchio, etc.
Archivio Italiano d'Otologia.

Arrangements have been made for the exchange with the French journal 'La Parole,' edited by Dr. Marcel Natier.

The following works have been added to the library during 1901:

Presented by Dr. de Havilland Hall.

Fränkel, Prof. Dr. B. Adenoide Vegetationen. (Separat-Abdruck aus der Real-Encyclopädie der gesammten Heilkunde.)
" " Angina. (Separat-Abdruck aus der Real-Encyc., etc.)
" " Die Demonstrationen des laryngoskopischen Bildes. (Sonderabdruck aus Therapeütische Monatsschrift-herausgegeben von Dr. Oscar Liebreich.)
Lange, Victor. Sur l'emploi de la Méthode galvano-caustique dans le Nez et le Pharynx. Remarques présentés à la sous-section de laryngologie dans la 7e session du Congrès International des Sciences Médicales (Londres, août 1881).
Mygind, Dr. Med. Holger. Die angeborene Taubheit. Beitrag zur Aetiologie und Pathogenese der Taubstummheit.
Scheppegrell, Wm., A.M., M.D. Congenital Occlusion of the Posterior Nares.

The following have been presented by their authors:

Bar, Dr. Louis. De la Tricophyte du Conduit auditif externe. (Extrait des Annales des Maladies de l'Oreille, etc.). 2 copies.
Downie, Walker, and Kennedy, Robert. Two Unusual Cases of Stricture of the Œsophagus.
Downie, Walker. Four Cases illustrative of the Local Lesions resulting from the swallowing of Liquid Ammonia.
" " Two Examples in Men of severe and prolonged Attacks of Asthma, associated with, and apparently dependent upon, the presence of Nasal Polypi, extirpation of which resulted in complete Immunity from Asthmatic Symptoms.
Hall, Dr. de Havilland, and Tilley, Dr. Herbert. Diseases of the Nose and Throat.
Joris, Dr. Alois. Ueber die Anwendung des Menthol-Jodols in der rhino-laryngolischen Praxis.
Krieg, Dr. Robert. Atlas der Nasenkrankheiten von Hofrat. (Specimen containing Tafel VI.)
Gougenheim, A., and Lombard, E. de Paris. Indications opératoires dans le Cancer du Larynx. (Extrait Annales des Maladies de l'Orielle, etc.) 2 copies.
Natier, Dr. Marcel. Syphilis tertiaire du Nez chez une jeune Fille: Infection au cours de l'allaitement par la nourrice; sequestres et polypes muqueux. (Avec 4 figures dans le texte.) 2 copies.
Ropke, Dr. F. Three cases operated on for Otitic Abscess of the Temporal Lobe, with Fatal Result.
Williams, Dr. Watson. Diseases of the Upper Respiratory Tract. (Fourth edition.)
" " The Therapeusis of Gonorrhœal Urethritis, with special reference to Gonal (published by F. Williams and Co.).

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Williams, Dr. Watson. The Treatment of Tuberculosis and Catarrhal Conditions of the Respiratory Organs by the Isovalerianic Acid Ester of Creosote and the Eosolate of Quinine (published by F. Williams and Co.).

The following PROCEEDINGS OF SOCIETIES, etc., have also been added:

Jahrbücher der Gesellschaft der ungarischen Ohren- und Kehlkopfärzte (Dr. Ludwig Polyak).
Sitzungsberichte der Gesellschaft der ungarischen Ohren- und Kehlkopfärzte (Dr. Hugo Zwillinger), 1901. No 1 (2 copies) and No. 2.
Sitzungsberichte der Wiener Laryngologischen Gesellschaft, 1900.
Transactions of the 22nd Annual Meeting of the American Laryngological Association, 1900.
Brighton and Sussex Chirurgical Society, 1900–1.
Niederländische Gesellschaft für Hals-, Nasen-, und Ohrenheilkunde, Arnheim, 1901.
Catalogue of Accessions to the Library of the Royal College of Physicians of London, 1901.
Fourteenth Congrès International de Médecin—Rules.
British Congress on Tuberculosis—Programme.
Société Française d'Otologie et de Laryngologie, Réunion annuelle, mai, 1901.

At an informal meeting consisting of the ex-librarians, Dr. de Havilland Hall and Dr. Clifford Beale, the outgoing librarian, Dr. Dundas Grant, and the nominate librarian, Dr. StClair Thomson, with Sir Felix Semon, inspected the unbound material in the library of the Society and a number of papers which had little or no bearing upon the work of the Society were laid aside for elimination. The librarian trusts that the Society will approve of their recommendation being carried into effect.

The library has now attained such dimensions that the accommodation for it at the rooms of the Royal Medical and Chirurgical Society is quite inadequate. In order to relieve subsequent librarians of the necessity of finding space for it, the present librarian recommends that some arrangement should be made for its accommodation. He would also advise that a catalogue should be printed and placed in the hands of the members of the Society, and spaces or leaves introduced on which they could add the names of whatever additions are made from time to time; he is convinced that in this way the use of the library would be much greater than it is at present.

The meeting then adjourned.

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SEVENTIETH ORDINARY MEETING, *January 10th*, 1902.

E. CRESSWELL BABER, M.B., President, in the Chair.

ERNEST WAGGETT, M.B., } Secretaries.
CHARLES A. PARKER, F.R.C.S.(Ed.), }

Present—34 members and 1 visitor.

The minutes of the preceding meeting were read and confirmed.

The ballot was taken for the election of the following candidates, who were unanimously elected:

As Honorary Member:

Thomas James Walker, M.D.Lond., of Peterborough.

As Ordinary Members:

A. Stanley Green, M.B., B.S., 9, West Parade, Lincoln.
James M. Browne, M.B., 27, Wellington Road, Cork.

The following cases and specimens were shown:

SPECIMEN OF A PEDUNCULATED ANGEIOMA OF THE LARYNX.

Shown by Dr. BRONNER. The patient, a strong, healthy man æt. 63, was seen in June, 1901. For the last twenty years the voice had been slightly hoarse, and he could not speak for any length of time with comfort. Five months ago the voice suddenly became very hoarse, and had remained so ever since. There was no dysphagia or dyspnœa. A large red raspberry-shaped growth was seen in the glottis, about the size of a marble; only a small part of the vocal cords was visible. A piece of the growth was removed for examination. The Clinical Research Association reported: "This seems to be a nævoid growth in the mucous membrane, which is ulcerated in the centre and become consolidated with fibrin and exudation.

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The vascular channels in the deeper tissues are large and numerous."

The growth was removed by Fränkel's forceps. There was now a small red swelling in the anterior part of the left vocal cord, but otherwise the larynx seemed to be normal. The voice was better than it had been for twenty years, and up to the present there had been no recurrence.

Mr. P. DE SANTI said that from the general appearance of the growth under the microscope there was, in his opinion, no doubt that it was a tumour of the nature of nævoid tissue, and that the case was one of "pedunculated angeioma." He understood that Dr. Bronner wanted to know if the Society agreed with his diagnosis.

CASE OF A FEMALE WHOSE SADDLE NOSE HAD BEEN TREATED BY SUBCUTANEOUS INJECTION OF VASELIN (PARAFFIN), WITH CASTS AND PHOTOGRAPHS TAKEN BEFORE AND AFTER TREATMENT.

Shown by Dr. SCANES SPICER. The patient, æt. 25, had applied for treatment for nasal suppuration and fœtor, which had lasted from childhood. There was a negative history as to traumatism or acquired syphilis, but some doubt as to evidences of congenital taint. She had a well-marked tip-tilted saddle nose and stunting of the nasal framework. Crescentic wrinkles from eye to eye over the bridge of the nose were well marked, as seen in Cast No. 1, taken the day before injection (May 6th, 1901). In addition to ordinary methods of treatment for nasal suppuration, the speaker suggested improving the shape of her nose by injecting sterilised vaselin as first described by Gersuny of Vienna. He had obtained the result indicated by Cast No. 2 and Photo. No. 2 (taken end of July, 1901).

The paraffin used was a mixture of hard and soft paraffin made to meet at 40° C. (105° F.), previously sterilised and kept in sealed bottles. The skin of the nose, etc., was cleansed first with alcohol and then with Liq. Hydrarg. Perchlor. The syringe and needle were cleansed and boiled in the steriliser, which was also used as a water bath to heat the paraffin. A German glass hypodermic syringe was used, like that for injecting tuberculin. Ten to twelve syringefuls were injected, some

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downwards over nasal bends, some upwards from the sides of the nose into the depressed gap, and the injected matter was moulded by an assistant's fingers so as to shape the part before setting. The skin was again cleaned and the points of injection sealed up with collodion. The syringe was removed for refilling from the socket in the needle, which, when once *in situ*, was allowed to remain there until it was judged that enough vaselin had been injected at that spot. There was no pain, though the nose looked a little tense and brawny. No paraffin passed into the eyelids apparently at the time. There was afterwards no pain nor inflammation, but in a few days the upper eyelids became somewhat œdematous. This had varied in amount from day to day ever since, and in left upper eyelid was a little nodule the size of a large shot. This had been cut down on, but it did not appear possible to get it out.

The result, as far as the appearance of the nose went, was very palpable, the skin over the bony bridge of the nose being bolstered up, produced a very decent-sized organ. As it was done eight months ago and now remained in the same state as when first injected, it might be regarded, as far as could be seen at present, as permanent. It was certainly a great improvement to her appearance, and the patient states that her mother was "proud of her in her altered condition." The patient indeed alleged that there had been an improvement in her general health and nasal suppuration since, but that was doubtless due to the general tonics and nasal washes she had used. The passage of a nodule of paraffin into the upper eyelid was disappointing, and so was the œdema of the lids. The former was not improbably due to the physiological action of the pyramidalis nasi, which would tend to shift movable bodies upwards and into the orbit. The latter might be due to a blockage of lymphatic vessels by the paraffin, some of which had probably got divided up into a molecular condition. It should be remarked, however, that the upper lids were inclined to be puffy before the injection. There was no œdema elsewhere in the body. In any future case Dr. Spicer thought still more care should be taken to put pressure on the root of the nose at time of injection, and he suggested that repeated injections of smaller quantities would in all probability be better than doing all at once. The method

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appeared to offer many advantages over plastic operations for this class of case. Gersuny injected cocaine before injecting the vaselin, but this, he thought, could be hardly necessary in nasal cases, as the only pain was the prick of the needle. In some of his cases of filling up cavities or formation of an artificial protuberance the effect produced by the vaselin had remained unaltered in shape or size for many months, the paraffin apparently having become encapsuled.

The PRESIDENT thought it a very interesting case, and would like to hear if anyone else had experience of the method. The paraffin injection seemed worth trying in such cases, provided precautions were taken to prevent the paraffin from running into neighbouring parts.

Mr. P. DE SANTI suggested that in treating these cases a piece of lead sheeting should be applied over the parts adjacent to the root of the nose, and firm pressure exerted on it during the injection of the paraffin. This method he had used successfully for removal of cirsoid aneurysm of the scalp. Such a piece of lead, properly cut and shaped, and applied round the neighbourhood of the root of the nose would, in his opinion, prevent the particular accident that had taken place in Dr. Scanes Spicer's case. If this were done he would also be in favour of not removing the lead for some little time after the operation. As he understood from Dr. Spicer that the infiltration into the eyelids had not taken place immediately after the injection of the paraffin, but some time afterwards, it would also be easy to keep up the pressure on the parts by means of the lead sheeting and bandaging. He congratulated Dr. Scanes Spicer on the fine nose he had made in this case.

Dr. BRONNER inquired if the paraffin had always been as soft as it was at present. He thought that by pointing the syringe downwards one would get over the particular difficulty that had arisen in this case. In a case of his own, which was similar to this, the nose was very much harder than that of the patient they had just seen, and his own difficulty was that immediately the paraffin was injected it assumed a certain shape, and retained that shape to such an extent that one could not mould it. Two or three weeks after the operation, in his own case, some inflammation set in. There was no pus, but the nose became red; in a few days, however, it settled down again to its normal state.

Dr. MILLIGAN asked what kind of paraffin had been used by Dr. Scanes Spicer, and what was the temperature at which it had been injected. It evidently was a very mobile paraffin.

Dr. LAMBERT LACK thought it might be possible to raise the skin and make a small cavity into which to inject the paraffin, instead of injecting it at random into the subcutaneous tissues. He thought the result in Dr. Spicer's case was excellent.

Dr. DONELAN said that with regard to preventing the rapid cooling of the paraffin, it might be possible to model a series of noses varying

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from the most aristocratic and refined to the most vulgar in type, and have them made on the principle of the Leiter's coil, with a double chamber, so that the temperature might be maintained at that of the injection, and the nose given any desired shape.

In reply, Dr. SCANES SPICER said that he put the bottle containing the paraffin and the syringe into a water bath and heated it till it was just mobile. Such a small quantity as was injected must very soon cool down to the body temperature. The paraffin described by Gersuny was described in the Austrian Pharmacopœia as unguentum paraffinum. It is said to melt at 40° C., *i.e.* 105° F. Rogers, of Oxford Street, had prepared it for him (and from this firm it could always be obtained) in hermetically sealed bottles. He was very careful to ensure asepsis. There was not the slightest reaction of any kind after injection in his case. The nose was possibly a little tighter at first than it was now. About six drachms were required to form the "bolster."

With regard to Dr. Lack's remarks, he wished to say the paraffin was not injected "at random." The point of the syringe was put down where the chief part of the bolster was required, and then the paraffin was injected little by little and slowly, and the lump rose before one's eyes. But he thought that speaker's idea of first making an incision and then a kind of cavity with a blunt probe beneath the skin a very good one, and if he had another case he would cautiously try it.. He feared, however, that bleeding might interfere with the operation. He tried to direct the shape of the bolster into that of a kind of omelette underneath the skin, between the skin of the nose and the bone. He had an assistant to help him while doing the operation, but the patient did not mind a bit, and did not even sit down for it.

SEQUEL TO CASE OF RADICAL CURE OF MULTIPLE SUPPURATIVE SINUSITIS AND POLYPOID DISEASE OF NOSE; PREVIOUSLY EXHIBITED APRIL 10TH, 1895, AND JANUARY 8TH, 1896.

Shown by Dr. SCANES SPICER. The patient, a male æt. 21, was first seen on November 4th, 1893, suffering from bilateral nasal obstruction due to polypi, accompanied by profuse suppuration. These conditions he had had for several years, for which repeated forceps operations had been performed. Lately he had lost 1½ stones in weight. Empyema of right antrum was indicated by symptoms, and corroborated by transillumination and by exploration through the canine fossa and irrigation. A day or two later the pus had collected near site of puncture and formed an abscess, which had burst into the mouth. The

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polypi were thoroughly removed, and also the anterior end of the right middle turbinated body and the polypoid masses about the ostium maxillare were thoroughly curetted. The discharge continued profuse. Radical operation, as described by the speaker, was recommended and performed in St. Mary's Hospital on December 2nd, 1893. A two ounce bottlefull of polypi, granulations, and cholesteatomatous *débris* were removed. There was severe febrile reaction afterwards, which soon subsided, and patient left hospital in ten days, and gained in first week at home 7 lbs. in weight. The polypi recurred and the nasal suppuration continued, though clearly not from the antrum, as when the patient blew through the antrum from nose to mouth or *vice versâ* no pus was seen. Removal of polypi and bone and curettement of the ethmoidal lateral mass under cocaine were persisted in on and off until March, 1895, when the bone about the right frontal eminence appeared swollen, and the skin over it tinged with an erysipelatous blush the size of a shilling, together with considerable pain and malaise. He had been losing weight again, and there was evening pyrexia. Retention of pus was diagnosed in the right frontal sinus, and the left was possibly involved also, though in a less degree. There were both polypi and pus in the left nostril, which had been treated throughout the case; the antrum on this side was translucent. Operation was recommended, and the frontal sinuses were opened on March 23rd, 1895. The patient had a very deep natural median furrow on the brow, so this was used for a mid-line incision. A half-inch trephine was used and applied centrally, its progress being carefully tested with clean quills. As soon as the sinuses had been entered on either side the crown was levered up from its attachment to the septum between the sinuses and detached. At once a membranous sac containing gelatinous polypi and yellow pus sprang from each sinus into the wound. Both sinuses were now thoroughly curetted out, passages made freely into the nose with sharp spoons, the cavities swabbed out with chloride of zinc, and a rubber drainage-tube passed through each sinus out through the corresponding nostril, their ends tied loosely together, and the skin incision sewn up. Warm boracic irrigations were used both through the tubes and in the nose, and

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the tubes were slightly moved each day, and were finally removed about the tenth day. The patient was shown to the Society on April 10th, and in the 'Proceedings,' vol. ii, page 74, is simply mentioned by name, as a case of antral empyema. The patient had gained eleven pounds in weight since the operation seven days previously, and there was hardly any discharge, while the skin wound had closed.

The patient was shown again at the annual meeting on January 8th, 1896, as an instance of a radical cure. There had been a gradual diminution of suppuration until it completely stopped, and no recurrence of it or the polypi had recurred for several months. The line of incision was almost invisible owing to the deep natural furrow.

During 1896 the patient entered the Army Medical Service and went to India on active work. He continued in the fullest enjoyment of health and energy till he injured his leg during prolonged riding on duty and developed phlebitis and thrombosis of the left saphena. On returning home in 1901 he was in St. Mary's Hospital. He then had not had any recurrence of polypus or nasal suppuration for over 5½ years. Unfortunately, however, the phlebitis in the leg persisted with relapses until, on October 3rd, he was considered to have recovered and to be fit to return to duty. He returned to London from the country with that view, when he was seized with cerebral thrombosis, from which he died in three days.

Dr. Spicer considered the interesting points about the case were its long duration, extensive diffusion, and obstinacy of the intra-nasal disease. Before coming under his charge irrigations only had been used, and removal of the larger polypi with forceps. He underwent constantly repeated operations at his hands for over 1½ years before the intra-nasal disease was finally eradicated, but in the end he was cured, and remained so for 5½ years, dying of a quite independent affection. Further, there was a remarkable gain in weight after each of the larger operations. Lastly, this was one of the first cases of cured frontal sinus empyema to be demonstrated at the Laryngological Society of London, and although the notes had not yet appeared in the 'Proceedings,' he thought they were of sufficient interest now the case is finally concluded.

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A Case of Bony Thickening over and Polypi within the Right Frontal Sinus in a Man æt. 40; Operation; Recurrence of Bony Growth and Commencing Similar Symptoms on the Opposite Side of the Face.

Shown by Dr. Scanes Spicer. The patient was first seen on November 23rd, 1901. A month previously a swelling had appeared over right frontal eminence with pain; the upper eyelid was œdematous and the palpebral fissure almost closed. There was a long history of nasal catarrh. Trans-illumination of the sinuses showed the most marked relative blackness over the affected eyebrow, with unusual translucency elsewhere. Dr. Spicer diagnosed intra-sinus disease with retention of fluid and distension of the anterior wall, and recommended exploration of the sinus. This was done, and it was found that the bone was unusually dense and thick, and a large amount of the diffuse osteoma was chiselled and gouged away. On reaching the sinus it was found to be filled with polypoid tissue; there was no communication with the opposite side. The sinus was gently curetted and washed out into the nose without difficulty, and then packed with ribbon gauze, the end being brought out through the forehead wound and the latter sewn up. The gauze was removed on the fifth day, and the patient made an uninterrupted recovery and was about within the week. Later he returned with a new rounded bony swelling on the frontal bone on the same side, which was slightly tender, and on the left side the eyelid was œdematous, and the palpebral fissure almost closed, and there was some ill-defined thickening of the left supra-orbital ridge. He said he had knocked himself there accidentally a few weeks before. He was ordered iodide of potassium gr. v, t.d.s., and directed to show himself in the beginning of the year.

It appeared to Dr. Spicer to be an unusual case. There was no history of rheumatism, gout, or any constitutional disease which might throw any light on the case. At the present date he has been taking the iodide for two months, the bony swellings had diminished, and the eyelids and palpebral fissures were both quite normal as well as the intra-nasal condition. The rapid

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diminution of symptoms under Pot. Iod. suggests "nodes" of a specific nature which, however, the extreme hardness of the bony tumour that was cut into would appear to negative, but opinions were invited as to the diagnosis of the case.

SPECIMEN OF PHARYNGEAL LIPOMA.

Shown by Dr. MILLIGAN. Mrs. H—, æt. 37, had suffered from her throat for from one to two years. She complained of slight dysphagia, a feeling of fulness in the throat and considerable amount of dyspnœa when lying down. Her general health had also depreciated and she had lost a certain amount of weight. On examination a large unilateral ovoid swelling was found under the mucous membrane of the posterior wall of the pharynx on the left side. The swelling extended upwards behind the level of the soft palate and downwards behind the larynx, where, indeed, the swelling was most prominent. To palpation the swelling appeared soft and doughy. There was no pain, no expectoration, and no temperature. Diagnosis lay between the possibility of a chronic abscess or lipomatous tumour. The fact that there was no indication of any bone disease present rather negatived the idea of abscess. The patient was put under chloroform with the intention of removing the growth through the mouth, but it was deemed advisable, owing to its size and to the dyspnœa from which she was suffering, during the chloroform anæsthesia, to make a lateral incision and remove the growth from the outside. This was accordingly done and the growth was successfully removed. The patient made an uninterrupted recovery, and was rapidly regaining her health and her strength.

The PRESIDENT thought it a very interesting specimen.

Dr. JOBSON HORNE thought it would considerably add to the value of the communication if Dr. Milligan would allow the Society to have a section of the specimen. As the specimen was in a bottle it was difficult to express an opinion as to its nature.

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Microscopic Section of Fibro-Sarcoma of Right Vocal Cord.

Shown by Dr. Milligan. H. C—, male, æt. 61, had suffered from his throat for six months. He complained of slight pain upon the right side, accompanied by progressive loss of voice. There was no expectoration, no loss of weight, and no history of any previous illness of any moment. When first seen there was slight congestion of the right vocal cord, but no appearance of any growth. When seen six months later the right vocal cord was found to be deeply congested, almost immobile, and growing from its upper surface, at about the junction of the middle with its posterior thirds, there was a smooth rounded reddish-looking growth about the size of an ordinary red marble. There were no enlarged glands. The rapidity of the growth, the almost complete fixation of the vocal cord, and the age of the patient made it probable that the growth was malignant. Its contour and its want of ulceration suggested a sarcomatous process. Immediate operation was advised. In the first place a tracheotomy was performed, and three days later the larynx was split and the growth fully exposed. It was removed entirely along with a considerable amount of contiguous mucous membrane. An uninterrupted recovery ensued, and at the present time, now nearly twelve months since the operation, the patient was in excellent health and with no appearance of recurrence.

Microscopically the growth had the structure and characteristics of a fibro-sarcoma.

The following is the report from the Clinical Research Association:—"On the free surface the specimen submitted shows considerable activity, and has the structure of a sarcoma, composed in the main of spindle cells, but also showing round and branched cells. The central part of the tumour is composed of fairly well developed fibrous tissue. From the appearances presented I think the tumour should be regarded as a fibro-sarcoma. The epithelium covering the tumour shows active proliferation, and at one spot there is irregular down-growth. At this point it is a question whether some of the large cells seen are not to be regarded as epithelial." Mr. C. H. Wells

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adds to this report: "I think, on the whole, that they should be regarded as derived from the connective tissues and not from the epithelium overlying them."

Dr. LAMBERT LACK suggested that both the above specimens should be referred to the Morbid Growths Committee. He thought there was considerable doubt as to the diagnosis in both cases.

Dr. MILLIGAN had not the least objection to the specimens being referred to the Morbid Growths Committee. With regard to the second, the piece shown was all he had, as the Clinical Research Association had not sent him back the remainder.

On the President putting the question to the Society, it was unanimously agreed to refer the two specimens—No. 5, specimen of lipoma of the pharynx, and No. 6, specimen of fibro-sarcoma of vocal cord—shown by Dr. Milligan to the Morbid Growths Committee for report and examination.

X-RAY PHOTOGRAPH SHOWING PLATE OF TEETH IMPACTED IN UPPER LARYNGEAL ORIFICE.

Shown by Dr. MILLIGAN. M. C—, female, æt. 32, swallowed her teeth during sleep, the place of impaction being doubtful. The X-ray photograph now exhibited was taken, from which it would be seen that the plate was lodged in the upper laryngeal orifice. By the help of a laryngoscope the plate was extracted, and the patient made a good recovery.

Dr. MILLIGAN also showed an X-ray photograph of a rubber tube which had slipped into the maxillary antrum in a case which had been operated upon for chronic maxillary antrum suppuration, and one of an ordinary Eustachian catheter passed into the frontal sinus of a patient suffering from chronic suppurative frontal sinusitis.

SPECIMENS OF PAPILLOMA OF THE TONSIL AND OF THE POSTERIOR PILLAR.

Shown by Dr. H. SHARMAN. The patient from whom these specimens were taken was a boy æt. 15, shown to the Society nearly four years ago, May 11th, 1898 (see p. 86 of vol. v of 'Proceedings').

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He had a sessile papilloma of the left tonsil and a pedunculated papilloma of the left posterior pillar of the fauces.

After the patient had been shown the tonsils were removed and the pedunculated papilloma also.

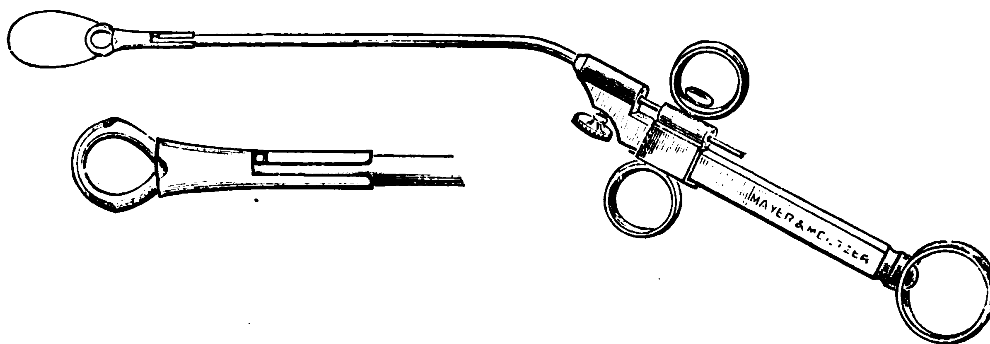
A section of the left tonsil through the papilloma was cut by Dr. Hewlett, and also a section through the papilloma of the posterior pillar. Both were true papillomata, with finger-like processes covered with stratified epithelium.

The interest of the specimens was that they showed that the papilloma of the tonsil grew from the *surface* of the tonsil proper (*not* from the interior of a lacuna), and that it apparently lay quite behind and unconnected with the expansion from the anterior pillar known as the "plica triangularis."

The slides have been presented to the Society.

A Self-Looping Nasal Polypus Snare.

Shown by Mr. Atwood Thorne. This snare was made by Messrs. Meyer and Meltzer, and consists of a Y-shaped end-piece fitted on to the usual Krause snare. The two upper ends of



the Y are joined by a slightly curved surface, and the polypus is caught between the wire and this surface.

The loop is tightened in the usual way by approximating the two finger plates. When the polypus is withdrawn from the nose by simply separating the finger plates, the loop is reformed without the usual fingering. As there is no knot or sharp twist in the wire, it has not the usual tendency to break.

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In addition to its use for simple polypus, it is particularly adapted for the removal of moriform growths from the posterior end of the inferior turbinal, as the instrument can be passed with the loop retracted, and when in its right position the loop can be ejected, when it will take on any curve to which it has been previously bent.

The instrument can be used for the larynx as well as the nose.

Messrs. Meyer and Meltzer can supply the instrument complete or will make the addition to a Krause snare for a small sum.

Mr. Bennett thought the instrument very ingenious, but doubted whether its practical application would be very useful. He used snares made on the same principle, though less perfectly finished than Dr. Thorne's snare. The objection was that a wire coiled round a large surface did not cut through if the tissues were at all thick, and then one had to tear the polypus off. In all tough growths this defect would be found a serious one, for in such cases one would have to use considerable traction.

Mr. Atwood Thorne had just heard that a similar device had been shown in Berlin about a year ago, but this was news to him. In the cases in which he had used it the results had been very good.

A Case of Nasal Obstruction in a Woman Æt. 24.

Shown by Dr. Jobson Horne. The patient had recently come under observation on account of symptoms attributed to nasal obstruction. The history was that some six or seven years previously she had suffered in a similar way, and had had the inferior turbinated bodies removed. An examination of the nose showed that the inferior meatus was very roomy, and there was evidence of a "spoke-shaving" operation having been performed, probably some years before. The middle turbinated bodies on both sides were hypertrophied and the middle meatus obstructed. The tonsils were somewhat enlarged, and there was hypertrophy of the adenoid tissue in the post-nasal space.

Dr. Jobson Horne brought the case forward with reference to two points. In the first place, the spacious inferior meatus with free expiration, and the occluded middle meatus with obstructed inspiration, supported the observations recently made by Mr.

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Parker ('Journal of Laryngology, Rhinol., and Otol.,' vol. xvi, p. 345) on the directions of the air currents in the nose; namely, that the current of inspired air passed upwards and backwards through the middle and superior meatus, entirely missing the inferior meatus, and that the current of expired air passed chiefly through the inferior meatus.

In the second place, the hypertrophy of the mucous membrane covering the middle turbinated bodies raised the question whether such hypertrophy could be consequent upon the removal of the inferior turbinated bodies, for if so, whatever the immediate result might be from inferior turbinectomy with a view to reducing inspiratory obstruction, the ultimate result might be the reverse to that anticipated, and most disappointing.

Dr. Herbert Tilley was very interested in the case, because he believed the nasal obstruction to be due, not to any of the intra-nasal structures, but to collapse of the alæ nasi. On asking the patient to breathe without a speculum in the nostrils, the alæ nasi on inspiration were both sucked in, and on expiration a considerable noise was made. But directly a speculum was inserted the patient breathed quite easily and noiselessly. Under these circumstances he considered that to carry out any operative treatment inside the nose would be both unjustifiable and unscientific. The possible and probable explanation of the condition was that as a child the patient suffered from adenoids or some form of nasal obstruction, and as a result of disuse the soft parts at the entrance of the nostrils had not developed, with the result which was evident in the case exhibited.

Dr. Bennett said there was another interpretation of the obstruction beside that given by Dr. Tilley. In most patients a sense of greater freedom was given when a speculum was inserted into the anterior nares. In this particular case the obstruction was not so much a real obstruction as a subjective obstruction. The patient stated that the right side was fairly free, but that the left side seemed blocked. Careful inspection showed that the anterior part of the left middle turbinal was in contact with the septum. Such contact often gives rise to a sense of obstruction. It can be cured by treatment which prevents this contact. In some cases this can be effected by the galvano-cautery, but the best method is to snare off a little of the redundant tissue on the inner side of the turbinal body. It is unnecessary to remove any bony tissue. He had come to the conclusion that it was very important in such cases to carefully distinguish between what might be termed objective and subjective obstruction.

Dr. Scanes Spicer was glad to hear Dr. Tilley's remarks in reference to the collapse of the alæ and the nasal vestibule as a factor in obstruction. He did not remember to have heard any special reference

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at this Society's meetings made to this, and yet, in his opinion, a great deal could be done for that factor in many cases of obstruction. What was wanted in this case was to secure efficient action of the dilatatores alæ nasi so as to lift away the alæ on inspiration. In many cases this could be effected by conscious education of those muscles by assiduous practice. In some of these cases this was much facilitated by a good stretching of the soft tissues of the alæ nasi with a Hill's dilator. This should be followed up by systematic lubrication of the nostrils, and the wearing at night of a support such as the celluloid nasal springs, or little pieces of red rubber tubing of the largest calibre the nostril could accommodate and as shallow as possible. Physical exercises also were adopted, which had the object of re-establishing the normal co-ordinated action between the alæ muscles and the other inspiratory muscles. He had obtained markedly good results in many of his own cases, and he did not think this matter had been brought forward as prominently as its relative importance and efficiency demanded, though he had no doubt many members used these measures. It was, however, undoubtedly true that in a large proportion of cases the alar stenosis element was ignored.

Dr. Burt had seen a similar case, and did not think operative interference would be of any use. By putting in a tube to force the alæ nasi to work well, some relief might be given. It was the only way in which he had been able to give relief in a case of his own, where the inferior turbinate body had been removed for some obstruction and the alæ nasi had collapsed. He did not think for a moment from his experience that mechanical dilatation would give permanent relief, for if the dilator were removed the alæ would soon fall in again.

Dr. P. McBride asked Dr. Scanes Spicer in what way he thought that forcible dilatation of the alæ could possibly affect the collapse. As far as he understood the cause, the collapse was due to paresis and resulting flaccidity; how, then, could stretching of the alæ possibly permanently enlarge the opening? He absolutely failed to see how it could be done. He was quite aware that Moritz Schmidt had written on the subject, and had come to the conclusion, after considerable experience, that mechanical dilatation, as accomplished by wearing a Feldbausch dilator, made the patients more comfortable, but he was unable to see how forcible stretching could permanently affect a condition of this kind.

Dr. Scanes Spicer asked Dr. McBride what he desired to infer by the term *paralysis* in these cases.

Dr. McBride said there was a dilator nasi, and he presumed the term "paresis," as applied to these cases, stood for paresis of the dilator nasi. He asked if after these measures described by Dr. Spicer patency was restored. What was the permanent outcome?

Dr. Scanes Spicer could not admit a "paralysis" in the true sense from nerve lesion. He thought that from long continued disuse (1) the alar muscles were weakened and paretic; (2) that the soft tissues of the alæ were stiff, rigid, and often contracted, and that the weakened muscles were unable to drag out the stiff tissues, especially when the action of the inspiratory air current led to a fall of atmospheric pressure in the nose; then the external atmospheric pressure

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drove in the alæ. He would therefore describe the condition as one of functional paresis of dilators from disuse, combined with a stiffness or rigidity of cellular tissues from disuse, similar to what occurred in an over-rested joint. He would therefore suggest, as an explanation of forcible stretching of the alæ, that the resistance against which the muscles worked was lessened, and they could overcome this lessened resistance in the same way that, after a stiff joint had been mobilised under anæsthesia, it could be moved after by its own muscles, and these could again recover good power by practice. It had happened to him several times that in the course of an operation under anæsthesia for complex intra- and post-nasal stenosis, he had ended up with dilating the alæ if collapsed and rigid, when immediately they began to resume their normal inspiratory rhythm, which was kept up afterwards by practice and tube supports.

Dr. McBride thought it would be most interesting if Dr. Scanes Spicer would show to the Society a case in which there was a collapse and in which this "mechanical dilatation" treatment had been tried, so that they could see if it was cured by that method.

Dr. Pegler said that with regard to the question raised by Dr. Jobson Horne as to whether in this case the middle turbinates were compensatorily hypertrophied, he did not think that these bodies were liable to this change. Here there was no hypertrophy of the left middle turbinate, but the right one showed signs of disease.

Dr. Milligan asked if there were any observations in the literature of the subject on what the paresis of the dilators was really due to. Had any microscopic examination of the muscle been made? If there was really an atrophy of the muscle, dilatation such as described could not have any possible value. If the muscle was atrophied, and it was dilated, would not the cicatricial contraction tend to narrow still more the vestibule of the nose? He was not aware of any observations having been made on the subject, but it was certainly one which might with advantage be investigated.

Dr. Jobson Horne, in reply, said he was glad to have heard so many suggestions and remarks; at the same time, it was a little difficult for him to accept the theory put forward by Dr. Tilley, attributing the obstruction to collapse of the alæ nasi. Dr. Horne said he was of the same opinion as Dr. Bennett in that the respiratory obstruction was caused by enlargement of the middle turbinated bodies and consequent narrowing of the meatus. He had brought the case forward mainly with reference to the two points stated in his opening remarks, but inasmuch as the treatment had been discussed he would mention that the patient had shown signs of commencing myxœdema, and had been taking extract of thyroid gland with beneficial results and subsidence of nasal symptoms. The case was therefore of value in illustrating the advisability of looking further afield for a cause in some cases of nasal obstruction, and of not overlooking the possibility of commencing myxœdema. He had no intention of suggesting further surgical treatment of the nose.

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Case of Herpes of the Palate.

Shown by Dr. H. Snell. The patient, a butcher æt. 40, had obviously been suffering from chronic laryngitis for the last three months. On December 25th he awoke with severe pain and feeling of choking in throat, which lasted badly for some hours. Since that time he had had pain in throat. When seen on January 4th there were several dark patches on the hard and soft palate (limited to right side), and on the right side of uvula there were two or three small, round, shallow ulcers. These appearances had now largely disappeared.

A Case of Syphilitic Laryngitis in a Man Æt. 52.

Shown by Dr. Donelan. The case had been brought before the Society on a previous occasion, since which he had been energetically treated by anti-syphilitic remedies, but though there had been improvement during the first few weeks, latterly the ulceration appeared to be spreading. The fixation of the left vocal cord was more marked than before, and he thought there was now evidence of malignancy, but desired the opinion of members.

Mr. de Santi thought it would be advisable to remove a piece of the growth and examine it microscopically. He thought it of a malignant nature. It certainly seemed to him to have altered a good deal since he last saw the case, there being greater thickening, ulceration, and fixity. But to clear up the diagnosis, recourse should be had to the microscope, and the case dealt with accordingly.

Dr. Donelan would endeavour to carry out the suggestions made by Mr. de Santi.

Case of Very Extensive Destruction of the Interior of the Nose, due to Tubercular Ulceration, in a Woman Æt. 31.

Shown by Mr. de Santi. The patient had been married seven years and had had one miscarriage. There was no history of acquired or congenital syphilis, and nothing to corroborate any such condition, except the state of the nose. For some four years

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the woman had suffered from chest trouble and hæmoptysis, and for three years she had been suffering from disease of the nose and larynx. There were well-marked physical signs of phthisis in both lungs, abundant tubercle bacilli in the sputum, and the larynx showed tubercular disease with ulceration. The main point of interest in the case was the very extensive destruction of the nasal cavities; the whole of the bony and cartilaginous septum had disappeared, and the greater part also of the turbinals; there was consequently great external deformity, due to falling in of the bridge of the nose. There was still active ulceration going on in the nasal cavities and tubercular ulceration of the larynx.

Mr. de Santi had never seen such extensive destruction of the nasal cavities follow on tubercular infection, and although there was no doubt about the tubercular nature of the case he considered there was a strong suspicion that syphilis played some part in the causation, in fact, that the case was one of mixed infection. As bearing on this question of syphilis, one could see on looking at the pharynx that there was a fenestra in the posterior pillar of the fauces on the left side; this was suggestive of syphilitic ulceration. Treatment so far had been entirely of an anti-tubercular character, and had been fairly successful in keeping the lungs and larynx from a rapid advance of the disease. He, however, now proposed to try anti-specific treatment as well.

The PRESIDENT asked if the sphenoidal sinuses had been investigated. He understood there was no doubt as to the tuberculous nature of the case, but something else besides tuberculosis seemed required to produce the deformity, *e. g.* syphilis. Accessory sinus disease might also be present.

Dr. FITZGERALD POWELL thought the patient was undoubtedly suffering from tertiary syphilis. He thought that there was not any appearance typical of tuberculosis. In reply to Mr. de Santi he said he had looked into the larynx, which appeared to him (from what was necessarily a cursory examination) to be the seat of syphilitic disease. With regard to the nose, he was quite convinced that the extensive destruction of the soft tissues and bone was the result of syphilitic ulceration. The same remark applied to the large perforation in the faucial pillar. Notwithstanding the fact that tubercle bacilli had been found in the nose, and that there was said to be tubercular disease in the lungs, he maintained that the extensive destruction of the nasal tissues was due to syphilis. This case presented very different

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appearances to cases of mixed disease he had observed, and some of which he had shown at a former meeting of this Society.

Mr. de Santi, in reply to the President, said he had not examined the sphenoidal sinuses. He adhered to his decision that the case was a tubercular condition; but he also considered it almost certain that a mixed infection of syphilis and tubercle existed, for he himself had never seen such extensive destruction of the interior of the nose from tubercular disease alone.

Case of Ulceration of the Nasal Septum with Marked Pain.

Shown by Dr. Bennett. Miss H—, æt. 22, came first under observation in 1898. She was pale, tired, overworked, and suffering from frequent gastralgia.

The right nostril was obstructed. The septum of the nose was perforated, causing whistling respiration, and there was a good deal of tenacious muco-purulent secretion in the naso-pharynx. There was marked pain in the nose, and especially high up on the right side, where the tissues were considerably swollen.

The pain and swelling gradually increased. Incision of the swollen tissues and the application of ice during a period of several days did little good. Soothing antiseptic ointments, calomel fumigations, tonics, iodides, etc., were tried, but all without good result.

In July, 1898, the swelling became very great and the pain intense, so under ether some of the middle turbinal tissue was removed and the septum curetted. For a few weeks there was slight relief. The removed tissues were examined on more than one occasion, but no light was thrown on the cause of the ulceration.

During the last two years there had been gradual extension of the ulceration until nearly all the cartilaginous septum had been destroyed. There had been very frequent small and occasional severe hæmorrhages. The pain had apparently been very severe on one or other side, and often it had been accompanied by redness of the side of the nose. The swelling of the septum had been very great, and it must have attained a thickness of about one inch.

In March, 1901, she consulted Mr. Bond, who advised removal

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of middle turbinal tissue so as to prevent the pain caused by the pressure of the swollen tissue. In June I removed more of the middle turbinals, and freely curetted the septal swelling.

Although there is relief as regards the nasal obstruction, the pain still remains as severe as before.

Dr. TILLEY said that the antra on both sides should be explored. From the right antrum at about the position of ostium, there was a small trail of yellow pus coming down. If there were pus in the antra, as he thought possible, he felt sure that their drainage would effect a considerable improvement in the condition of the nose. He had recently seen in consultation the case of a lady addicted to the cocaine habit, and who, under the influence of that drug, had picked away the whole of the cartilaginous septum, so that the combined nasal cavities were covered with a thin veneer of dried mucus and scabs producing an appearance identical with that showed by Dr. Bennett.

Dr. DUNDAS GRANT considered it a tuberculous condition of the septum. It might be lupus. It was too extensive for any form of simple perforating ulcer.

Dr. SCANES SPICER asked whether the ulceration *commenced* on the cartilage or on the bone. If the former he thought it was lupus, if the latter, syphilis. He had had a similar case, and showed it at the Society some three years ago. It had remained practically the same.

Dr. MILLIGAN thought it might be traumatic and the result of picking the nose followed by extensive ulceration. Was there any history to corroborate this view?

Dr. LAMBERT LACK suggested it might be a case of syphilis. He had never seen sinus suppuration cause a progressive destruction of the septum, whilst in cases of nasal syphilis, sinus suppuration was often seen.

Dr. BENNETT, in reply, said there was no disease of the ethmoidal or sphenoidal sinuses, and he should be astonished if the antra proved to be affected.

ERRATUM.

69th Ordinary Meeting.

Page 19, paragraph ii, line 2, *for* "lard" *read* "hard."

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

SEVENTY-FIRST ORDINARY MEETING, *February 7th*, 1902.

E. CRESSWELL BABER, M.B., President, in the Chair.

CHARLES A. PARKER, F.R.C.S.(Ed.), } Secretaries.
JAMES DONELAN, M.B., }

Present—37 members and 3 visitors.

The minutes of the preceding meeting were read and confirmed.

The ballot was taken for the election of the following candidates, who were unanimously elected as Ordinary Members:

Arthur Roberts, F.R.C.S.Edin., M.R.C.S.Eng., Reading.
Herbert Elwin Harris, M.B., F.R.C.S., 13, Lansdown Place, Clifton.

The following report of the Morbid Growths Committee was read:

1. On Dr. MILLIGAN's case of fibro-sarcoma of the right vocal cord. Shown on January 10th, 1902.

"After examination of the specimen submitted, the Committee report that they can find no sufficient evidence upon which to base a diagnosis of fibro-sarcoma or malignant disease. The bulk of the growth consists of fibrous tissue. The Committee

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suggest that the structures observed are the outcome of a slow inflammatory process."

2. On Dr. MILLIGAN's case of pharyngeal lipoma. Shown on January 10th, 1902.

"The microscopic examination confirms the diagnosis."

The following cases and specimens were shown:

CASE OF TUBERCULOSIS OF THE LARYNX WITH MARKED SWELLING OF THE THYROID CARTILAGE IN A MAN ÆT. 37.

Shown by Mr. RICHARD LAKE. The patient had been sent into the Mount Vernon Hospital at the end of 1898, where he remained for three months, during which period at least forty pieces were removed from his larynx. The lung was only slightly affected, and, as far as physical examination went, this was entirely cured when the patient left the hospital. His larynx also was cured, and remained so for about eighteen months. During the latter half of 1901 he complained of occasional swelling of his thyroid cartilage; this, however, went down with a small amount of treatment, the interior of his larynx never showing any signs of recurrence.

He was not seen again until about three weeks ago. The condition was then much what was seen now: the thyroid cartilage was enormously thickened, was rather hard, and inclined to be uneven on its surface. Internally there was a pointed or conical projection forwards of the right ventricular band. He appeared to be more anæmic and thinner than he had been three months previously. His voice was much worse than it was; in fact, he could only make himself intelligible with great effort, which effort was accompanied by pain.

The case was brought before the Society for an expression of opinion as to the nature of, and best form of treatment for, the disease of the thyroid cartilage.

Dr. DUNDAS GRANT thought the condition looked like tuberculous perichondritis of the thyroid cartilage, but the progress was certainly rather slow. He had seen this in a case of laryngeal phthisis, eventually resulting in an abscess, but, if he recollected the case

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aright, its course was much less indolent than that of Mr. Lake's case As regards treatment, he suggested that the right course would be to open it, and having explored, to drain and inject with iodoform. It would be unfortunate if the whole thyroid cartilage were to come away as a sequestrum, since the obstruction following that would be very severe.

Mr. R. LAKE said he last saw this patient only a fortnight ago, and until then he had not seen the man for some time. The swelling was not then so extensive, but much harder. Four months ago when he saw him there was some temporary perichondrial trouble. He showed the case because he wanted suggestions as to what was to be done.

CASE OF RHINORRHŒA OF SOME YEARS' DURATION IN A WOMAN ÆT. 38.

Shown by Mr. L. A. LAWRENCE. The patient had had discharge of a clear fluid from the nose for many years. This followed an attack of general œdema at the age of 20, probably of acute renal origin.

The rhinorrhœa, from being occasional and fairly profuse, is now nearly constant, except when the patient has cold, during which time it stops almost entirely.

In 1895 she was seen several times by Dr. Edward Law, when the nose was fairly clear and dry at the back. Her sense of taste and of smell in those days was perfect.

Now she had largely lost these senses. Her nose on the right side showed deflection of the septum to the right, and some enlargement of the inferior turbinate bone, and a polypoid condition of the mucous membrane covering the middle turbinal.

On the left side the same sort of condition existed, but the turbinal swelling was more marked. The rhinorrhœa was more marked on the right side, and was excited by any kind of stimulus—draught, shutting a door suddenly, etc. Patient had a very large appetite, and slept abnormally well during an attack. She had had some vaso-motor disturbances about her fingers, and analgesia of thighs and hips and upper arms, which was more or less transient.

Local treatment for the nose had been tried—chromic acid and alkaline douches, and the cautery—without avail. Internal remedies—iron, arsenic, and strychnine—seemed to have done

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more good; supra-renal extract had also been tried, but none of them had given any certain relief.

The PRESIDENT suggested in reference to the question of treatment that a trial might be given to the method he had employed in a case he had shown to the Society three or four years ago, where the rhinorrhœa was arrested by the application of the continuous current externally to the nose. He looked upon the condition as a vaso-motor neurosis.

Dr. HERBERT TILLEY thought the symptoms were the outcome of some obscure local vaso-motor neurosis, but that failure to give relief in this case should not be assumed until certain obvious pathological defects within the nose had been relieved. In the left middle meatus was a polypus the size of a horse-bean, and similar chronic inflammatory changes could be seen in the right nasal cavity, although the exact definition of such changes was obscured by a very prominent deflection of the septum towards the right side. It was highly probable that the removal of such obvious pathological changes would give at any rate partial relief to the symptoms.

Dr. H. LAMBERT LACK agreed with the last speaker as to the condition of the middle turbinates, and considered the case just one of those in which local disease in a neurotic subject was responsible for the rhinorrhœa. The same local conditions in another patient might not cause such symptoms. He thought that both middle turbinates should be partially removed.

Mr. F. H. WESTMACOTT said that the part which at first sight looked like a polypus, having a glazed translucent appearance, was, he thought, really due to some of the discharge having dried upon it. On looking carefully one might see a condition of lobulated hypertrophy of the middle turbinate bone. He had had a good many of these cases, and had been struck with the advantage accruing from removal of one or more of these protrusions of the mucous membrane and applying pure carbolic acid every day for about a fortnight. As carbolic acid was an anæsthetic, the application was painless, except for a little momentary smarting. Patients stated that the anæsthetic effect of the acid remained for quite twelve hours, and in some cases for twenty-four hours. He found this treatment effected a considerable diminution in the rhinorrhœa, and if, as in this case, the inferior turbinals were not so much affected, a good deal of improvement took place. As regards the mode of application, this was done by means of cotton wool wound round the end of a wire probe; the wool was dipped into the acid and then applied the whole way round the edge of the middle turbinate bone.

Dr. PEGLER said that no mention had been made of the deflection of the septum to the right side, which was a source of trouble in continually keeping up contact with the outer wall. The polypi of the middle turbinate might be attributed to the general sodden state of the mucous membrane. Glacial acetic acid would be a good application to try in this case, but the result was not reliable.

Dr. DUNDAS GRANT said that the correction of the septal deviation

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either by straightening or by removing a projecting part would be very advisable for the purpose of manipulation of the deeper parts of the nose. He did not think it likely that the septal deflection was directly one of the elements in the production of the trouble. The attacks of so-called cold seemed to be almost daily, and answered very much to the description of hyperæsthetic rhinitis. He asked whether adrenalin had been tried.

Dr. FitzGerald Powell was of opinion that this case represented what was understood as hypertrophic rhinitis. The middle turbinate was enlarged, and the inferior turbinal slightly so, and there was a distinct spur on the septum. He thought that the only chance of getting much relief would be to remove in some way portions of the middle turbinate, either by shaving them off or by the use of the cautery. Local application of washes, etc., in his opinion, would have no effect until the abnormal portions referred to were removed.

Mr. L. A. Lawrence said that adrenalin had been tried, but without benefit. He was much obliged for all the suggestions that had been made, but they were all offered with the idea of relieving the nasal obstruction. With regard to that, he supposed that most of them would agree that the nasal obstruction should be removed, but was the nasal obstruction the cause of the rhinorrhœa? That was the important point. Many people had a deflected septum, or an enlarged turbinate, or polypoid masses, but they did not suffer from rhinorrhœa as a consequence. The patient was of an extremely neurotic tendency. He was afraid if he followed all the advice given there would not be much left of the interior of the nose. He wanted to hear if there was any experience of cases of this nature having been treated otherwise than by removal of obstructions and portions of the turbinates, etc., and would welcome any suggestions of that sort.

Case of Lupus Nasi.

Shown by Mr. F. G. Harvey. The patient, a man æt. 24, had suffered from an obstruction to breathing in the right side of the nose ten years ago. A swollen condition of the right inferior turbinal was noticed at that time, and the disease had since successively implicated the skin of the tip of the nose, the posterior choana and pharyngeal roof on the right side, and the epiglottis. The region of the inferior turbinal and the skin of the nose had been cured by the use of the curette, but the disease remained active in the roof of the naso-pharynx.

Mr. Parker said that this case had been under his care for many years. He first saw the patient in 1894, when he came to the hospital suffering from nasal obstruction of three years' duration. There was apparently, then, an ordinary hypertrophic outgrowth from

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the inferior turbinal. This was removed. Instead of healing the wound became ulcerated, and assumed the characteristics of a tuberculous ulcer. The chest was then examined, and well-marked signs of phthisis discovered. It was an interesting point as to whether the outgrowth originally removed was a tuberculoma or whether it was hypertrophic, and whether, if the latter, the resulting wound had been infected from the lungs. The ulceration had extended and affected the pharynx, and in May, 1895,* the case was shown here as one of "tubercular ulceration of the nose and pharynx." After this date the patient developed typical lupus in the skin of the nose, and a little later the epiglottis became affected. Meanwhile the condition of the lungs improved, and then became quiescent. Whilst under his care Mr. Parker had tried both local and general treatment, but the only thing which did him any real good was a very severe attack of erysipelas, after which he was very much better for a long time. The speaker had last seen the case about three years ago, and he thought the present condition was very much as it was then.

Case of Partial Membranous Occlusion of the Right Posterior Choana.

Shown by Dr. Lambert Lack. The boy, æt. 18, had thin crescentic bands passing from the roof of the naso-pharynx down towards the base of the nasal septum attached along the outer side of the space, almost completely hiding the choana on the right side, and less prominent on the left side. There was a small perforation of the septum, and the boy said he had had a discharge of thick matter from the nose some years ago, but no reliable history could be obtained.

The President had made a careful examination, but did not think the partial occlusion was on the choana itself, but behind it. It was a band extending up from the Eustachian cushion, and looked like a cicatrix, but he was unable to obtain any history of an operation. There was also perforation of the septum.

Dr. Scanes Spicer agreed with the President as to the membrane being posterior to the choana and in the naso-pharynx; the band extended upwards from the right Eustachian cushion to the adenoid tissue at the apex of the right choana, and it had the appearance of a cicatricial band, as frequently seen here.

Dr. Dundas Grant thought the case presented a great many points of interest, and it would be valuable if Dr. Lack would describe the history more thoroughly. The patient said that at one time a mass of some sort came away from the back of the throat. It was crumbly in consistence. After that he was able to breathe

* See 'Proceedings,' vol. ii, p. 83.

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through the nostrils, although previously he was unable to do so owing to the great obstruction. He thought that these partial web-formations were cicatricial, but felt some difficulty in surmising as to what it was which had come away. It might be simply some inspissated cholesteatomatous matter, which was sometimes seen in the nose, or it might be a soft rhinolith or a sequestrum. From the deformity of the part he thought it quite possible that a small sequestrum had come away.

Mr. SPENCER thought the diagnosis turned on the question of the septal perforation. The cicatrix seemed rather far back to have been the seat of operative interference. The perforation was probably due to inherited syphilis. Perhaps a sequestrum had come away, which would explain the history given. There also had to be taken into account the facial aspect and the eye symptoms.

Dr. StCLAIR THOMSON thought he could throw some light on the perforation of the septum. He inquired of the man if he had had an operation performed. He had. The patient had performed it himself! He had in his pocket a horse-nail, which he had once pushed up his nose. Dr. Thomson felt so sure on examining the cicatrix that it was traumatic in origin that, when there was no history of any operation by a surgeon, he cross-questioned the man with the result stated. When he once had some nasal obstruction the man pushed the nail up to relieve the obstruction; he then felt something come away; this was followed by profuse hæmorrhage. From the appearance and the situation of the perforation, which was not in the bony septum, but at the back of the cartilaginous part, he thought the patient's own explanation was a very probable one. He would like to hear from Dr. Lack if he had put his finger into the choana, because he (Dr. Thomson) could not say from inspection of the case that it agreed with the description of "membranous occlusion." It was situated entirely on a posterior plane, and there was a somewhat similar condition on the other side. The occlusion really extended from the cushion of the Eustachian tube up to the roof of the pharynx. Such an occlusion was not uncommonly left by adenoid remains.

Dr. FITZGERALD POWELL said it would be rather interesting to get a portion of the band away and have it examined under the microscope to make out the exact construction of the tissue. It might be, as suggested, cicatricial tissue, but it was difficult to explain exactly how it came to exist there. Whether it was a developmental growth and had always been there or whether it was a growth of adenoid tissue arising in the fossa of Rösenmuller which had become attached to the cushion of the Eustachian tube was doubtful. If there had been nasal obstruction, and this was cleared up by something coming away, it was probably a large crust.

Mr. SPENCER doubted whether it was possible for the patient to have pushed such a nail through a healthy septum. To have done so there must have been previous ulceration or softening. He probably pushed away a crust or sequestrum which was obstructing the nasal passage.

Mr. WESTMACOTT thought that a man could easily injure the

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septum with a nail of that size. It was well known how easily an ulceration in the septum following traumatism did spread through to the other side and leave a typical perforation such as they had now before their notice.

Dr. H. LAMBERT LACK, in reply, regretted that the history was incomplete and unreliable. He should say that the mass which was said to come from the post-nasal space was probably a sequestrum. He had put his finger into the space and had found a very definite band with a concentric margin, which was quite different to anything he had ever felt before in the adhesions which occurred in a man with adenoids. He did not think it was due to adenoid growth, but more likely to congenital syphilis.

CASE OF ŒDEMA OF THE LARYNX FOR DIAGNOSIS.

Shown by Dr. LAMBERT LACK. The patient, a man æt. 40, had been in the London Hospital for three months suffering from hoarseness and slight dyspnœa. The voice had been affected now for nearly six months. There was no difficulty in swallowing and very little expectoration. There was some wasting, but the patient felt well and strong. There were no physical signs of phthisis, and no tubercle bacilli had been detected in the sputum.

On examining the larynx the right arytænoid region was seen to be an immense œdematous swelling, smooth and not ulcerated. The œdema extended slightly to the right side of the epiglottis. The left arytænoid appeared normal, but was partly hidden by the swelling on the right side. The interior of the larynx could not be seen.

Mr. W. G. SPENCER thought the diagnosis of this case very interesting. It looked almost as if it were a malignant condition, but there were no glands in the neck, and in epithelioma in that particular region the glands in the neck were so early enlarged; in fact, very often the glandular enlargement preceded the discovery of primary epithelioma. The disease could not very well be tuberculous owing to the length of the history and the absence of glands in the neck. He was therefore of the opinion that it must be of syphilitic origin.

Dr. STCLAIR THOMSON had shown a very similar case to the Society about a year ago. It ran a very erratic course. Several members thought it might be malignant. He watched the patient and had to perform tracheotomy later on. Very soon afterwards the patient's health broke down, and he died of tuberculosis, bacilli having been

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found previously. Dr. Horne had possession of the larynx. The post-mortem examination was confirmed by sections.

Dr. H. LAMBERT LACK said he brought the case forward because he could not arrive at a diagnosis. The case had been thoroughly treated with iodide of potassium and mercury, and he had been kept in bed in hospital for three months. There were no tubercle bacilli, and further, if the case had been tubercular in nature, it would probably have got markedly worse under iodides. The man was wasting. He did not know if sarcoma was a possible diagnosis, but it might have to be taken into account.

CASE OF (?) SYPHILITIC ULCERATION OF SOFT PALATE OCCURRING DURING A COURSE OF ANTISYPHILITIC TREATMENT.

Shown by Mr. ATWOOD THORNE. The patient, a man æt. 23, contracted syphilis in May, 1901, since when he had been treated with mercury, and latterly with mercury and potassium iodide by the mouth. After eight months' continuous treatment he was found to have deep ulcers on the soft palate, and despite active local treatment with silver nitrate the patient had got worse and lost his uvula and a part of the soft palate; he looked exceedingly ill and was very feeble. He complained that he had lost a great deal of flesh, and had some difficulty in swallowing. On examining the throat, the uvula and part of the soft palate adjacent to it were now missing, the edge of the remaining portion being covered with a dirty white slough, and on the posterior wall of the pharynx and on the posterior edge of the septum nasi there was a yellowish thickened exudate. Crepitations were heard at both apices, but no tubercle bacilli could be found in the sputum. Antisyphilitic remedies had been stopped, and every endeavour made to feed up and strengthen the patient.

Mr. Thorne asked for the opinions of the members on the nature of the case; personally he took it to be at any rate due partly to syphilis, but was surprised that the condition should commence while the patient was being actively treated for syphilis.

Dr. STCLAIR THOMSON would like to hear again what treatment the man was having. He looked very cachectic, and as if he would not stand very much. He regarded the case as one of syphilis only.

Dr. DUNDAS GRANT thought there was a tubercular element in

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this case. They knew that occasionally in secondary syphilis ulceration and destructive lesions occurred, but they were very uncommon. The very extreme ulceration occurring so soon in the course of the disease, together with the general characteristics of the patient, made one ask if there were any further evidence of tuberculosis.

Mr. SPENCER said it might be a "mixed" case of tubercular-syphilitic infection. If the iodide were continued the man would certainly die. He recommended keeping the patient in bed and putting him on the "tonic" treatment; very little mercury should be given.

Mr. R. LAKE thought it was a perfectly straightforward case of syphilis without any question of tuberculosis. He did not think twelve months so very short a period for even such extensive lesions as were present in this case, for ulceration might commence early and be followed by severe destruction of tissue when a case was going to be really severe.

Dr. LAMBERT LACK agreed with the previous speaker's remarks. It was purely a case of syphilis, and if the man were treated by being put to bed and fed on plenty of milk and eggs, with a little anti-syphilitic treatment, in a month he would be practically well.

Dr. FITZGERALD POWELL thought that large doses of iron and strychnine were very necessary in such a case as this. He had found that iodide of potassium and mercury in cases where a man was in an anæmic condition were worse than useless. If it were possible he would send this man to the seaside, and as he improved in health, in addition to the iron and strychnine, he would give him just a little iodide of potassium and mercury; under this treatment he would soon get better.

Mr. ATWOOD THORNE, in reply, said that on examining the chest, he found distinct evidence of phthisis, but there were no bacilli in the sputum. While the man had the chancre, he was put on mercury, but during the last month a small amount of iodide had been added. He thought it was a mixed case and would feed the man up and give him small doses of iodide and mercury.

CASE OF MYELOMA OF THE NOSE IN A WOMAN ÆT. 30.

Shown by Mr. WAGGETT. The patient, previously quite healthy, began to notice nasal obstruction in June, 1901, three months after confinement. Obstruction increased until, at the time of her first visit, in October, the right side had become completely blocked, and epistaxis was frequent.

On examination the right nostril was found to be filled by a large dark red growth, with an intact smooth surface, feeling elastic to the touch, and bleeding readily. The right eye was more prominent than the left. Under an anæsthetic the large

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tumour, which completely filled the nose, was removed piecemeal and without serious hæmorrhage. The tissue was dark in colour, of firm consistence, and contained a sponge-work of bony trabeculæ.

Microscopic examination showed the structure to be typical of myeloma, containing numerous giant-cells (specimen exhibited). During the operation it was found that the growth had created a smooth-walled pressure cavity encroaching upon the orbit. Proptosis disappeared within two days of operation. In consequence of the microscopical diagnosis of tumour of only a local malignancy, a more radical operation was undertaken a few days later.

The seat of origin of the growth seemed to be in the region of the middle turbinate or of the unciform process. Rouge's operation was therefore performed, the anterior wall of the antrum and part of the septum were cut away, and the greater part of the inner wall of the antrum and of the inner wall of the orbit was removed.

The exact anatomy of the parts, deformed by encroachment of the tumour and obscured by free hæmorrhage, could not be determined, but apparently a thorough removal was made of all suspicious tissue. Free access could not be obtained until laryngotomy had been performed and the gag removed from the mouth. Apart from the effects of orbital hæmorrhage the patient did not suffer much from the operation, and healing took place within the nose very rapidly. This process was accompanied by so marked and rapid a diminution in the size of the cavity that suspicion was aroused that the restriction was due not merely to cicatrisation, but to recurrence of the growth. Opinions were invited upon this question. Against the diagnosis of recurrence were the healthy appearance of the mucous membrane, the absence of epistaxis and want of any noticeable change during the last six weeks. The operation was performed early in November. The general health was excellent and pain absent.

Mr. W. G. SPENCER would not say that the growth had recurred, he would wait till it bled continuously, for these tumours were very vascular. The nose required to be kept very clean as in atrophic rhinitis.

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Dr. H. LAMBERT LACK asked if the nose was still gradually closing, because if that were so it might be due to recurrence. He did not think it would be possible to do any more if a recurrence took place.

Mr. E. B. WAGGETT said, in reply to Dr. Lack, that he thought the contraction took place during the first month, and that it was not contracting now. Three months had now elapsed since the operation. The contraction was especially noticeable in the region of the right choana where the septum seemed to pass away into the outer wall of the nose, which was precisely the part not affected, so that he was in hopes that the structures were cicatricial and not evidences of regrowth.

TERTIARY SYPHILIS OF THE PHARYNX AND LARYNX; PHONATION WITH THE VENTRICULAR BANDS.

Shown by Dr. H. J. DAVIS. The patient, a groom æt. 31, had laryngeal ulceration when the subject of secondary syphilis three years ago. He was admitted into the Middlesex Hospital two years ago for urgent dyspnœa, the swelling of the right ventricular band being so great as to almost occlude the glottis. Ulceration followed and stenosis had resulted.

His present condition showed ulceration of palate, which had a peculiar worm-eaten appearance, fixation of the true cords, phonation being accomplished by the ventricular bands.

LARYNGEAL TUBERCULOSIS, WITH GRANULATION TISSUE BETWEEN THE CORDS.

Shown by Dr. H. J. DAVIS. The patient, a woman æt. 25, had pulmonary tuberculosis in the quiescent stage, and well-marked signs of the same disease in the larynx. She had lately undergone an open-air treatment, and had benefited materially.

At present, where there had originally been ulceration, a granulating mass extended downwards between the cords, which were thickened and fringed with granulations. On phonation the cords encountered the obstruction, the muscles failed to overcome it, and the cords quivered and then sprang apart.

The voice varied from a deep croak to a mere whisper, but the

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patient stated that in wet weather the voice was always improved. Pallor of the palate was well marked.

Dr. Jobson Horne said the appearance of the larynx in this case was interesting and rather unusual. The tissue between the cords was described as granulation, but he would like to ask whether any member might feel disposed to speak of it as a tuberculoma.

Dr. H. J. Davis said there had previously been ulceration in the same position, and lactic acid had been rubbed in, but during the time the woman had been away undergoing the open-air treatment granulation tissue had grown on the surface of the ulcer.

Case of Abeyance of Nasal Breathing in a Female Æt. 23; Nasal Passages Free; Hysterical Aphonia; Rhinalgia.

Shown by Dr. Pegler. The patient had been shown in 1899 for functional aphonia and recurrent apsithyria, which still persisted. Soon after that occasion she had developed mouth breathing, and her speech, though aphonic, became "clipped," a defect known as *Rhinolalia clausa.* There being a pad of adenoids and considerable turbinal hypertrophy in both chambers, these impediments to nasal breathing had been radically eliminated, but instead of the patient gaining any benefit, the above-named symptoms grew worse, and so they remained. Rhinalgia had been much complained of, especially recently; the mouth was always open, and the breath was peculiarly disagreeable, possibly owing to this fact. Before speaking, with a view, perhaps, to getting some use of her nose, she made a clicking kind of sound with her palate. The velum, on inspection, appeared paretic, but the exhibitor had no hypothesis to offer, especially in the light thrown upon this case by the next one, except that the nasal breathing and resonance were shut off by spasmodic contraction of the soft palate.

The photograph marked 1 showed this patient before her various hysterical symptoms set in, and when she was teaching in a school; the mouth was closed, and the expression highly intelligent. No. 2 photograph had been taken recently, and showed a very marked deterioration in this respect, with open mouth and dilated alæ nasi.

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The PRESIDENT thought it a "hysterical" case. One had seen such cases, in which people occasionally talked without using their noses although there was no obstruction, and were unable to pronounce "m" and "n," and converted these letters into "b" and "d." He put down similar cases he had seen to neurosis of the palate. Dr. Pegler thought that in his case there was a spasm of the palate, but whether that was proved or not he was not aware.

Dr. SCANES SPICER thought this case a very important one. Dr. Pegler had quite satisfied him personally that there was now no organic obstruction, and yet, when the mouth was closed, no air entered on the patient attempting to inspire. After a time, unable to do without air any longer, she opened the mouth and violently inspired. The explanation appeared to be a functional spasm of the soft palate and pharynx—a hysterical contraction at a time when normally there should be a relaxation or yielding to the incoming air-current. It might otherwise be regarded as a hysterical holding of the breath by the soft palate. There was evidence of hysteria in the adductor laryngeal paralysis, so that apparently there was in this palatal spasm another instance of perverted respiratory rhythm parallel to what was occasionally seen in the larynx in hysterical subjects. The case demonstrated without doubt the abeyance of nasal respiration without any organic obstruction in the nasal passages to compel such abeyance. He thought the patient would be benefited by treatment of the causes of obstruction he had pointed out. Perhaps stretching the soft tissues of the alæ, followed by the use of rubber dilators at night, and education of the dilator muscles, would be ample. As to the soft palate in this case, he thought it was paretic rather than spastic.

Mr. WAGGETT suggested that the woman should be treated like a hysterical person with aphonia, namely, by forcing her to breathe through her nose by shutting the mouth and tying it up.

Dr. FITZGERALD POWELL said that as the patient could blow out a spirit lamp held under the nose whilst her mouth was closed, there could be no real obstruction. Apparently the soft palate seemed to suffer from some neurosis just in the same way as the cords suffer from neurosis in functional aphonia. There was a greater or less degree of post-nasal catarrh with a good deal of mucus coming down from behind, and probably the palate was in a more or less rigid condition. He hoped to be able to show a similar case at a future meeting suffering from functional obstruction to the breathing. The nose had been cleared of all objective causes of obstruction, but nevertheless the breathing had become worse.

Dr. WILLIAM HILL thought that in this case there was a want of co-ordination between nasal inspiration and the muscular actions of the palate and pharynx.

Mr. ATWOOD THORNE said that as the patient had a good current of air up and down both nostrils, he would advise breathing exercises with a forcibly closed mouth, and the usual general treatment for hysteria.

Dr. DUNDAS GRANT said that in this case there was a condition of

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anæsthesia; as the patient did not feel the air which passed through the nose, she therefore did not think it did pass.

Dr. JOBSON HORNE inquired whether the possibility of tuberculosis had been entirely excluded as a factor in the aphonia.

Dr. PEGLER agreed with Dr. Hill, and thought the term hysterical inco-ordination of the muscles of the soft palate and pharynx would supply what was wanted in that regard. It was remarkable that since the nasal operations the symptoms had been aggravated; this might be due to the influence of auto-suggestion.

CASE OF ABEYANCE OF NASAL BREATHING, THE PASSAGES BEING FREE, PALATE AND FAUCES HYPERÆSTHETIC.

Shown by Dr. PEGLER. A. G—, æt. 31, came to the Metropolitan Ear, Nose, and Throat Hospital a few days ago complaining of her speech. ("Her bother said there bust be subthig the batter with her throat because she always spoke through her dose.") Patient dated the defect from November last, when she was sent to the North-Eastern Hospital as a case of supposed diphtheria. On her return she states that in drinking fluids returned through her nose. Dr. Cuff, however, assured the exhibitor that the case was one of tonsillitis only, and that three separate cultures failed to disclose any Klebs-Loeffler bacilli.

The mouth is kept open constantly. Examination of the nose and naso-pharynx gives a negative result in so far as explaining the total absence of nasal breathing and resonance were concerned. The pharynx was so irritable that repeated cocainisation was necessary in order to gain a satisfactory inspection of the post-nasal space. There was no nasal anæsthesia, but pain was complained of over the bridge. There was paræsthesia of the pharynx in the form of a pricking sensation in the throat, and the patient was constantly "clicking" and "hemming." Following the suggestions made in Dr. Lermoyez's paper on a similar case, Dr. Pegler closed the patient's mouth with his hand, when she held her breath till cyanosis set in, but after a violent effort the patient respired through the nose. Suspecting that palatal spasm was operating here as in the last case, Lermoyez's other experiment was tried, and the palate tied up by a tape passed through the nose, naso-pharynx, and mouth, the two ends being secured over the upper lip. After a slight effort the patient

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breathed comfortably through the nose, her mouth being closed. The (moral) effect of this treatment was permanent, for the speech defect was now nearly absent. The photograph marked A shows this patient prior to her throat attack; the mouth is closed and the features natural. B shows the patient taken previous to treatment the other day, and is in obvious contrast to the former one.

Dr. SCANES SPICER took exception to Dr. Pegler describing the air-passages in this case as being entirely free, since insufficiency was proved by marked collapse of right ala on inspiration. There were three objective causes of obstruction: (1) the right nostril was a slit, and the ala collapsed on that side on attempting inspiration; (2) the septum was deflected, the deviation being sigmoid; (3) there was enlargement of the right middle turbinate with dry crusts. Certainly this case could not be placed in the same category as the previous one.

Dr. VINRACE said that regarding the doubt as to whether this patient had had diphtheria, he would like to point out that the regurgitation of fluids through the nose after the attack was, to his mind, stronger evidence in favour of diphtheria than the failure to find bacilli was against it. He would like to know whether this condition was or was not the result of diphtheria.

In reply to Dr. Vinrace, Dr. PEGLER said he was content to accept Dr. Cuff's assurance with regard to the absence of diphtheria, besides which no point was made supposing the disease had existed; there might have been a paretic palate in the first instance, but the speech and breathing defect pointed to the opposite condition of spasm.

Dr. VINRACE remarked that if one searched for the bacillus and failed to find it, it did not follow that the patient had not had diphtheria.

Dr. PEGLER, replying to Dr. Scanes Spicer, said he was sorry that he could not persuade that gentleman to regard the case in the same light as he did. The unilateral insufficiency was not of a kind that he should treat by operation, seeing that an armed probe passed comfortably through the narrower chamber, whereas in the companion one he was able to discern the pharyngeal wall easily without the aid of cocaine. As in the previous case, he looked to the vagaries of the tensor and levator palati muscles for an explanation of the phenomena, and thought the simple experiment of tying up the palate was conclusive in its result. Kyle alluded in his book to spasmodic affections of the palate, and in this case there were other evidences of choreic or spasmodic action in the upper air-passages. The inspection of the larynx showed contraction of the ventricular bands on phonation, which perhaps explained the hoarseness of the voice.

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Case of Progressive Ulceration of the Nose.

Shown at the last meeting by Dr. Bennett. It had been suggested at the last meeting that the ulceration of the septum might have been due to antral suppuration. Dr. Bennett had therefore explored, but found no discharge.

Case of Œdema of the Larynx with Thickening of Palate, Uvula, and Fauces in a Boy æt. 10.

Shown by Mr. F. Hunter Tod. This case was under the care of Dr. Percy Kidd at the London Hospital. The boy's mother had noticed that for two years he had breathed through his mouth, and was very noisy in his sleep. Between October and December, 1900, he had had four operations on the tonsils and the back of the throat, but without relief. There had been wasting and day and night sweats, and difficulty in breathing at night.

At the present time the patient was thin, pale, and pigeon-chested. There was slight bronchitis, but no signs of pulmonary phthisis. The temperature was normal. No bacilli had been found in the sputum. There were no signs of congenital syphilis. There was laryngeal stridor, which was much worse at night, accompanied by retraction of the chest, but cyanosis had never occurred. Examination of the larynx showed enormous enlargement of the epiglottis, which was smooth and of a pale colour, and prevented a view of the interior of the larynx being seen. The tips of the arytænoids could be seen, both, but especially the left which seemed fixed in the middle line, being pale and much swollen. No ulceration was visible. The condition had remained unchanged since admission to the hospital four weeks ago. The uvula was much enlarged and œdematous, and there was considerable thickening of the palate and fauces. Mr. Tod suggested that the diagnosis rested between tubercular laryngitis and congenital syphilis, and that the patient should be fed well and given antisyphilitic treatment, and that tracheotomy should be performed if it should become necessary.

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The PRESIDENT said the condition reminded him of congenital syphilis.

Mr. SPENCER said this was an interesting case, but he did not know what its origin was. There was some danger of his dying of suffocation suddenly one night. Something ought to be done to avoid this; for instance, tracheotomy combined with rest for a time, and careful treatment on the same lines as those proposed by Hunter Mackenzie for laryngeal growths in children. One might, in addition, remove the tonsils, and the lower pharynx, including the epiglottis, might be lightly scarified, and astringents rubbed in or cauterised.

Dr. DUNDAS GRANT asked if any albumin had been found in the urine. He had shown a case (March, 1897) to the Society of a boy who had had scarlet fever, with subsequent albuminuria, in which the œdema persisted very much as it had done in Mr. Tod's case, although he had some suspicion that the boy was the subject of inherited syphilis. He asked whether tuberculosis had been excluded in Mr. Tod's case. Tuberculin might afford information in a case of great doubt.

Dr. POWELL considered it a case of hereditary tertiary syphilitic infiltration, and would like to hear if the boy had been put on antisyphilitic treatment. If not, he suggested that the boy's general health should be attended to by tonics, and that then antisyphilitic treatment should be employed. If there was any danger of laryngeal spasm tracheotomy ought, of course, to be done. At present there did not seem to be any spasm.

Mr. LAKE said he would give the boy Hyd. c. Cretâ.

Mr. HUNTER TOD said that Dr. Percy Kidd was inclined to think that it was a case of tubercular laryngitis, although there was no sign of pulmonary phthisis nor tubercle bacilli in the sputum. He had not been put on antisyphilitic treatment because he wished to see the effect of good diet and tonics. On admission there was so much laryngeal obstruction that tracheotomy was nearly performed, but at present there was no danger of suffocation as the boy could sit up all day quietly, and could sleep all night in the recumbent position.

ETHMOIDAL SUPPURATION IN A MAN COMPLAINING OF EXCESSIVE PAIN.

Shown by Mr. WAGGETT. The patient had been under treatment for some years. The greater part of the ethmoidal cell region had from time to time been removed. Both frontal sinuses had been opened and found healthy. Very severe frontal and vertical pain was complained of, and suggestions for treatment were asked for. A marked neuropathic element was present.

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Dr. VINRACE wished to know what were the indications for the operative treatment of the frontal sinuses which had been resorted to twice in this case, and what were the beneficial results which were claimed after each of these two operations. Further he did not see why the left side had been interfered with when it was the right side on which there was the nasal obstruction. In the first instance it seemed that vertical headache was the prominent symptom, and in the second instance there was supra-orbital pain on the left side; and subsequent to the second operation, new symptoms had been introduced, and he would like to know if these were to be attributed to the second operation. As far as he could ascertain the sight had been affected and the patient was very giddy. It was very gratifying to him to hear of such good results following these operations, but the perplexing point was that. according to the account of the patient, when the first operation was done, the only pain he had was that of vertical headache, there being an absence of symptoms in the region of the frontal sinuses.

Dr. LAMBERT LACK thought the man had now had sufficient done to the nose, and the results of the operations were good. The man was now suffering from neurasthenia.

Dr. JOBSON HORNE said that this man was under his care for some few weeks after being under the care of Mr. Waggett, but he could find no sufficient cause for operating, and he thought that was the reason why the patient left him. The patient seemed to attach too much importance to his symptoms, and he advised him to undergo no further treatment for a while.

Dr. FITZGERALD POWELL said that this man had also visited him. He came to him after leaving Mr. Waggett, but he had only seen the man once; he did not recommend active enough measures. It was evident that there must be some considerable amount of pain in the frontal sinuses or forehead, whatever might be the cause of it, or he would not be so persistent in complaining of it. He suggested to Mr. Waggett putting in a seton, as in some cases frontal headache had been considerably relieved thereby. If the patient had remained under his care, he would have put in the back of the neck an ordinary tape, which might have had the effect of removing the pain to some extent. He would like to hear whether the frontal sinuses had been obliterated by operation.

Mr. F. H. WESTMACOTT asked whether it was not an experience quite commonly found after operation in cases of frontal sinus disease that the patient did very well for a time; the discharge ceased and the patient became apparently well. But after a time there was a periodical recurrence of the symptoms as regards the pain, etc., and yet on looking into the nose there was nothing, or very little, to account for the recurrence. In one or two such cases he had given considerable relief by simply passing up a cannula into the infundibulum and inflating the frontal sinus, after which the pain went away instantly. If in two or three weeks the patients again complained of their pain he repeated the process and with the same temporary success. He had come to look upon this state of affairs as very largely due to neurotic causes. There might be some foundation for the pain no doubt in local congestion.

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Mr. Waggett said that this man had in the first place ethmoidal suppuration, and in the second place he was undoubtedly a hypochondriac of the worst type. He had treated him according to the rules of rhinology, with the exception that he had not yet explored the sphenoidal sinuses. The frontal sinuses were explored as severe frontal pain and tenderness were experienced, and the ethmoidal cells in the neighbourhood were suppurating.

Case of Subjective Nasal Obstruction.

Shown by Dr. Dundas Grant. Miss E. E—, æt. 34, was first seen by Dr. Dundas Grant on Feb. 6th, 1902, when she complained of a feeling of suffocation and inability to breathe through the nose. The right nasal passage was almost normally free, and the left one patent to an abnormal degree. There was considerable atrophy of the left inferior turbinated body, the posterior wall of the pharynx and the "arcade" of the posterior choana being visible to a considerable extent. There was a very slight tendency to alar collapse, but not sufficient to interfere with breathing. The mucous membrane was abnormally tolerant of manipulation with the probe, and in fact there was a considerable degree of anæsthesia. The exhibitor attributed the subjective obstruction to this anæsthesia. The patient did not feel the air passing through the nose, and had consequently acquired a fixed idea that it did not do so, and that she could therefore only breathe through the mouth. Dr. Grant said that this was the mechanism of many cases of subjective nasal obstruction.

Dr. Scanes Spicer was of opinion that there was marked insufficiency of passages in this case, due to stunted evolution of the nostrils, and there was collapse on inspiration. He thought the insufficiency would be overcome by dilation, wearing rubber tubes, and re-establishment of normal action of nasal inspiratory muscles. When this was done he believed, from his experience of similar cases, that the patient's sense of stuffiness would disappear.

Dr. Dundas Grant said the patient was a very highly neurotic subject, and there was some, though not very great, tendency to collapse of the alæ. The left nostril, in his opinion, was at all events abnormally patent, and there was ample room for breathing purposes if only she were conscious that the air could go through.

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Considerable anæsthesia of the nasal mucous membrane was present on both sides, and he believed this was a large factor in many of these cases.

A Specially Constructed Glass Tube for the Inhalation of Medicinal Powders into the Larynx.

Shown by Dr. Dundas Grant. A glass tube of about 6 inches in length is bent at one end into a crook of about ½ inch, while 2½ inches of the other extremity are bent downwards at an obtuse angle. The short crook, lying downwards, is pushed by the patient to the back wall of the pharynx, and the opposite extremity is allowed to dip into a small quantity of light powder in a watch-glass or plate; the patient then closes his lips and draws in his breath rapidly through the tube so as to inspire some of the powder. This, following the inspiratory blast, finds its way, according to the inventor of the method, into the larynx. It is a method of great simplicity, and has the advantage that it can be carried out by the patient himself under the direction of his medical adviser. Its inventor, Dr. S. Leduc, of Nantes,* strongly recommends the use with it of the powder known as di-iodoform, and he deprecates the employment of crystallines such as those of ordinary crystallised iodoform. Dr. Dundas Grant had used with it orthoform and resorcin, and had seen by the laryngoscope the powder adhering to the interior of the larynx. It had given great relief to several patients with laryngeal phthisis to whom he had given it.

Mr. A. J. Hutchison said that these tubes were not new, for he had known of them for four years. They were brought out first on the Continent, either in France or Germany. To the small extent he had employed them he had found them very useful.

Wooden Probes and Cotton Carriers.

Shown by Dr. StClair Thomson on January 10th, 1902. Dr. Thomson had met with these wooden probes in a throat clinic in

* See 'La Gazette médicale de Nantes,' 16 novembre 1901.

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Germany last summer. There was nothing particularly novel in them beyond the fact that they were remarkably cheap and reliable. They were cheap because they were originally manufactured wholesale for use in the making of sausages, and were known as "Wurststäbchen," and were carefully sterilised under Government control. They could be cut in suitable lengths, and were useful as probes for applying caustics, as cotton carriers, and for other purposes. When cotton-wool pledgets had to be left in the nose, it was much easier for the patient to remove them if the cotton were first wound round a wooden probe which was then cut off flush with the orifice of the nostril. These wooden probes were kept in stock by Messrs. Mayer and Meltzer, and by Mr. Rogers, of Oxford Street.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

SEVENTY-SECOND ORDINARY MEETING, *March 7th*, 1902.

E. CRESSWELL BABER, M.B., President, in the Chair.

CHARLES A. PARKER, F.R.C.S.(Ed.), } Secretaries.
JAMES DONELAN, M.B., }

Present—34 members.

The minutes of the preceding meeting were read and confirmed.

The following cases, specimens, and instruments were shown:

CASE OF COMPLETE RECURRENT LARYNGEAL PARALYSIS IN A MALE ÆT. 24 WHICH HAD REAPPEARED AFTER A PERIOD OF RECOVERY.

Shown by Dr. FITZGERALD POWELL. This patient was first seen on December 30th, 1901, complaining that he had lost his voice quite suddenly on *December 28th.* He could give no explanation as to the cause, unless it were strain from singing.

He further stated that in *February or March of* 1901 he had lost his voice quite suddenly in the same way. At this time he was not feeling very well, and three or four days after the voice

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became affected he had a severe cold, with rise of temperature, which was considered by his doctor to be due to influenza.

On this occasion he was under treatment by Dr. Bronner, of Bradford, and after three months his voice returned completely, and had kept quite strong until December 28th last, when he again lost it.

There was no history or evidence of syphilis, and nothing abnormal could be found in the chest. He complained of periodic headache and attacks of supra-orbital neuralgia. He had a spur on the right side of the septum nasi and a polypus causing nasal obstruction.

The most careful examination and investigation of his case failed to give the slightest explanation of the cause of what was found in the larynx, viz. *complete paralysis of his left vocal cord*, which hung in the cadaveric position, the inner edge of the cord being curved with the concavity towards the median line.

So far as could be observed there was an entire absence of the usual causes which produce this paralysis.

As regards treatment, the spur on the septum had been removed and the polypus snared, and he was placed on iodide of potassium up to twenty grains three times a day, and strychnine had been administered.

On February 19th the paralysis was still complete, but on March 5th there was some movement in the cord, and the patient stated that on February 22nd his voice had suddenly improved and was now much better, though still hoarse and weak.

The same treatment is being continued.

Sir Felix Semon suggested that the most likely explanation of the occurrence of the paralysis in such a case was peripheral neuritis. The history in this case of influenza would be quite sufficient to account for the occurrence of the first paralytic attack. The nerve being afterwards left in a weakened state, recurrence of the paralysis on slight provocation was no unlikely sequel; some extra vocal effort on the part of a patient or a cold would be sufficient to produce such a recurrence. It was now becoming a general opinion that peripheral neuritis was a rather frequent cause of laryngeal paralysis. He had lately read a very interesting monograph by Cahn, of Strassburg, endeavouring to establish that the most frequent cause of laryngeal paralyses in tabes was peripheral neuritis. At any rate, it was a subject well worth any one's while to follow up.

Dr. FitzGerald Powell thanked Sir Felix Semon for his remarks

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on the causation of the alternating condition of this case, but he would like to hear from him what was the cause of the peripheral neuritis. Did he look on influenza as the cause, although there was no *definite* history of the patient having had it previous to the first attack, and he certainly had not had it on the last occasion of the paralysis?

Sir Felix Semon said, in reply to Dr. Powell's question, he regarded the toxin of influenza as the cause of the peripheral neuritis.

Case of Hæmatoma of the Vocal Cord in a Female æt. 29.

Shown by Dr. FitzGerald Powell. The patient was first seen on March 4th, complaining of hoarseness and loss of voice, which came on suddenly in February of this year. On examination of the larynx the left vocal cord was seen to move very sluggishly on phonation, and an extravasation of blood was seen in its whole length, forming what he might describe as a "hæmatoma of the cord." The nose, pharynx, and larynx were the seat of chronic inflammation. The patient had lost her voice three years ago, but it returned after six months' treatment.

Dr. F. de Havilland Hall asked if the attack of hæmorrhage coincided with the menstrual period, or whether there was any catamenial disturbance, because most of these cases occurred in women, and either coincided with or preceded the catamenia, or else some menstrual disturbance.

Dr. Dundas Grant said it would probably be within the memory of some of the original members of the Society that he had showed a case identical with Dr. Powell's case at one of the earliest meetings, in which the hæmatoma recurred on several occasions. To the best of his recollection it was associated with menstruation, but he had not had an opportunity of looking up the notes, and would not therefore speak with certainty on this point. The case was reported in the 'Proceedings' of the Society.* Ultimately a small angeioma near the junction of the anterior and middle third developed on the upper surface of the left vocal cord. The patient had gone to South Africa, and he did not know what had happened since.

Dr. J. Donelan thought the case was the result of influenza, from which the patient was still suffering; she had the characteristic eye. He had had two cases under his care—both the patients were men—in whom the hæmatoma had followed influenza and severe coughing. Some of the subglottic veins were enlarged, and from these tracheal hæmorrhage had also taken place.

* See vol. i, p. 2.

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Dr. FitzGerald Powell regretted to say that though he had promised to inquire with regard to the menstrual periods he had forgotten to do so, but he would ask the patient the next time he saw her. So far as influenza was concerned, he supposed the last speaker hardly wished to infer that influenza was the cause of the extravasation of blood otherwise than by causing trauma from coughing.

A Modification of Mackenzie's Laryngeal Forceps for Removal of Growths in the Anterior Commissure and Drills for draining Maxillary Antrum through Tooth Socket.

Shown by Dr. FitzGerald Powell. The forceps were simply Mackenzie's laryngeal forceps with the cutting ends turned forwards. He found that they were useful in removing growths from the anterior commissure, and he thought others might find them useful in cases where there was a difficulty in removing these growths with the straight forceps. At the same time he did not claim any "proprietary rights" in the instrument, which was Mackenzie's with the slight alteration mentioned. The chief point of interest in the drills was their size, the largest being the size of a No. 14 silver catheter; these drills, he thought, provided a means of curing the great majority of cases of empyema of the antrum. They made a large opening through the tooth socket, after extraction of the first molar or second bicuspid, through which a tube could be introduced, and through which the antrum could be freely curetted and washed out. He thought there were only a few cases in which what is known as the radical operation was required.

The President thought that unless more than one tooth was extracted the drill and tube were rather large to get in without damaging the teeth at the sides of the socket.

Dr. StClair Thomson presumed that the exhibitor, in claiming that the majority of cases of empyema of the antrum might be radically cured by drainage through the tooth socket, included only those cases in which none of the other cavities were affected. At one time he himself was inclined to enlarge the alveolar opening, but he came to the conclusion that it was not the size of the opening that was of importance in effecting a cure, because when one had had considerable experience in opening antra, one found that there were many cases in which a large drainage through the alveolar border would

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never overcome the difficulties. He referred to those cases with dissepiments from the floor, or with the mucous membrane in so altered a condition that suppuration was liable to be started again by the first fresh infection. Perhaps Dr. Powell did not mean that the cases were *permanently* cured.

Dr. Dundas Grant, in referring to the alveolar perforation, said he generally made use of a hollow trephine, the advantage of which was that it cut out the piece of bone which one removed instead of sending it or the bone-dust into the antrum. On one occasion, however, when he fancied he must have used almost excessive speed with it, there was actually a sequestrum of a little piece of bone around the trephining hole. Others had observed this fault as well, but he did not know the cause of its appearance. He thought it might be due to the intense heat generated; he did not use an electric motor, but a foot-drill.

With regard to the forceps, he thought the variation a most excellent one. If criticism *a priori* were permissible, he would say that the vertical shanks were rather too long; the upper angle would impinge upon the hard palate in a good many cases. Otherwise the instrument was an admirable one.

Dr. Herbert Tilley said that an almost precisely similar forceps had been in use for the last two years at the Throat Hospital, Golden Square, and was introduced there by Dr. Lack.

Dr. Lambert Lack said the forceps very greatly resembled some he had had made, and which had been in use at the Throat Hospital for over three years. In addition to the curve at the tip his forceps had an obtuse angle, which he thought a great additional advantage, as it held the epiglottis out of the way.

Dr. FitzGerald Powell, in reply to the President's remarks on the drill, said that it would be clearly seen in the example which he showed them, where the hole was made by the largest instrument, which was bigger than that of a No. 14 silver catheter, that the teeth were not impinged upon in any way. Cases were occasionally met with in which the teeth were so close together that there was some difficulty in this respect, but in the vast majority of cases one obtained a good large opening in the way he advocated, through which drainage could be thoroughly effected, and *through which the antrum could be curetted.*

In reply to Dr. StClair Thomson, he said that if the ethmoidal sinuses were affected, it would be necessary to curette the sinuses at the same time that the antrum was being opened. One came across cases occasionally in which it was necessary to open the anterior wall and curette the sinuses very freely, but in all ordinary cases—which constituted the great majority—the measures he recommended were sufficient to effect a cure. With regard to Dr. Tilley, he only wished to emphasise that the forceps he showed were Mackenzie's laryngeal forceps, modified by having the cutting point turned forward, and they were absolutely and totally different from Dr. Lack's forceps, which were short and very light, with an obtuse angle instead of the right angle of Mackenzie's, and were practically only suitable for children.

In using Mackenzie's forceps he had found some difficulty in re-

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moving growths in the anterior commissure, and it occurred to him if the points could be turned forwards the growths could be more easily reached. Hence the forceps he now showed.

Case of Paralysis of the Left Vocal Cord.

Shown by Dr. Willcocks. The patient, a postman æt. 45, had complained of cough and huskiness of the voice since last Christmas. On examination the left vocal cord was found to be completely paralysed, both cords were white, and there was no local swelling in the larynx. There was no history of syphilis, and no signs of any source of intra-thoracic pressure, such as aneurysm or tumour.

Dr. de Havilland Hall said that though they must remember the possibility of peripheral neuritis in this case, yet there was less evidence of it than there had been in the case of Dr. Powell's patient. At the age of forty paralysis of the left vocal cord indicated very possibly the existence of an aneurysm. He called to mind a case of Dr. Fincham's at the Westminster Hospital, where the only sign of an aneurysm for many months—in fact, nearly a year—was the cadaveric position of the cord. Eventually the patient developed well-marked physical signs of aneurysm, from which he died. In this case there might be no physical signs of aneurysm for many months to come, but they must still bear in mind the possibility of its being aneurysmal.

Mr. P. de Santi had shown a similar case to the Society only two meetings ago, in which, if he remembered correctly, Sir Felix Semon had considered there was an aneurysm in spite of the absence of the physical signs. The patient, a woman, was skiagraphed, and a well-marked dilatation of the arch of the aorta was easily made out; since then he believed the patient had been under the care of Dr. de Havilland Hall.

Sir Felix Semon had seen comparatively often the production of laryngeal paralysis in cases in which the aneurysm was so small that there were practically no physical signs to be obtained. The absence of physical signs of aneurysm in the chest was certainly no proof of its non-existence. He recollected a case which would serve as a very apt illustration. Many years ago the head-master at one of the big public schools consulted him on account of frequent fatigue of the voice. On examination of the throat he found paralysis of the left abductor. He then examined the chest, and thought there was possibly a very little dulness over the lower part of the sternum. Barring this dulness, there were no physical signs whatever; still, he suspected the presence of aneurysm. The patient was induced to see Dr. Ord, of St. Thomas's Hospital, who found the same condition and

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agreed entirely with the speaker as to the probable existence of aneurysm. The patient was at the time just about to start for a tour in Switzerland, where he intended spending the holidays. Both Dr. Ord and he advised him to go home and rest, and undergo a course of Tufnell's treatment. Dr. Ord knew the family medical attendant, and wrote to him expressing their joint opinion as to the case, in reply to which he received a letter saying that the writer wished devoutly there were no consultants in London, for they only needlessly frightened patients, and that he had strongly advised the patient to proceed with his arranged plans and go to Switzerland. This was done, and the patient died four weeks afterwards from hæmorrhage, caused by the bursting of a small aneurysm, which had, indeed, been present. The moral was obvious.

Dr. DONELAN said, in reference to the remarks just made by Sir Felix Semon, he had shown to the Society in June, 1901, a sketch of an aneurysm of the aorta in which paralysis of the left vocal cord was the only physical sign during life. The patient was an Italian man æt. 39, whom he had been asked to examine. He considered that the paralysis was probably due to an aneurysm. On the morning of the day following this examination the patient was suddenly seized with what seemed to be angina pectoris, became rapidly collapsed, and died within two hours of the seizure. The *post-mortem* showed a small oval aneurysm on the postero-superior aspect of the aorta, immediately outside the origin of the left subclavian, compressing the recurrent nerve.

Dr. WILLCOCKS had no further remarks to add, except that he was glad of the hint given by Mr. de Santi with regard to the X-ray examination. He had not taken a skiagram yet, but would do so. He thought Dr. Hall was most likely correct in referring to the case as of aneurysmal origin. He saw the case for the first time a month ago, when he had examined the man very carefully with that view in mind, but he had been totally unable to satisfy himself as to the existence of an aneurysm; he had shown the case to some of his colleagues at Charing Cross, and they were all of opinion that at present there was no obvious sign of aortic dilatation.

CASE OF LARYNGEAL STENOSIS DUE TO CICATRICIAL CONTRACTION IN INTERARYTÆNOID REGION.

Shown by Mr. H. BETHAM ROBINSON. The patient, a young man æt. 20, was brought to him on account of the difficulty in breathing on exertion.

According to the history he had had a severe attack of what was stated to be diphtheria some years ago; after it he had had no voice, but this had come back very slowly. Eight months

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ago the voice was only a squeak, but recently there had been great improvement, so that now there was only huskiness.

Examination showed a very large perforation of the nasal septum, involving both bone and cartilage, and loss of the uvula. In the larynx there was slight catarrhal reddening of the vocal cords, but the marked feature was the loss of abduction of the cords on deep inspiration with some stridor. On phonation the cords came together to the mid-line, except between the arytænoids. This laryngeal condition was due to a cicatricial web passing between the arytænoids, evidently the result of previous inflammation. Although no history could be obtained, syphilis explained the three lesions mentioned.

The PRESIDENT said the question was whether the cause of the condition was syphilis or diphtheria; the nasal trouble might, he thought, be caused by the latter, and possibly the laryngeal trouble also. He suggested that the man ought to have tracheotomy performed as soon as possible.

Sir FELIX SEMON drew attention to the adhesion between the posterior ends of the vocal cords in the very small part just visible above the interarytænoid fold. Supposing the cicatrix had been a little bit lower, everybody would have looked on it as a case of bilateral paralysis of the glottis openers. This case reminded him of the well-known case of Sidlo's, of Vienna, in which a similar diagnosis was made, and after death a cicatrix was found on the posterior wall of the larynx. The case to which he referred was extremely interesting as showing how careful one had to be, if the cords were lying close together, not to rush to the conclusion that the condition must needs be of nerve origin, and to remember the possibility of a mechanical origin. As to the particular case under discussion, he thought the perforation in the nasal septum and the absence of the uvula would make him very sceptical in regard to the diphtheritic origin of the case; there was, on the contrary, strong evidence in favour of syphilitic mischief.

Dr. DUNDAS GRANT thought it was very likely a case of perichondritis, such as occurred in typhoid fever; there was decubital ulceration from the pressure of the cartilages against each other. If the man were left *in statu quo* he was in considerable danger, but he did not consider that the operation for the relief of these cases was very satisfactory.

Dr. STCLAIR THOMSON said that in the absence of reliable history the evidence in favour of syphilis was not more than a suspicion. If the perforation in the nose occurred when the man was not having any treatment, it was very usual to find retraction afterwards causing some falling in of the nose, and even retraction round about the perforation, just in the same way as was found with the soft palate and uvula in inherited syphilis. It might be a coincidence that the

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syphilitic process in the larynx took place exactly in the middle line, but he thought it more likely to be of diphtheritic origin. He agreed with the President in thinking that tracheotomy was urgently called for.

Mr. Robinson, in reply, thought all the lesions were due to syphilis, and could not agree with the diphtheria explanation put forward. Of course, if they wanted to explain the condition by two causes, diphtheria and syphilis would do, but such was unnecessary when one common cause was sufficient. With regard to the question of operation, the lad was a pupil-teacher, and the whole matter had been put clearly before him and his parents, explaining the risks he ran. They were, however, unwilling, bearing in mind that he was dependent on his voice for his living, to have anything whatever done, and there the case must rest.

Sections of Tuberculous Growth of Mucous Membrane of Right Middle Turbinal in a Man æt. 50.

Shown by Dr. Adolph Bronner. The patient from whom this growth was removed was first seen on June 20th, 1901. He had had nasal obstruction off and on for some years, with discharge into throat; he could never smell well, but taste was fairly good. He gave a history of an ulcerated throat one year previously. The nose had been worse for some weeks, with pain over the bridge. He had noticed a rather offensive smell from the right nostril for two or three weeks.

The apex of one lung was affected. Both nostrils were blocked by swollen mucous membrane of lower turbinals. This was removed by a snare and galvano-cautery.

On July 25th the right middle turbinal was much enlarged, and on it a large patch of ulcerated mucous membrane. A piece was removed by snare for examination. Trichloracetic acid was applied, and aristol insufflations were ordered.

On September 24th there had been very little discharge or bad smell or pain for three to four weeks, and the nares were patent. The right middle turbinal was still enlarged, but the ulceration had healed.

The Clinical Research Association reported: "This growth consists of tuberculous granulation tissue in which are many miliary tubercles with large giant-cell systems."

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Dr. StClair Thomson suggested that Dr. Bronner be invited to give a specimen to the museum, because, as far as his recollection went, it was extremely rare to see a specimen of tuberculosis of the middle turbinal. The best article he knew on primary tubercle in the nose was that written by Mr. Steward in the 'Guy's Hospital Reports,' vol. liv, where it was pointed out that primary tubercle in the nose generally attacked the septum, and that next in frequency came the inferior turbinal, but that the middle turbinal was very rarely subject to tuberculosis.

Case of Tertiary Intra-nasal Syphilis in which the Right Frontal Sinus had been opened twice with Negative Results, in a Married Woman æt. 48.

Shown by Mr. P. de Santi. The patient was first seen five weeks ago, complaining of great pain at the back of the nose and head, also of a foul discharge from the nostrils and occasional discharge of pieces of bone.

She had been married seventeen years, and had had three miscarriages and one seven months child born dead.

Nine years ago she first noticed a discharge of small hard lumps of a greenish colour from the left nostril, also occasional swelling at the root of the nose; soon afterwards a similar discharge occurred from the right nostril, and the discharge, which had included frequently pieces of bone, had continued ever since, and had got worse and worse. Three and a half years ago she had had paralysis of left facial nerve, which came on suddenly, and cleared up entirely after about eighteen months' time.

In 1901 the patient was an in-patient at University College under Mr. R. Johnson for nasal discharge and headache. There was pain over bridge of nose and right frontal sinus, slight diminution to tactile sensation over left side of body, and slight apparent weakness of facial muscles on the left side. The right frontal sinus and maxillary antrum were explored, and found to be healthy.

The patient left the hospital unrelieved, and on September 25th, 1901, was admitted into Charing Cross Hospital, under Mr. Waterhouse, and the right frontal sinus was opened, a little purulent material exuding; the mucous membrane was

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in a thickened and catarrhal condition. An attempt to pass a small rubber tube down the infundibulum was unsuccessful, and a strip of gauze was substituted. The frontal sinus was packed with iodoform gauze, and the usual dressing applied. After the third day a No. 2 catheter was passed down infundibulum, and this was done daily, the parts being washed out with boracic solution. The fœtor became less, and after a few days' treatment the patient passed a large mass of necrosed bone, which consisted of a part of the lateral mass and ethmoidal cells. The frontal wound was gradually allowed to heal. Patient was discharged on October 10th, 1901, unrelieved. She now complained of intense headache, loss of sleep, diarrhœa, and a half-choking sensation. The pains in the head appeared to be referred to the back of the nose and frontal regions.

Examination of the nose showed large greenish-black sloughs in the posterior region of the intra-nasal cavity; there had been extensive destruction of the bony lateral masses, but the septum was intact.

The patient's condition, in Mr. de Santi's opinion, was due to syphilis, and she had had large doses of iodide of potassium, but without benefit. Suggestions as to operative treatment were invited.

Dr. Dundas Grant said the woman seemed to be in a very serious condition. He strongly suspected tertiary changes were taking place in the sphenoid, and probably there was a sequestrum at the junction of the sphenoid and the vomer; he thought Mr. de Santi might explore this region with his finger. He had had a similar case to this under treatment, which consisted in taking the patient into hospital and giving her the good feeding up which her circumstances at home rendered impossible. He was giving her inunctions of mercury with iodide of potassium and opium internally. He recommended the same treatment to Mr. de Santi's patient.

Dr. Herbert Tilley agreed with Dr. Grant as to the possibility of deep-seated bone mischief in the sphenoidal region, and cited a similar case which died of basal meningitis after temporary improvement by mercurial inunctions and constant nasal douches. The pus between the middle turbinal and the septum, the pain on the top and at the back of the head, together with deep-seated pain in the right eye and frequent disturbances of vision, were all symptoms very suggestive of suppuration in the sphenoidal sinus.

Dr. Vinrace said he thought that before any further operation was proposed in this case, it might be desirable to review very briefly what had been done. He had, on a previous occasion, asked what were the

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indications for opening the frontal sinus, and what were the benefits claimed for it; and the answer he received was that the operation was performed in accordance with the best canons of rhinological surgery, and that the patient was very much better for it. This answer only left him to speculate in what details the benefits accrued. In this particular case he would like to know why it was that the frontal sinus was opened. It was opened for the first time about two years ago, but nothing of a morbid character was found. Twelve months afterwards it was opened for the second time, and he believed it was stated that a *little* pus was found in it. Now what he wished to know was exactly what benefit had followed the surgical measures adopted in these two operations. As far as he could gather from the patient, she had been in trouble for nine years, but never in serious trouble till the operations were performed. To use her own words, she had a "dirty nose" for several years. After the first operation was performed, as he gathered from her, she was worse in health and new symptoms arose; even after the second operation, the patient admitted that her symptoms were very much aggravated. Having regard to these reports from the patient, he thought very great care should be exercised before any further operation was done. Assuming that when the first operation was done the patient was suffering from active syphilis, one of the last things that it would have occurred to him to do would have been to operate on the nose in the extravagant way in which it had been done in this case. He did not wish to put any member in the position of an oracle pronouncing judgment upon this question, least of all the exhibitor, since the surgical interference referred to had been carried out before the patient came under his care, but if any member could enlighten him upon the points he had raised he would indeed be grateful.

Mr. DE SANTI, in reply, said the first point to be mentioned was in regard to the diagnosis which was raised by Dr. Grant. There could be no doubt that the woman was suffering from tertiary syphilis of the nose, and that the disease had penetrated as far back as the region of the sphenoid bone. Nor was there any doubt that her condition was a somewhat serious one, and that she must undergo some further operation. She should, he thought, be examined thoroughly under an anæsthetic, and the posterior nares be carefully explored with the finger, and, of course, what might be done afterwards depended on what might be found. If the sphenoid bone were necrosed and firmly fixed, it would not be safe or wise to try and get the necrosed bone away, unless it would come away with the exercise of very little force. If a sequestrum had formed, as he feared, its removal might be quite easy, or, on the other hand, difficult and dangerous.

With regard to Dr. Vinrace's remarks, he had to say that when the patient first went to University College Hospital, and was under the care of Mr. Johnson, she had very intense headache, and there was considerable pain over the bridge of the nose and the right frontal sinus. The patient localised most of the pain in the head on the right side of the frontal bone, and the area of tenderness to pressure was over the right frontal sinus, and he supposed these were the reasons why the right frontal sinus was opened. Moreover there was a nasal

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discharge consisting of thick greenish pus, and this was seen mostly in the middle meatus. He could not go further than that as to the reasons which probably prompted Mr. Johnson to operate on the right frontal sinus. Later the patient was at Charing Cross Hospital, complaining of similar symptoms, only they were aggravated. It was only fair to Mr. Waterhouse to say with regard to the second operation on the frontal sinus, that although the woman now denied it, it was against his advice that the operation was undertaken. The patient insisted on Mr. Waterhouse doing it, and it was done under protest. One of his colleagues at Charing Cross, Mr. Bloxam, felt certain there was nothing the matter with the right frontal sinus before it was operated on again by Mr. Waterhouse, but was of opinion that there was a mass of dead bone at the back of the nose.

He could not go further into the subject of the indications for and advantages of the frontal sinus operation, but as regards this particular case, the reason for operation was the pain referred to the right frontal sinus, which was constant and excessive before the sinus was opened.

A Case of Angioneurotic Œdema of Right Hand with recently developed Attacks of Difficulty in Breathing.

Shown by Mr. P. de Santi. The patient, a married woman æt. 26, was in the London Hospital four years ago with swelling of the right hand and forearm, and angioneurotic œdema was diagnosed. The treatment consisted in elevation of the limb.

Since then she had had several further attacks, always of the right hand. The attacks began with a feeling of tightness in the hand, rapidly followed by great swelling of the fingers, hand, and forearm, the fingers becoming almost black in colour, and the rest of the affected parts bluish red. The attacks lasted a variable time, and then the parts returned to the normal. There was no particular periodicity in the attacks, and no family history of similar conditions. About six weeks ago the right side of the face became swollen, and for three weeks the patient was unable to open the mouth properly, having to live on slops. Then followed suffocative feelings in the throat, which occurred both by day and night, the patient feeling as if the throat were being tightly gripped. The attacks were slightly relieved by adopting the sitting posture. The hand had not been affected for four months.

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Examination of the larynx revealed no œdema or abnormal condition. The case was brought forward as, in these cases of angioneurotic œdema, of which Mr. de Santi had seen two, sudden œdema of the larynx proving fatal might occur.

Osler had knowledge of one family extending to five generations in which twenty-two various members had been attacked by angioneurotic œdema, and in which two had died of œdema of the larynx. This disease was characterised by the sudden onset of local œdematous swellings, more or less limited in extent and of transient duration. The parts attacked were usually the face, back of the hands, the buccal or pharyngeal mucous membrane, or the larynx. Mr. de Santi would be glad if any members could inform him if they had had any experience of throat trouble in these cases of angioneurotic œdema—otherwise called Quincke's disease.

Dr. DE HAVILLAND HALL thought this an extremely interesting case. He had a case under his care which he saw from time to time, the patient being a lady of forty-four or forty-five years of age, who was subject to attacks of angioneurotic œdema of the neck and buccal mucous membrane, and as she had had on one or two occasions great difficulty in breathing he inferred that the symptoms extended to the larynx. Unfortunately he had never been able to see the larynx affected; but usually he saw the buccal mucous membrane in an œdematous condition. This patient was undoubtedly a gouty subject, and she had derived most benefit from a course of treatment directed to the gout, and from alkalies. She was formerly a patient of his late colleague, Mr. Bond, who had been treating her with bicarbonate of potash and bark with considerable benefit, and occasionally doses of blue pill. He had not seen the patient now for three or four months, but he had heard that the attacks were getting less frequent. He sent her to Llandrindod Wells for a course of treatment, and she had come back very much better. He had seen another case in a boy who had no throat complication, but who was subject to attacks of angioneurotic œdema, which were located in the back of the left hand and wrist. It was an interesting case, as the patient had developed cyclic albuminuria. When in the recumbent position there was no albumen in the urine, but on getting up and about a trace was found. He thought this combination of the two conditions—angioneurotic œdema and cyclic albuminuria—in the same patient a matter of some interest.

Dr. EDWARD LAW thought that some of the members might remember that five or six or seven years ago he had brought before the Society a case of well-marked Quincke's disease.

Mr. DE SANTI, in reply, said he should be pleased to adopt the treatment mentioned by Dr. Hall.

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Case of rapidly recurring Papilloma of the Larynx.

Shown by Dr. Lambert Lack. The patient, a Swiss waiter æt. 21, had suffered from hoarseness for four months. When first seen six weeks ago there was what appeared to be an ordinary fairly large papilloma on the anterior part of the right vocal cord.

This was at once removed under cocaine. Subsequently there was considerable congestion of the vocal cords, which increased during the following three weeks until both cords appeared red, thickened, and irregular, resembling the "fleshy granulating" cords often seen in tubercular disease. The patient was "run down," and had considerable cough and expectoration. He was now much better, and the local condition had cleared up, but on examining the larynx it would be seen that the growth had recurred, and there were at least two distinct fresh growths on the other cord.

Mr. Lake said he could not help thinking that in this case if Dr. Lack removed the growth, the careful bacteriological examination of a portion of such a rapidly growing papilloma might throw some light on its causation; micro-organisms that were found might serve as an important aid.

The President, from a cursory examination, thought the case was suitable for the application of the galvano-cautery.

Case of Traumatic Tracheal Obstruction.

Shown by Dr. Dundas Grant. Edith C—, æt. 22, was first seen on February 13th, 1902, complaining of difficulty and loudness in breathing, especially when hurrying. These symptoms had existed since an accident at three years of age, when she fell on the blade of a knife and punctured her windpipe. She had no difficulty in breathing at night, but the dyspnœa had been getting worse during the last six months. It was worse after food. There was no indistinctness in her speech, but a slight apparent effort. The left vocal cord was completely fixed, and without doubt the left recurrent laryngeal nerve must have

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been injured. The extremely late period at which the narrowing had more strongly asserted itself was difficult to explain; it was hardly likely that there was anything in the way of a polypoid granulation, but more probably cicatricial contraction. Dr. Grant had advised that she should come into the hospital for a more thorough examination, and if possible for the introduction of a tube into the trachea for direct inspection.

Case of Rhinorrhœa in a Girl æt. 9.

Shown by Dr. Cathcart. Since the patient was two years old she had had a thin watery discharge from both nostrils, which caused excoriation of the upper lip. During the last six years she had twice been operated on for adenoid growths, and on four other occasions the nose had been examined under an anæsthetic and either curetted or cauterised with nitrate of silver or the electro-cautery.

Everything in the way of drugs had been tried, both internally and locally, but the discharge still continued.

The President said information was desired as to the treatment to be pursued.

Dr. de Havilland Hall had had a case at Westminster Hospital, and on measuring the fluid he found it amounted in the twenty-four hours to nearly a pint. The fluid was clear and limpid, and came undoubtedly from both nostrils, and not from any other part. At that time he had thought the case due to a vaso-motor condition. His patient had derived most benefit from mustard foot-baths with morphia and atropine. He had originally been under his care sixteen or seventeen years ago, and he had seen him quite recently—during last week,—and he had now nasal polypi. When he felt the attacks coming on he put his feet into the mustard foot-bath and took a dose of 1 minim atropine and 5 of solution of hydrochloride of morphia. In Dr. Cathcart's case he would feel inclined to try a weak spray of adrenalin solution.

Dr. StClair Thomson said it was very rare to find this condition of uncomplicated nasal hydrorrhœa in a patient so young as nine years. The cases which had come under his observation had been much older. As to their treatment, speaking from personal experience, he thought it extremely unsatisfactory. By giving placebo treatment many cases would undergo a temporary spontaneous cure, but the symptoms were quite likely to come on again at any time. Yet a certain number of cases seemed to be relieved by the use of

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atropine, particularly if it was combined with Liq. Strychniæ, as suggested by Lermoyez, whose contention was that the atropine checked the glandular secretion, and that the strychnine was beneficial to the vaso-motor paresis. He had given a pill containing extract of belladonna, quinine, and extract of nux vomica. The results were uncertain from the use of adrenalin, for cases were published in which the adrenalin, instead of being beneficial, made the patients very much worse. He had heard of a city man who particularly wanted to attend a public meeting, and had adrenalin administered to him in order to tide him over the meeting, with the result that he was so much worse that he was unable to go at all, whereas without the adrenalin he could have got through with two or three handkerchiefs. He would like to hear from other members what results, even if negative, had followed the use of adrenalin in their hands. In more than one case in which he had explained the condition of affairs, and refrained from local treatment, the patients had gone elsewhere, and had a great deal of the galvano-cautery, but with what results he did not know. General treatment and that of hydrotherapy at different health resorts had at the least an elevating effect.

The PRESIDENT said he could only suggest the same treatment he had recommended for Mr. Lawrence's patient at the last meeting—the application of the continuous current externally to the nose. He wished to add that adrenalin required to be used carefully; if it was applied too strong it might produce prolonged sneezing. He employed a solution of 1 in 10,000 of adrenalin chloride to contract the nasal mucous membrane.

Sir FELIX SEMON said he had lately frequently used adrenalin in view of the many recommendations bestowed upon that remedy, and he found that for about an hour or two after its administration it produced a stoppage of secretion and feeling of absolute dryness in the nose, followed by infinitely greater discharge than previous to its use.

Mr. WAGGETT considered that it was worth while to make trial of the treatment of Lermoyez in its entirety, for he had had three or four lady patients under his care who had taken the trouble to pursue the treatment regularly, and had obtained complete relief of hydrorrhœa. Whether or no this was to be permanent he was unable to say. The syrup used contained strychnine and atropine (*vide* 'Journal of Laryngology,' vol. xv, p. 442).

Dr. LAW, replying for Dr. Cathcart, said that adrenalin had been tried, but without success, also many other remedies.

Dr. BRONNER asked if any member had tried the desiccated suprarenal extract, which was in the form of a powder, and was used as a snuff. He thought it acted better than the solution of adrenalin. It was used 1 in 10 with boric acid and a little menthol.

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CASE OF ATROPHIC RHINITIS IN WHICH MELTED PARAFFIN HAD BEEN INJECTED INTO THE INFERIOR TURBINATE BODIES WITH GOOD RESULTS.

Shown by Mr. G. LAKE. The patient, a woman æt. 25, had been afflicted with fœtid atrophic rhinitis for many years. Crust formation had been got under by the usual treatment, but the patient was dissatisfied, as she felt no air passing down the nose. This suggested to him the idea of contracting the passages by making an artificial inferior turbinate by means of submucous injections of paraffin.

The injections were made under the posterior surface of the remnant of the inferior turbinate, about ♏ v each time with intervals of one week. The total increase of length obtained was not great, but the relief was most satisfactory to the patient.

The needle required was one of fair calibre, three inches in length, and attached to the syringe by means of a screw. The syringe employed was one with metal bands connecting the metal ends and worked with a screw piston to overcome the friction caused by the long needle.

The PRESIDENT asked Mr. Lake if the patient had benefited as far as the symptoms were concerned.

Dr. DUNDAS GRANT said that the turbinated bodies looked an excellent size at present. He asked whether a local anæsthetic was required, and whether cocaine was contra-indicated, owing to the fact that the contraction it would produce would militate against the successful injections.

Mr. WAGGETT thought the most remarkable point about the case was the colour of the inferior turbinals, which was now practically of a normal tint. He had closely questioned the patient, and from her replies he had gathered she must have enormously improved. He heartily congratulated Mr. Lake on his very ingenious new method of treatment.

Dr. LAMBERT LACK said that although the patient herself was positive that she had derived great benefit, the treatment seemed to him utterly irrational and against the modern ideas of the pathology of the disease. He thought much more evidence was required before this treatment could be accepted.

Mr. LAKE, in reply, said he had used cocaine, and that it answered very well. With regard to the symptoms, the girl bothered him after the crust formation ceased because she could not blow her nose; she had plenty of room, but she could not feel air pass down the nose.

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He was pleased to hear Dr. Lack's strictures, because it was a question of some considerable interest as to what was the pathology of the disease. People talked of the destruction of the turbinals as if this were part of the disease, but why did they disappear?

In the present case the patient expressed herself as more comfortable with the substituted inferior turbinals, which merely relieved the symptoms. He did not feel so confident in the present pathology of atrophic rhinitis as described in the text-books to quite accept the explanations given by them as correct.

Papillomatous Growth on the Posterior Edge of the Vomer.

Shown by Dr. Herbert Tilley. The patient, an adult male, had been under treatment for almost complete nasal obstruction in the left nostril. In the course of examination a small whitish growth the size of a yellow pea was seen by posterior rhinoscopy situated on the posterior edge of the vomer about the middle of its length. The growth was dead white in colour, contrasting very markedly with the normal redness of surrounding structures.

The growth had not been touched by finger or instrument, and hence the exhibitor could say nothing of its feel or consistence. He had once seen a definite papilloma growing from that spindle-shaped mass of mucous membrane so often seen on the posterior edge of the vomer, but had never met with a condition similar to that in the case exhibited. He regarded it as a harmless curiosity.

The President said in regard to this case of growth on the edge of the vomer, he would not like to say without feeling it with his finger whether it was papillomatous or cartilaginous in character. He thought the growth different from the ordinary swellings seen near the posterior margin of the vomer.

Sir Felix Semon said that in that part of the vomer one often saw little symmetrical thickenings. This growth might simply represent an excess of the ordinary thickening.

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Case of Syphilitic (?) Disease of Larynx simulating Malignant Disease.

Shown by Dr. Herbert Tilley. The patient was a well-proportioned man æt. 28. For six weeks he had complained of "hoarseness," and for the past week of pain on swallowing, which shot from the throat towards the right ear.

The irritation in the throat caused a cough, but at no time had he expectorated blood. The patient had syphilis about five years ago.

The larynx was uniformly congested, but the right vocal cord was motionless on phonation, and there was considerable, but uniform, swelling of its posterior half. Below the level of the cord for about half an inch in a vertical direction well-marked ulceration was seen; there were no prominent edges or projections from the surface of the ulcer. The right arytænoid cartilage moved on phonation. A hurried examination of the chest had been made, but so far as it went no evidences of tubercular mischief were obtained. The appearances in the larynx simulated malignant disease, but at present the patient was being treated on the hypothesis that the lesion was a syphilitic one.

Dr. FitzGerald Powell did not quite catch whether or not the chest had been examined. It seemed to him, from the appearance of the condition, it was much more likely to be tuberculosis than either syphilis or malignant disease. The larynx was pale in colour, there was present to a fairly large extent cough and expectoration, according to the man's own account. He seemed to have been having night sweats, and showed other symptoms of tubercle; under these circumstances he thought that until the sputum had been examined, and they knew the condition of the chest, it was almost impossible to come to a definite conclusion with any certainty as to the condition, but he believed it to be tubercle.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

SEVENTY-THIRD ORDINARY MEETING, *April* 11*th*, 1902.

E. CRESSWELL BABER, M.B., President, in the Chair.

CHARLES A. PARKER, F.R.C.S.(Ed.),
JAMES DONELAN, M.B., } Secretaries.

Present—32 members and 1 visitor.

The minutes of the preceding meeting were read and confirmed.

The following gentleman was nominated for election:

Woods, Robert Henry, 39, Merrion Square East, Dublin.

The following cases, specimens, and instruments were shown:

CASE OF LARYNGEAL GROWTH IN A MAN ÆT. 50.

Shown by Dr. WYATT WINGRAVE. The patient was a dock labourer, and when first seen, about two months ago, complained of hoarseness of twelve months' duration, with some dyspnœa on exertion for past four months. He admitted having a "chancre" twenty years ago, but without any sequelæ.

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On laryngoscopic examination, two smooth opalescent swellings were seen overhanging the right half of the glottis. The cords were normal in appearance and texture. He was ordered sedative inhalations, and carefully watched. The symptoms considerably improved, but the swellings distinctly increased in size, a third one appearing just above the left capitulum.

Fourteen days ago considerable œdema of uvula and palate appeared.

The voice was at the present time very good, and there was very little dyspnœa on exertion.

He had not lost weight, and felt quite well. There were no enlarged cervical glands.

Case of Tumour of Larynx.

Shown by W. H. Kelson. The patient, a woman æt. 74, came to hospital suffering from hoarseness of nine months' duration. On examination, there was seen to be a rounded greyish coloured tumour, about the size of a marble, lying on and concealing the anterior part of the left vocal cord, and apparently originating from the left ventricle. It was firm when touched with a probe; the cords moved well, but were prevented from coming into apposition by the growth.

He thought it was probably a cystic fibroma.

Dr. Scanes Spicer thought the tumour was a cyst. It was white, and shaped like a pearl.

The President also thought of its possibly being a so-called prolapse of the ventricle, but it did not look solid enough for that.

Dr. Jobson Horne said he could not be quite sure from inspection alone whether the growth lying on the left vocal cord were solid and dependent from the roof of the ventricle, and therefore similar in its pathology to one he had described (*vide* 'Proceedings,' vol. v, p. 98), or whether it were of a cystic nature, and formed by the prolapsed lining of the ventricle. Its appearance, he thought, was suggestive of the latter.

Dr. StClair Thomson had seen a similar case in a small boy. On being punctured a fluid came out, and the whole thing collapsed. A fortnight later the patient returned to hospital with the growth filled up again. It was removed with forceps, and found to be a cystic fibroma.

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Sir **Felix Semon** was of opinion that this was a cystic fibroma. The surface was too granular for a simple cyst.

Dr. **Kelson** himself thought it was a cystic fibroma. He had cocainised the larynx and felt it with a probe, and it seemed to be rather firm.

Case of Tuberculous Disease of Larynx.

Shown by Dr. W. H. Kelson. This occurred in a woman æt. 42, who came complaining of loss of voice for two months and loss of health for two years. There was swelling and loss of movement of the left arytænoid, and a pink granuloma projecting from the left ventricle and overlapping the left cord. There were indications of phthisis at both apices. A very few bacilli were to be found in the sputa.

Dr. **Grant** said it seemed a very pretty case of what was sometimes described as prolapse of the ventricle, which was supposed to be an eversion of the mucous membrane, whereas really it was just a growth of granulation tissue—possibly tubercular—from the ventricle.

Case of Syphilitic Laryngitis, possibly Complicated with Tuberculosis.

Shown by Dr. StClair Thomson. The patient presented fixation and ulceration of one cord. There was also ulceration of one faucial pillar, and some ulceration on the posterior pharyngeal wall. This assisted in the diagnosis of syphilis, and the condition improved considerably under specific treatment. Still, in spite of large doses of iodide of potassium the condition did not entirely clear up, and, while the cord improved, there seemed to be more infiltration in the inter-arytænoid region. There were no constitutional symptoms of tuberculosis, and the temperature was always subnormal. The man had gained in weight.

Dr. **Permewan** asked why Dr. Thomson thought this was possibly a case of tubercle. To him it seemed that there were no marked tubercular symptoms, and that it was simply syphilitic.

Dr. **StClair Thomson**, in reply, thought the case tubercular because of the intra-arytænoid thickening, which had slightly increased, though the patient had improved with regard to the fixation and ulceration of the cord.

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Case of Congenital Absence of the Front of the Nose with Occlusion of the Anterior Nares.

Shown by Mr. Arthur H. Cheatle. The infant was six weeks old. It was the mother's first child, and was born at full time. There was no history of syphilis; the nasal bones were present, but the framework of the nose in front of the nasal bones was absent. The palate was normal, and no other deformities were present.

The President considered this a highly interesting case. Whether it was due to intra-uterine syphilis or not was the only point which might be raised.

The case showed that a person could sleep perfectly quietly when the nose was completely obstructed. Though with polypus of the nose causing partial obstruction there was often great difficulty in breathing and noise during sleep, yet when there was complete obstruction the patient might after a time sleep comfortably.

Dr. FitzGerald Powell said it was a very interesting point whether this was congenital or whether it was due to intra-uterine syphilis, but one would expect to find some other evidence of syphilis in the child if this was a case of intra-uterine syphilis. He should think it would be a case for a plastic operation in later years.

Dr. William Hill asked exactly what was meant by describing the condition of occlusion of the nares as congenital. Did those who employed the term here mean a closure from an inflammatory process occurring during intra-uterine life? Looking at the matter from a purely developmental point of view, the term "congenital" was usually applied rather to a *defect* of closure from arrested development; in this case the nares, formerly patent, had obviously been closed up later by an active inflammatory process *in utero*.

Specimen of Rhinolith.

Shown by Mr. Arthur H. Cheatle. This specimen was removed from a woman æt. about 50 years, who had been troubled with the right side of her nose for twenty years. From the prescription she brought the origin was syphilis. The fœtor was extreme. The rhinolith, which had to be broken before it could be extracted, weighed 140 grains. The nucleus apparently was a portion of necrosed inferior turbinal, as the configuration

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of the largest portion of the stone demonstrated. After removal the inferior turbinal was seen to be absent.

Mr. Jackson, of King's College, reported that the stone was composed of calcium phosphate and carbonate in almost equal proportions, together with a trace of organic matter.

A New Form of Laryngeal Forceps.

Shown by Dr. Lambert Lack. These forceps were mentioned at the last meeting. They were similar to Mackenzie's well-known forceps, but the blades formed an *obtuse angle* with the shaft, and thus, when in the larynx, held the epiglottis out of the way. The forceps were also thus removed from the direct line of vision, and enabled a better view of the growth to be obtained at the moment of seizing it; for this reason, also, the blades were much more slender than Mackenzie's. One pair of the forceps were curved forwards at the tip of the blades to enable a growth in the anterior commissure to be more easily reached. The forceps had been used for over three years by various members of the staff at Golden Square, and had been found useful.

Dr. FitzGerald Powell again produced the forceps he had shown at the March meeting, and pointed out how they differed from Dr. Lack's.

A Case of Thyrotomy for Tuberculosis of the Larynx.

Shown by Dr. Lambert Lack. The operation had been performed for what at the time was diagnosed as epithelioma of the larynx, and Dr. Lack thought the case presented many features of interest.

The patient, a finely made, robust man æt. 66, was an old soldier, and, apart from wounds, had never had a day's illness. He was first seen in April, 1901, for hoarseness, which had commenced three months previously and was gradually increasing. On examination an ulcer with raised edges and some surrounding thickening was seen occupying the centre of the

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right vocal cord, the movements of which were considerably impaired. The rest of the larynx was of normal colour and contour. The patient had some cough and expectoration, which he stated was not unusual to him during the winter. Examination of the chest showed signs of bronchitis. The sputum was examined for tubercle bacilli with negative result; the patient was otherwise in good health, and no enlarged glands could be felt. The diagnosis pointed so strongly to epithelioma, and the case was so eminently suitable for operation, that thyrotomy was advised and immediately carried out. The entire right vocal cord was removed in the usual way, and the patient's recovery was uninterrupted.

The growth macroscopically looked like an epithelioma, but Dr. Horne, after microscopical examination, reported it as tubercle.

The patient made good progress until the commencement of August, 1901, when enlarged glands were noticed in the neck. In September there was a hard lump under the upper part of the right sterno-mastoid about the size of a walnut, and rather fixed. Immediate removal was advised and at once performed. The operation involved removal of part of the sterno-mastoid muscle, of the spinal accessory nerve, and of the internal jugular vein. Some of the mass of glands, which was removed entire, were found to be breaking down, and looked suspiciously like suppurating tubercular glands. This opinion was confirmed by microscopical examination, and there was no doubt but that this case was really one of tuberculosis throughout. The patient had since remained in his usual state of good health, but had no voice, the cicatricial band which usually takes the place of a removed cord not having formed. The left cord moved freely, but had an apparently hollow space opposite to it. This case seemed a remarkable one for the following reasons:

1. The laryngoscopic appearances of the localised growth on the vocal cord, the normal condition of the rest of the larynx, the patient's age and vigorous health, the absence of signs of tubercle in the chest, the absence of tubercle bacilli in the sputum, etc., all pointed to a diagnosis of epithelioma. (This was confirmed by my colleague, Mr. Parker.)

2. Even after the pathologist's report an error was suspected,

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especially when enlarged, hard, fixed glands appeared in the neck.

3. The good result of the operation, although performed for tuberculosis.

4. There were no signs of the presence of phthisis even now.

5. The failure of the formation of the cicatricial band which usually takes the place of the removed cord, and the consequent continuance of aphonia.

Sir Felix Semon thought the case very interesting from many points of view. First of all from Dr. Lack's description of the case, *i. e.* from the clinical appearances, there seemed to be hardly any doubt that it was a case of malignant disease. When the microscopic examination disproved that, he could quite understand that Dr. Lack was very much inclined to disbelieve the microscopist in this particular instance.

Then came the glands in the neck, which would help to increase the belief in the malignant nature of the disease. Nevertheless this view was again disproved and the case ultimately shown to be one of tuberculosis.

Thirdly, there was a fact to which Dr. Lack had drawn his particular attention. They knew that usually in cases of thyrotomy undertaken for malignant disease of the larynx, a ridge formed corresponding to where the diseased vocal cord had been removed, and that the voice materially improved, usually up to the end of the first year, but in this case there was a complete absence of such a ridge, and it was impossible to say why.

He was most interested, too, in the appearance of the left vocal cord during phonation. In the latter part of phonation one saw quite distinctly the arytænoid cartilage not merely move inward but make quite a quarter-turn inwards, so that its vocal process pointed directly into the glottis, and the vocal cord assumed a completely triangular form instead of its usual linear outline. He had never seen this before, and, again, it was practically impossible to say why it should be so. It was, of course, due to the action of the lateralis muscle, but why this should contract in this exaggerated way it was difficult to see, unless a sort of subluxation had been produced by all possible energy being put into the action of the remaining vocal cord in the effort to get a better voice.

Dr. Permewan had also noticed this appearance of the left vocal cord with some interest, and it struck him as a sort of rotation or turning on itself which might be due possibly to the fact that the anterior end of the cord might have been cut across. He asked whether the thyrotomy had been only unilateral or whether the excision had extended to this side as well.

Mr. Parker had seen this case with Dr. Lack from the first, and from the clinical appearances when he first saw the patient he quite agreed with Dr. Lack that there was little doubt as to the malignant

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nature of the disease and that the proper treatment was immediate operation.

Dr. Scanes Spicer said this case raised to his mind the question whether resort should not be had in certain cases of tuberculosis of the larynx to the external operation and the removal of the affected area, more especially in those cases in which the tubercular process was definitely localised.

Dr. Jobson Horne said he was the pathologist and microscopist referred to. He had expressed the opinion that the disease was tuberculosis, and not epithelioma, and, as Dr. Lack had stated, he had not departed from that opinion, notwithstanding the surprise the result of the examination had occasioned, for it was not the first time he had microscoped a vocal cord believed to be the seat of epithelioma, and had found tuberculosis. He considered that the statistics had been enriched by Dr. Lack having published this case. It went to show how fallacious and misleading statistics must be which did not include negative cases. To obtain trustworthy statistics of operations for epithelioma of the larynx, Dr. Horne said, there were at least two essentials; the first was to have a microscopic examination made in every case of the parts removed by the operation, and the result of the examination appended; the second, which was, perhaps, more important, was to have the name of the microscopist also stated.

Referring to the suggestion made by Dr. Scanes Spicer, that the result of the case opened up a field for further operations of the kind for tuberculosis of the larynx, Dr. Horne said the results rather disproved than supported the theory. The cord itself presented under the microscope the appearance of chronic, quiescent, and, one might say, arrested tuberculosis. Four months later some glands were removed from the same side of the neck, which doubtless would have been removed at the same time as the thyrotomy was done had they been sufficiently affected. The sections of the glands showed recent and more active tubercle, and suggested a lighting up of old disease with a reinfection, consequent upon the disturbance of the old tuberculous focus in the larynx itself. Dr. Horne expressed himself desirous of showing the sections to the Society at the next meeting.

Mr. W. G. Spencer did not quite agree with the last speaker. He thought this case ought to be classed with those of senile tuberculosis, which had been mentioned by surgeons. They were more common in connection with the bones, but there were other forms of senile tuberculosis occurring in old people, who otherwise had no connection with the disease—no family history—and who had not shown tuberculous lesions in earlier life. All these cases of senile tuberculosis were progressive forms of the disease, and he thought that the operation in this case was amply justifiable, and would contribute to their knowledge of other cases of senile tuberculosis in different positions. As to the frequency of such cases, it might possibly be greater in the larynx, but even here must be very rare. He thought it was of further interest, pathologically, in connection with the question that had been raised of carcinoma of the larynx, *i. e.* whether in old age or towards old age there was a diminished resistance

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against the pathological lesion causing epithelioma. Here some chance tubercle bacilli getting on to the patient's cord, and he possibly having less resistance against the attack than in early life, tuberculous disease had developed.

Dr. LACK said the case was such an exceptional one that he did not think it afforded any reasons for operating in other cases of laryngeal tuberculosis. Thyrotomy and even tracheotomy were generally disastrous in these cases. He did not think this could be called an arrested growth, as the hoarseness was of only three months' duration and was increasing. Nor did he think complete excision of a focus of disease likely to spread the infection to the glands.

SPECIMEN OF CYSTIC GROWTH OF THE SEPTUM AND MICROSCOPIC SECTION.

Exhibited by Dr. PEGLER. The tumour was removed from a male patient æt. 30, who came to the hospital January 31st, 1902, complaining of what he thought was a polypus in the nose, creating obstruction. On examination a pendulous body was seen occupying the left middle meatus, bluish grey in colour, and resembling a polypus to all intents and purposes, though less flattened and rather more opaque. A distinct attachment to the left side of the septum was traced by the probe, at about the region of the tubercle or a little higher. Dr. Clayton Fox also examined the case, and an œdematous septal polypoid hypertrophy was diagnosed. It was removed with a Mackenzie snare with the usual antiseptic precautions, and neither bleeding nor serous fluid escaped. The after-appearance of the middle meatus was peculiar, the septum showing a marked indentation, and the anterior half-inch of the middle turbinal being strongly deflected outwards at the site occupied by the growth, which might therefore be presumed to be either of congenital origin or, at all events, to have existed for a long period. It proved on inspection to be a cyst with a short, hollow pedicle. The patient wrote three days later excusing himself from keeping his appointment at the hospital on account of "a bad influenza cold," and did not subsequently return. For full notes of the after-history the exhibitor was indebted to the patient's private medical attendant, who was called in on February 7th. At this time the patient was found to be

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suffering from shiverings, pains in the limbs, and headache, with a temperature of 100°. There being three other cases of influenza in the house, this disease was diagnosed. After a temporary improvement the case took an unfavourable turn, and by February 9th symptoms of meningitis had developed. The left arm and leg became paralysed, coma set in, and the eyes were drawn to the left. Later, large twitchings and convulsions invaded the right side of the body, arm, and leg, and the patient died on February 15th. The report states that the initial symptoms indicated right-sided brain trouble, but that the patient had no local signs drawing attention to the nose during the illness, neither swelling, pain, tenderness on pressure, nor discharge, and on this account the exhibitor had not been communicated with. The tumour, which had been placed in spirit immediately after removal for subsequent examination, was handed over to Mr. Bland-Sutton, as there seemed reason, in the light of what had followed, to suspect meningocele. That gentleman had carefully examined it, both macro- and microscopically, but thought " the source of the cyst was a matter for conjecture." The micro-sections showed two distinct zones of tissue; the outer consisted of nasal mucous membrane; it was surrounded by columnar, non-ciliated epithelium, and contained racemose glands, but no sinuses. The inner zone was much thicker in certain situations than others, and was made up of connective tissue containing many elastic fibres, but did not appear to have a definite squamous epithelial lining. The appearances were well shown in the drawing handed round. The specimen had been mounted by Mr. Pollard, of Middlesex Hospital, who also made the micro-sections.

Dr. Dundas Grant thought they all ought to express their indebtedness to Dr. Pegler for bringing forward the case. When a case ended fatally, as this had, the interest was enormously increased, and its instructiveness was increased, perhaps, in geometrical proportion. If Dr. Pegler had only mentioned to them at the outset that the case had terminated fatally, they would have been able to follow his minute description of what seemed rather small details with much greater interest. But he thought the points brought before them showed that the diagnosis he had made as to the site of the tumour was correct, and no doubt he wished to eliminate any possible idea of its being a tumour connected with the meninges, such as a menin-

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gocele. The case was a very interesting one, and there was always the possibility of such a coincidence occurring in any one's practice which had to be kept in mind when carrying out even minor operations during a period of epidemics. Many of them had been much distressed by rashes occurring which turned out to be scarlet fever, and the patients suffered considerably, and they themselves were subject to grave anxiety. He thought Dr. Pegler's description should be accepted as correct.

Dr. WINGRAVE said that the evidence of the histology rather showed that whatever central connection the swelling had, it consisted to a great extent of distension of some of the lymph or connective spaces of the periosteum. One could see very clearly the normal mucous membrane covered with what appeared to be the olfactory cells in a somewhat fragmentary state. Underneath that one found a very thick connective-tissue layer with elastic fibres conforming very thoroughly to the description of periosteum. In that deep periosteal layer one would find large distended spaces, so that it was quite possible that it might have been a cystic distension of the periosteal layers, and even possibly that it might have been a continuation of the dura mater. In the absence of a definite statement as to where it was removed from, and in the absence of any histological evidence of meningeal structure, it was a pure assumption to say that it was directly connected with the cranial cavity. Certainly the cyst was not lined with any kind of epithelium suggestive of subdural continuity, or that could be differentiated from the connective-tissue cells themselves.

Dr. HILL suggested that the specimen and sections be referred to the members of the Morbid Growths Committee, who should have power to add other clinicians to their number in order that the questions raised might be thoroughly investigated. The clinical history did suggest very forcibly to many present that this was a case of meningocele. If one removed a polypus from the nose of a patient who soon after died from meningitis, and if it were then found that the presumed polypus was a cyst, and came from the septum of the nose, a strong case was made out in favour of its being a meningocele. Of course, the remarks of both Drs. Pegler and Wingrave went to show that the tumour was not like a meningocele histologically, but then they all knew that congenital abnormalities often underwent alterations in structure. The case was almost unique, and the references in medical literature to the subject were very vague. Whether it turned out that one really had to deal with a genuine cystic tumour of the septum or a meningocele, an important case would have been elucidated and added to their records.

Dr. STCLAIR THOMSON suggested that the possibility of a congenital meningocele should not be dismissed without such a full investigation of the subject as Dr. Hill had proposed.

In investigating the literature of the subject in connection with cerebro-spinal rhinorrhœa, it was suggested by one authority—and it seemed to be a working hypothesis—that some of these cases of spontaneous cerebro-spinal rhinorrhœa might be congenital meningoceles which had spontaneously ruptured. He found amongst the literature that many cases had been put on record of patients who,

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sooner or later, became infected through the nose, and a great many of them died with meningeal symptoms.

The importance of the nature of this tumour being definitely settled was so great as to merit the investigation of the Morbid Growths Committee.

The PRESIDENT thought the Society was much indebted to Dr. Pegler for bringing forward this interesting case.

Dr. PEGLER said, in reply, that on receiving the report of subsequent events, his first impression, supposing any connection between the removal of the cyst and the meningitis existed at all, was that the growth had been a meningocele. He had since been led to relinquish that suspicion as a result of the microscopic investigation over which, in addition to Mr. Bland-Sutton, he had the assistance of Dr. Wyatt Wingrave.

The microscopic appearances certainly tallied with his recollection of the attachment of the pedicle. He was anxious that the sections should be referred to the Morbid Growths Committee, but he feared that, there having been no necropsy, a great deal in connection with the case would have to remain conjectural. Anyhow he had brought it forward as a matter of duty, as well as on account of its unique interest, for he had found but little in the literature of septal tumours that had thrown light upon this case. It was stated by unequivocal authorities that cystic growths of the septum and also meningoceles under certain conditions should be excised.

On a show of hands it was unanimously decided to accept Dr. Pegler's offer to refer the specimen and sections to the Morbid Growths Committee.

CASE OF EPIDERMOLYSIS BULLOSA IN A WOMAN, ASSOCIATED WITH MOUTH AND THROAT LESIONS.

Shown by Dr. WILLIAM HILL.

Dr. VINRACE asked Dr. Hill if he proposed to adopt any treatment, and whether he had acquainted himself with any line of treatment which had been acted on in the past in the many hospitals this patient had atttended.

Dr. HILL, in reply to Dr. Vinrace, said that no treatment did any good in these cases as regards the skin lesions.

CASE OF TUMOUR OF THE RIGHT VOCAL CORD FORMED DURING INFLUENZA, IN A MAN ÆT. 50 (FOR DIAGNOSIS).

Shown by Dr. DONELAN. The patient had attended the Italian Hospital two months ago, suffering from influenza. The

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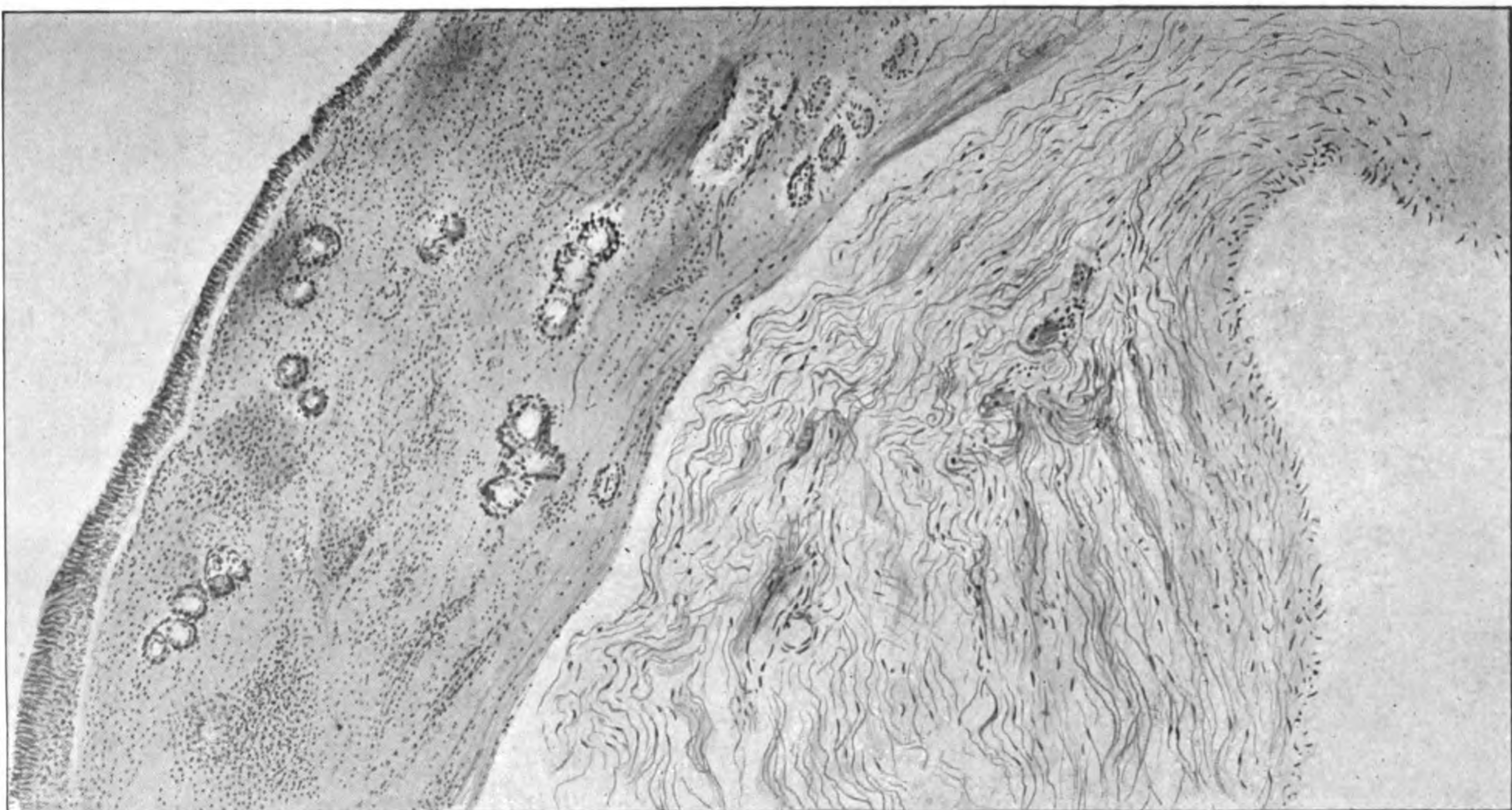

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Dr. Pegler's Case of Intra-nasal Cyst (pp. 103—114).

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paths of infection appeared to have been the pharynx and larynx, as there were well-marked symptoms of true *grippe*. The larynx was intensely congested; there was, however, no growth, and the patient had a clear voice up to the time of attack. Seen again two days ago, a growth about 4 mm. long by 2 mm. wide projected backwards and inwards from about the middle of the right vocal cord. Apart from the hindrance to approximation of the cords due to the growth there appeared to be also some paralysis of the arytænoid muscles.

Dr. StClair Thomson did not altogether follow the description of this case, but there seemed to be some ulceration on the left vocal cord and a good deal of inter-arytænoid thickening. The man had lost weight, the pulse was quick, and he had night sweats. He thought the subject of tuberculosis ought to be borne in mind in connection with this case, for it frequently developed rapidly after influenza.

Dr. Donelan, in reply, said he had seen the patient only at an interval of a month or five weeks, and as the growth had developed only during the last nine weeks he had not had much opportunity of studying the case. The patient had syphilis twenty years ago, which might alter the view taken as to the diagnosis.

Specimen of Fibroma removed from Left Maxillary Antrum of Male æt. 18.

Shown by Dr. FitzGerald Powell. This patient came under observation complaining of nasal obstruction. On examination his septum nasi was seen to be deflected to the left, preventing a good view of the nostril from in front, but on examination of the posterior orifice with a mirror a small growth was observed filling the upper half of the left choanæ; the appearance was that of a polypus or enlarged turbinate. An effort was made to snare it under cocaine, but only a small portion could be removed by the snare. The patient was put under a general anæsthetic, and an attempt made to remove the growth from behind with Howell's adenoid forceps, but in attempting to seize the growth it slipped out of reach, and on pushing the finger in after it a considerable soft mass was felt lying in the left maxillary antrum, through an opening in the posterior third of the inner wall.

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Keeping the finger on the growth, a long-handled, sharp spoon was pushed in through the nostril from in front, and using considerable force the growth was freely curetted from its attachment to the under surface of the floor of the orbit and scooped into the nostril, where it was seized by the adenoid forceps pushed up the nostril from in front and drawn out.

It was found to be a dense fibroma about the size of a small kidney. Hæmorrhage was very free during the operation, but stopped when the growth was removed, and the patient was at present doing very well, and had not had a bad symptom since the operation, which was done a week ago.

The PRESIDENT thought it was difficult to extract such a large tumour through the nose so as to be sure of its complete removal.

Dr. POWELL said that nobody was more surprised than he was when the tumour came through the nose entire. When he put his finger into the post-nasal space and felt the mass in the left maxillary antrum, he had no idea that it was of the size it turned out to be. It seemed to have grown from underneath the floor of the orbit. There could not have been a very wide attachment to it, and from the general contour of the tumour he thought that it had come away entirely, though, of course, he was not absolutely certain.

If one had known the size of the tumour it would have been advisable to open the antrum from the front and remove it, or else remove the jaw. But as it came out as it did he was very well satisfied with the result. The case was being kept under inspection to see if there was any recurrence.

CASE OF MALIGNANT GROWTH IN THE NOSE OF A MALE PATIENT ÆT. 61, PROBABLY OF THE NATURE OF ALVEOLAR EPITHELIOMA.

Shown by Dr. DUNDAS GRANT. John C—, æt. 61, presented himself at the Throat and Ear Hospital a week ago on account of complete obstruction of the right nostril and partial obstruction of the left. The right nostril was completely filled with a polypoid growth of a pinkish colour but irregular in shape, and rough over the greater extent of the surface. The irregularities were interspersed with small masses of shiny myxomatous growth. The soft part of the external nose was bulged out-

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wards, but there was no displacement of the nasal bones and no bulging of the superior maxilla. There exuded from the nostril a sanious discharge which irritated the margins, and the nose emitted a peculiar heavy smell suggestive of putrefying flesh, and distinct from the odour of ozæna or simple polypus or antral suppuration. Dr. Grant had observed this smell in connection with sarcoma, syphiloma, and epithelioma, and was disposed to think it of some diagnostic value. By posterior rhinoscopy there was seen to be a large mass blocking up the right choana and extending over the back of the left one; it was of the same nature as what was seen in the front, and after palpation showed marks of hæmorrhage. There was no distension of the antrum in any direction, and on transillumination it was found to be perfectly translucent. The trouble dated from the earlier part of last year. In May he spat up some blood which did not appear to come from the lungs; in June and July the back of the throat became somewhat obstructed, and in August a fleshy lump dropped down from the back of the nose into the pharynx, about the size of a small shelled walnut and of a dark colour. During the later months of the year numerous polypi were extracted, but apparently without effecting a complete clearance. In March of this year an endeavour was made to clear the nose through the nasal passages by a surgeon of the highest ability, who considered the growth to be malignant, and although a large quantity was removed, recurrence had taken place by the time he came under Dr. Grant's care.

The case now presented the characters of malignant disease growing from some portion of the nasal cavity, but in all probability not the antrum. There was no enlargement of glands.

A small portion of the growth had been removed and examined microscopically by Dr. Wingrave, who found it to consist of a stroma formed of densely packed fusiform cells and enclosing irregular alveoli which were filled with epithelial cells; the surface epithelium was stratified, the deepest portion consisting of columnar cells covered by nucleated spheroidal cells ; this epithelium invaded the stroma, filled the alveoli, and expanded irregularly to become cystic; the cells in the alveoli fell out during preparation. Dr. Wingrave considered that the epithelium had invaded both from the surface and from the glands;

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he considered it probably malignant, but the opinion of members was invited as to the nature of the specimen. It might be stated that there was no history of specific infection, and that the patient had of late been gaining flesh, although he had lost it to some degree during the later part of last year.

Dr. Grant suggested an external operation, making an incision round the side of the nose and through the upper lip, to which could be added one below the orbit if excision of the upper jaw, completely or in part, should seem necessary.

Mr. SPENCER thought this a very malignant case, and that it was the worst form of burrowing epithelioma or carcinoma of the antrum, and would require removal of the upper jaw. The glands were beginning to enlarge under the jaw which, if taken away at a second operation, might prolong the patient's life a little, but he was afraid the results in these cases were always bad, and hardly any cases with this particular form of growth were cured. Although the section shown was rather thick, yet the chief element was distinctly cylindrical epithelium arranged in alveolar masses, and not sarcoma.

Mr. ROBINSON thought it doubtful if it was a case of carcinoma at all. In the main it appeared to be sarcomatous with the normal glands embedded in this structure. It certainly was not the usual type of alveolar or glandular carcinoma, such as would arise from the lining membrane of the antrum. Transillumination, which had been done, might here assist, as the antrum appeared to be free. The growth seemed rather to spring from the nasal wall.

Dr. WINGRAVE said that one of the specimens was somewhat thick, yet clearly showed its epithelial nature, which, he thought, was strongly suggestive of "duct cancer."

Dr. LACK said the section was not a satisfactory one, and hoped the specimen would be referred to the Morbid Growths Committee.

Dr. DUNDAS GRANT expressed his willingness to have the growth submitted to the Morbid Growths Committee, but thought it would be undesirable to postpone the operation on that account.

CASE OF PARALYSIS OF LEFT VOCAL CORD IN A FEMALE ÆT. 27.

Shown by Dr. WYATT WINGRAVE. The patient had complained of hoarseness and shortness of breath for fourteen months, also slight deafness since childhood.

There was a history of two attacks of acute rheumatism.

The voice was weak, and there was dyspnœa and palpitation on the slightest exertion or excitement.

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She stated that the voice suddenly changed after a bad cold, and had remained more or less hoarse and weak.

Laryngoscopy showed complete fixation of the left cord in extreme abduction.

There was a double basic systolic murmur, with cardiac dulness extending to supra-sternal notch, associated with thrill and pulsation, although the pupils were equal and radial pulses were equal in volume and synchronous.

The evidence was strongly in favour of an aneurysm involving the left recurrent.

Dr. PERMEWAN said he was rather surprised to hear Dr. Wingrave in his description say that the cord was in extreme abduction. This would be a very unusual condition of things. To him the position of the cord was just the ordinary cadaveric position. He suggested it was a case of recurrent paralysis with a certain amount of swelling of the ventricular band concealing the cord.

Dr. WINGRAVE mentioned the fact that the left cord was extremely abducted when first seen, being completely hidden by the ventricular band. To-day one could see a little of it, but at the same time he felt that it was somewhat external to the cadaveric position.

A CASE OF BULBAR PARALYSIS IN A FEMALE ÆT. 23.

Shown by Dr. WYATT WINGRAVE. The patient sought relief for "a lump in the throat and difficult breathing" of fourteen years' duration, but much worse lately.

The voice was weak and articulation imperfect; she spoke indistinctly, as if her mouth were full. She suffered frequently with dyspnœa on the slightest exertion, but worse during sleep. Deglutition was normal. The pupils are equal and react to light and accommodation. The tongue was deeply fissured, red, and slightly tremulous, and its action feeble. There is well-marked facial palsy; knee-jerks are exaggerated.

The larynx showed both cords fixed in a position somewhat mesial to the cadaveric, leaving but a very narrow aperture. Tension was fair, but other movements wanting, with the exception of slight abduction in the right cord. There was a prominent sarcous-looking projection in the posterior commissure, and some slight periarytænoid swelling.

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The mother's story was that she had enjoyed fair health, but that fourteen years ago a piece of slate pencil was removed from the right ear under chloroform, which was followed by face paralysis (right side).

She had five healthy brothers and sisters, and neither syphilitic nor tuberculous history could be obtained.

Mr. Tod said that the growth between the cords suggested fixation of the cords rather than paralysis.

The case had been under Mr. Hovell at the London Hospital, and there were some notes to the effect that there had been some disease of the crico-arytænoid joint. This referred to some years back.

Mr. Parker said he had seen this case at the Throat Hospital, Golden Square, some three months back. He then formed the opinion that the facial paralysis was probably traumatic, due to injury by a slate pencil in the ear; at any rate the paralysis was first noticed immediately after its removal under chloroform, when the patient was between seven and eight years old. Shortly after this the voice began to change, which led the mother to seek the advice of the late Sir Morell Mackenzie, since which time the patient had been taken to various laryngologists and various hospitals.

Dr. Lack said that one point of interest about the case was that the patient slept perfectly quietly, although she had dyspnœa when walking about. He did not think she required tracheotomy.

He had seen a case of paralysis and wasting of the arm immediately following the administration of chloroform for a simple operation, and wondered if the history in the case afforded any support to a similar origin.

Dr. Wingrave said that the history of the patient was somewhat involved and unreliable.

She undoubtedly had facial palsy and weakness and tremor of the tongue, but the palate moved perfectly well.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

SEVENTY-FOURTH ORDINARY MEETING, *May 2nd*, 1902.

E. CRESSWELL BABER, M.B., President, in the Chair.

CHARLES A. PARKER, F.R.C.S.(Ed.), } Secretaries.
JAMES DONELAN, M.B., }

Present—35 members and 5 visitors.

The minutes of the preceding meeting were read and confirmed.

The following gentleman was unanimously elected as an Ordinary Member of the Society:

Robert Henry Woods, B.A., M.B., B.Ch.Dublin, F.R.C.S.I., 39, Merrion Square East, Dublin.

The following report of the Morbid Growths Committee was read:

On Dr. DUNDAS GRANT's case of malignant growth in the nose (*vide* 'Proceedings' for April, 1902, p. 108).

The report on this case was postponed for the purpose of examining further sections of the growth.

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On Dr. H. Pegler's case of cystic growth of the septum (*vide* 'Proceedings' for April, 1902, p. 103).

After examination of the specimen and sections submitted, the Committee report as follows:

1. The cyst was evidently of old standing, there being displacement and atrophy of the septum nasi and middle turbinate.
2. The wall of the cyst is composed of the fibrous layer of the periosteum covered with mucous membrane normal to the parts.
3. There is insufficient evidence on which to speak definitely as to the nature of the lining membrane of the cyst. If it was endothelial, no cells now remain.
4. There is no evidence of any embryonic tissue, *e. g.* nævoid.
5. Meningoceles have generally been seen in the middle line, and usually connected with other congenital deformities.
6. The Committee suggest the possibility of a cyst arising in a dilated lymph space of the nasal periosteum, which, perhaps, had a communication with the subarachnoid lymph space.

The following cases, specimens, and sections were shown:

Sections of a Large Recurrent Papilloma, which seemed to grow from the Left Maxillary Antrum.

Shown by Dr. Bronner. The patient, a woman æt. 40, was seen November 14th, 1901. She had had left nasal obstruction for over one year, and for five or six weeks had noticed a purulent and offensive discharge from the left nostril. A large grey mass completely blocked the nostril. This was removed by the snare. There was slight hæmorrhage. A fortnight later there was recurrence. The nostril was scraped, and a large smooth cavity could be felt with the finger, corresponding in position to the antrum, but much larger in size. There had been slight recurrence of the growth, which was removed by the snare. There was now very little discharge, and it was no longer offensive, and there had never been much pain or

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external swelling or hæmorrhage. The symptoms at first seemed to point to epithelioma, but microscopical examination showed the growth to be papilloma. The fact that there had never been much hæmorrhage or pain or external swelling, and that the growth had practically disappeared, also seemed to point to papilloma, from a clinical point of view.

Specimen of Sarcoma of Right Tonsil.

Shown by Dr. Walker Downie. The patient, a woman æt. 58, when first seen on August 17th, 1899, complained of a swelling of the right tonsil, which had been slowly increasing in size since the beginning of that year. It had come on without any apparent cause, and at first gave her only slight discomfort. This discomfort, however, persisted, so she consulted a doctor in March, 1899, who informed her that the tonsil was inflamed and ulcerated. The tonsil was at this time evidently enlarged, and she had some difficulty in swallowing, but there was no marked pain. During the next three months the affected tonsil slowly increased in size, and the patient lost flesh and strength.

In June she consulted another doctor, who proposed to excise the affected tonsil, but on her return two weeks later to have this done the tonsil was found to have increased so much in size in that interval that he had deferred operation, and on August 17th sent the case to Dr. Walker Downie. At this time there was no doubt as to the nature of this new growth. Her temperature was normal. She appeared to be in moderately good health, though complaining of weakness and exhaustion on slight exertion. Her speech was somewhat thick, and she complained of pains shooting up the right side of the throat to the right ear. She could swallow with comparative ease. On examination through the mouth, a tumour occupying the position of the right tonsil was seen, somewhat resembling an hypertrophied tonsil. It was barely the size of an average walnut; it had the form of an enlarged tonsil, and was of a deep red colour, with several greyish patches of superficial erosion distributed over its surface. It was firm to the touch, non-fluctuant, and palpation caused no pain. The faucial pillars

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were not adherent to the tumour, which was, as a consequence, freely moveable, and the lymphatics in the neighbourhood were unaffected.

She was admitted to the infirmary with the least possible delay, and on August 23rd the tumour was removed under chloroform. This was effected through the widely opened mouth, and the growth was enucleated by the finger-nail and scissors. Firm pressure over the raw surface checked what bleeding there was. Ice was given frequently for the first few hours after operation, and thereafter small doses of dilute hydrochloric acid were administered several times daily until the parts were healed.

Swelling and ecchymosis of the faucial pillars on the right side followed the operation, but this rapidly subsided, and the patient was dismissed on September 2nd with the parts completely healed.

On microscopic examination the tumour was seen to be a spindle-celled sarcoma. The entire tonsil had been replaced by tumour growth. Towards the surface of the tonsil, however, there was a layer of well-formed connective tissue, covered by the epithelial investment of the tonsil. This latter (not complete in the sections) presented no evidence of invasion by the growth. The tumour, however, in other parts had reached the surface. A spindle-celled sarcoma might, as was known, remain encapsuled for a considerable period, and the glands remain unaffected, and if recognised and enucleated whilst still encapsuled, there was every hope that the operation would effect a cure. Such being the conditions in the present case, this result was hoped for. The patient was not seen again till October, 1901, two years and two months after operation.

On examining the mouth, a small smooth rounded projection about the size of the tip of the little finger was seen springing from the soft palate at a level of the upper border of the right anterior pillar, and close to it. On palpation this projection and the surrounding parts of the palate and fauces were found to be the seat of an infiltration—hard, nodular, and firmly fixed.

Externally there was a fulness just behind the angle of the right lower jaw. On palpation this was found to be hard and

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fixed, and to nearly fill the space between the angle of the lower jaw and the tip of the mastoid process.

The woman's health was still fairly good; she was stout and florid, and the local manifestations had increased but slowly, the only additional complaint being that of pain and throbbing in the right ear, aggravated by lying down.

Specimen of a Fibrous Growth removed from the Naso-pharynx of a Boy æt. 14.

Shown by Dr. Walker Downie. The patient, who was first seen on February 21st, 1901, had complete obstruction of the right naris for many months, and latterly the left naris had been similarly affected.

This obstructive difficulty was accompanied by frequent tickling cough, shortness of breath on slight exertion, and disturbed sleep, with loud snoring and suffocative attacks. There were several mucous polypi in the right naris. The naso-pharynx was very completely occupied by a large bluish-grey growth, the lower portion of which, rounded and smooth on the surface, projected below the level of the free border of the soft palate for fully half an inch during respiration, and during deep inspiration a much larger portion of the growth was exposed to view. The movements of the tumour were restricted by the completeness with which it filled the naso-pharynx. This growth was removed by means of a cold wire snare introduced through the mouth. Its removal, though carried out slowly, and by torsion rather than by cutting, was followed by a very profuse hæmorrhage. This was checked by pressure exerted by long strips of lint, packed firmly into the naso-pharynx through the mouth and through both nares.

On microscopic examination the tumour was found to be a richly vascular and very œdematous fibroma, consisting of a dense reticulum of curling fibres, and comparatively few cellular elements.

The operation was followed by continued improvement in the boy's health, and, so far, there had been no recurrence.

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Specimen of a Fibrous Growth removed from the Naso-pharynx of a Boy æt. 11.

Shown by Dr. Walker Downie. The patient had had difficulty in breathing through the nose for years, and for at least eighteen months he had snored loudly while asleep; he complained of dry mouth, of occasional frontal headache, and some deafness.

The naso-pharynx, on examination, was found to be completely occupied by a large fleshy growth which bled readily on manipulation.

By digital examination, under chloroform, the growth was found to spring from the vault of the pharynx. Its extirpation was attempted by means of a chain écraseur passed through the nose, but this instrument broke while crushing through the firm fibrous pedicle. It was latterly removed by torsion, while firmly grasped by a curved wire rope écraseur. This was on November 12th, 1892. Twelve months later the left superior maxilla began to swell, and the left naris became obstructed. The left upper jaw, which was then found to be the seat of a sarcoma, was excised, and the result had been subsequent immunity.

Microscopic examination showed this tumour to be a dense fibroma, in which, however, the cellular elements were comparatively numerous.

The tumour was the seat both of hæmorrhage centrally and inflammatory changes along its external aspect.

Specimen of Sarcoma of the Fauces.

Shown by Dr. Walker Downie. The specimen consisted of the soft palate, fauces, pharynx, larynx, and gullet. The patient, a man æt. 33, had been first seen on February 26th, 1901. He then complained of sore throat, pain on deglutition, and huskiness of some three months' duration. On examination the fauces were seen to be in a state of deep congestion, and the left faucial pillars and the greater part of the buccal pharynx

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ulcerated. The ulceration, though extensive, was superficial, and was considered to be a late secondary manifestation of syphilis. He was anæmic, emaciated, and feeble, conditions which favour the rapid extension of syphilitic lesions.

Chromic acid solution was applied to the raw surfaces, and mercury with iodide of potassium was prescribed. He improved very greatly up till the end of June, when, without any apparent cause, his cervical glands became enlarged, and he again experienced difficulty in swallowing.

On August 17th, 1901, he was admitted to hospital, and the local lesion was found to have extended very considerably, both in area and in depth. Not only were the left faucial pillars and the buccal pharynx ulcerated, as when first seen, but the whole naso-pharyngeal cavity was raw, and the ulceration had extended down to the opening of the gullet. At the lowest part of the pharynx the mucosa was undermined, and a pocket with gaping mouth was found on the left side, into which food entered, and, to further complicate matters, the posterior wall of the larynx—the arytænoids, and interarytænoid membrane—was greatly swollen. He was, as a consequence, quite unable to swallow any food (in attempting to swallow food it returned through his nose), and a bougie could not be passed into the gullet. It was therefore necessary to resort to rectal feeding, which was maintained till death. The odour of the discharge secreted by and covering the raw surfaces was not only foul, but loathsome.

On admission to hospital his palate had been swollen and inflamed. A few days thereafter liquefaction occurred in the centre of a reddened swollen area to the right of the middle line in the soft palate. The small perforation which resulted steadily increased in size, and at death readily admitted the little finger.

On September 20th he was pale, cachectic, and exhausted, as much from septic absorption as from insufficient food. His pulse was rapid and feeble. In the afternoon he had two attacks of syncope, and early on the following morning he died.

On admission to hospital the cervical glands on the right side formed a swelling considerably larger than a duck's egg, and this swelling slowly increased in size till four days prior to

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death, when it very rapidly shrank, and at death was scarcely perceptible.

The man was married. His wife had had no miscarriages, and he was the father of a healthy child of seven months. Up till about twelve months ago he had enjoyed good health, with the exception of frequent attacks of sore throat, which, from his description, appear to have been of the nature of simple acute tonsillitis. He was an iron-turner, of temperate habits, and he denied having contracted any form of venereal disease.

The foregoing lesions were considered to be due to late secondary syphilis. During the earlier course of the illness the ulcers had tended to heal under treatment, and in the later stages the swelling of the palate, which ended in perforation, followed the usual course of a syphilitic infiltration of the palate.

The results of the post-mortem examination were wholly unexpected. The extensive ulceration of the palate, fauces, and pharynx, accompanied by swelling which resembled inflammatory œdema, might well have passed for a syphilitic lesion. But on proceeding further new growths were found in the lungs, the liver, and the kidneys, in all of which the essential features presented were those of round-celled sarcoma.

Case of Laryngeal Stenosis in a Man Æt. 50, resulting from a Large Syphilitic Ulcer of Left Side of Larynx.

Shown by Dr. Donelan. Patient was shown at November and January meetings on a question of diagnosis, as there was some suspicion of malignant disease. No decided opinion was given, but the exhibitor was advised to continue the mixed anti-syphilitic treatment under which improvement had taken place. The ulcer was almost healed, but the patient was shown now on account of the stenosis which appeared to be increasing, and in evidence of the fact that even extensive syphilitic disease of the larynx might be successfully treated without any local measures.

Dr. StClair Thomson suggested punching out pieces of the syphilitic infiltration. He had under his care a 'bus driver for four

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years whom at times he had threatened with tracheotomy, but on punching out the infiltration of the interarytænoid space and persevering with antisyphilitic treatment, and trying to persuade the patient to drink and smoke less, the man was able to return to his work for a few months.

Case of Syphilitic Contraction of Posterior Pillars of the Fauces in a Man æt. 44.

Shown by Dr. Donelan. This might appear a misdescription without the history. The patient was admitted to the Italian Hospital last September, suffering from pneumonia and a large tertiary ulcer, involving the naso-pharynx, posterior aspect of vomer, and back wall of pharynx. He was in an extremely debilitated state, but, notwithstanding, was given a course of twenty-five inunctions of ʒj of blue ointment, with iodide of sodium internally. The naso-pharynx was regularly sprayed in the first few weeks with perchloride of mercury (1 : 5000), and the patient steadily improved. During his subsequent mixed treatment as an out-patient contraction of the cicatrix gradually took place, and the posterior pillars were gradually drawn together until they are as might be seen now.

Complete Occlusion of Right Nasal Vestibule in a Man æt. 32.

Shown by Dr. Herbert Tilley. The condition followed the insertion of a strong styptic which was applied to check severe bleeding during an attack of pneumonia. The cartilaginous portion of the septum deviated very markedly to the right, and it was thought probable that the occlusion was the result of cicatrisation of the two closely apposed surfaces, the ulceration of which had been induced by the styptic. The exhibitor, at the express desire of the patient, purposed to remove the scar tissue, and at the same time to perform Asch's operation on the septum.

The President said that there was so much deflection of the septum that a cicatrix might easily form across from one side to

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the other. There appeared to be no evidence that the case was congenital in character.

Dr. Watson Williams thought it was an interesting point that this condition should have followed immediately upon an attack of acute pneumonia. The question of pneumococcal ulceration was so new, and so few cases were known of or described, that it was impossible for him to do more than throw out a suggestion that some of these cases of ulceration might be due to pneumococcal infection.

Advanced Destruction of Intra-nasal Structures associated with Suppuration of the Right Maxillary Sinus.

Shown by Dr. Herbert Tilley. The patient, a man æt. 42, had had syphilis six years ago, and the intra-nasal structures had been extensively destroyed. A portion of the vomer alone remained of the septum, and the right middle turbinal was absent. The mucous surface was covered with a thin veneer of dry blood-stained muco-pus. In several features the case resembled that shown by Dr. Bennett at a recent meeting, but in that instance no history of syphilis was present, neither was there any pus in the antra.

The exhibitor wished for the opinion of the Society as to whether such a condition might not arise independently of syphilis, and as a result septic infection of the nasal mucosa.

The President suggested that this might be a case of syphilis; it looked very much like it.

Dr. Pegler said that Dr. Bennett, who was unable to stay to the discussion, requested him to say that he did not see any parallelism between his case and Dr. Tilley's. In the present one there was not nearly so much perichondrial thickening, nor was there any pain, and in every essential point he thought the two cases quite different.

Case of Great Symmetrical Thickening of the Upper and Anterior Part of the Nasal Septum.

Shown by Dr. Lambert Lack. The patient, a man æt. 33, had been under treatment for the past twelve years for nasal obstruction. This apparently depended upon a very marked thickening in the neighbourhood of the tubercle of the septum. This

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thickening was so great that the case had been diagnosed as a cyst of the septum. It had been cut away and cauterised many times, but had always recurred after a few months or a year. Dr. Lack first saw him about a month ago, and with snare and cutting forceps removed the growth from one side, which is now clear, but the curious growth can still be seen on the other. If this swelling was simply an exaggeration of the boggy thickening of the septum often seen in this region, it was by far the most marked example he had ever met.

Mr. Waggett asked if pus, as at the present time, was always to be found in the nose, and whether there was any possibility of this being a case of perichondritis and suppurative disease of the septum itself.

The President asked whether there was any suppurative disease in the left maxillary sinus. He had noticed pus in the left nasal cavity.

Dr. Hill thought that there was some suppuration present, but he imagined that that was not the point which Dr. Lack intended to emphasise in connection with the case; it was rather the recurrence of the large thickening of the septum after it had been freely cut off in large portions with, presumably, a knife. He had had the same difficulties and disappointments himself, and he had almost come to the conclusion that there was a tendency in all soft thickenings of the septum to recurrence after removal, and sometimes even in hard structures also.

Dr. Pegler had had an almost exactly similar case under his care. He operated two or three times upon the swollen septum and then the patient ceased attending, probably only slightly benefited. He thought these cases were probably syphilitic in origin.

Sir Felix Semon suggested that on some future occasion this very important question which had just been raised by Dr. Hill should be made a subject of general discussion. He was glad to hear he was not the only unfortunate person with regard to these cases. It had so often struck him after operations on the septum that the difficulty one had in subduing the subsequent swelling was very great, and literature afforded hardly any assistance as to the after-treatment of these cases.

Dr. Lack regretted that the appearance of this case had completely changed since he last saw it. There was then no pus. The discharge the patient said had commenced during the last week. Dr. Lack was surprised to hear there was often difficulty in preventing recurrence after operations for thickened septum. He had small experience in cases of this kind, but in bony thickenings of the septum he had found no recurrence after operation.

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Case of Inherited Syphilis of Nose, Pharynx, and Larynx, with Complete Occlusion of Anterior Nares.

Shown by Dr. Lambert Lack. The patient was a boy who had come under observation three weeks ago with complete occlusion of the left nostril and a red granulating ulcer of the right nostril, with nearly complete atresia of this side also. The soft palate was infiltrated with small nodular patches, and in places there was slight ulceration and scar tissue. The upper part of the larynx was similarly affected, the epiglottis being partially destroyed, and the stump greatly thickened and distorted. Under treatment with potassium iodide internally, and mercury ointment locally, the ulceration of the right nostril had healed, and there was now complete atresia of both anterior nares, with remarkably little sign of loss of tissue or of scarring.

Sir Felix Semon doubted from the appearance of the larynx whether this case was due to syphilis alone, though that disease might in part be the cause. He would think lupus a more probable explanation of the condition, and had no hesitation in saying that the appearance of the epiglottis was almost typical of lupus. Of course, the nose made the diagnosis doubtful, as did the result of the treatment. He thought some tissue ought to be removed and examined for tubercle bacilli. He drew attention to the fact that whilst there was complete occlusion of the nose, there was no deafness.

Dr. Lack would remove a piece for the microscope. He admitted that the condition of the palate and larynx strongly resembled lupus, but considered the favourable result of treatment pointed strongly to syphilis.

Case of Large Laryngeal Growth in a Woman.

Shown by Dr. T. W. Bond. Patient, a married woman, had had some huskiness of voice for thirteen months. She had had no cough, no difficulty or pain in swallowing, no night sweats, and her temperature was normal. There was no history of syphilis. She had had one severe attack of stridor. There were no enlarged glands.

On right side of larynx there was a large red mass, firm to

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palpation, extending from below cord to level of tip of epiglottis. The right arytænoid and the ary-epiglottic fold were merged in the mass. The case was shown for the purposes of diagnosis.

Dr. DUNDAS GRANT took the growth to be a sarcoma, and wished to know whether Dr. Bond had also come to this conclusion.

Dr. LACK said some members might remember a somewhat similar case he had shown to the Society in February (see vol. ix, p. 60). This patient had marked œdematous infiltration of one side of the larynx, and especially of the arytænoid, and had been under observation for three months, and taking iodide of potassium without any improvement, and without developing any sign of phthisis. Quite lately, however, tubercle bacilli had appeared in the sputum, and Dr. Lack considered that the large majority of doubtful cases of this kind proved, ultimately, to be tuberculous. He thought this should be the diagnosis of Dr. Bond's case.

Mr. R. LAKE thought there was a difference between this case and the one Dr. Lack had shown them in February last, for the latter was a large smooth growth and not nodular, whereas in this patient the growth was very nodular. He thought the growth here looked as if it had been palpated, and he would like to know whether the redness was due to injury by a finger.

Dr. STCLAIR THOMSON said that this case reminded him of a case he had shown to the Society of a growth in a similar situation in a man about fifteen months ago. The patient was somewhat older than Dr. Bond's patient, being forty-five. It was, when shown, taken by the Society to be a malignant growth, the patient at the time being without any symptoms of tuberculosis. Some two or three weeks after showing him his health broke down, and tubercle bacilli were found. Tracheotomy had to be performed, and the man died of tuberculosis. He thought he had previously mentioned that Dr. Horne had possession of the larynx, which was distinctly tubercular.

Sir FELIX SEMON said that in such cases he thought it was much better not to speak at once of a "tumour" or a "growth," but rather of an "infiltration" or a "swelling," in order not to prejudice one's own diagnosis. Personally, he preferred to call the "growth" in the larynx of this patient an "infiltration." For there was a general infiltration, a little nodular, as Mr. Lake had said, of the right half of the larynx. As soon as one spoke of a "tumour," or a "growth," one's thoughts were immediately directed to the formation of a *new* growth, and left out the other alternative which had been mentioned by Dr. Lack, with whom he agreed in thinking that this would turn out to be tubercular.

Dr. BOND said that, in his opinion, in the *present* condition of the case, he did not think anyone had a right to diagnose it, although one might be permitted to suspect tuberculosis of the larynx. But there were several points against the tubercular supposition; so far as he could learn from the husband, there was no loss of weight, no night sweats, and no cough. When he himself took the temperature for the first time it was normal. To-day, at the end of the examinations,

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it was 100°, but as she was at present suckling an infant of four months this rise could easily be explained.

It was a firm feeling growth, but he had not palpated it that day. He did not know whether anyone had done so. He saw the woman six days ago, when there was a red patch on the surface of the tumour. It was open to all to say that it might be a sarcoma, for there was some justification for this opinion. But there were no glands enlarged, and there was a history dating back thirteen months. In such a case one might on operating find the glands enlarged, although they could not be made out as enlarged from a surface examination. He intended to watch the patient, and would be glad to give a further report later on. Probably he would examine a small piece of the growth microscopically.

Glosso-labio-laryngeal Paralysis, with Complete Paralysis of one Vocal Cord and Abductor Paralysis of the other.

Shown by Dr. StClair Thomson. The case was specially interesting, as the progress of the laryngeal paralysis had been watched from an early stage. The patient had complained of thickness of speech for some twelve months. In November last there was only paresis of the abductor muscles. A month ago Dr. Thomson had tried to bring the case before the Society as one of complete double abductor paralysis. Since then the affection had made further progress, for it would be noted that the left cord was completely fixed in the cadaveric position, while the right cord failed entirely in abduction, and on phonation crossed the middle line in its attempt to close with the lifeless left cord. In other words, the only action to be found in the cords was that of adduction in one—the right.

The patient's speech was so thick and indistinct that the poor fellow had been taken up by the police for drunkenness when he was quite sober, and he had great difficulty in earning a living.

Phonation was unimpaired. The vowel sounds were successfully produced, but there was distinct failure of some of the consonants, both labials and dentals. There was conspicuous speech defect owing to failure of co-ordination, yet it was difficult to detect any appreciable paresis of the muscles of the lips; the tongue could be protruded with apparent facility and without tremor, and the soft palate showed no failure in its reflex movements. He could

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inflate his cheeks, but could not whistle. There was no dysphagia, but occasional spasm and coughing on drinking. The reflexes and pupils were normal.

The PRESIDENT said an important question in this case was whether or not tracheotomy should be performed, and it would be valuable to have the opinion of members on that point. There was scarcely any interval between the cords. He inquired as to whether there was much anæsthesia of the larynx.

Dr. WATSON WILLIAMS suggested that as the paralysis had developed so rapidly, the probability was that before very long, there being already complete paralysis on one side, there would be complete paralysis on the other side also. The danger of asphyxia would then be greatly lessened. Any operation might only still further complicate the case, and add a new danger.

Dr. STCLAIR THOMSON asked whether tracheotomy was in any way contra-indicated from the existence of anæsthesia of the larynx, which was often present in these cases. Should he be hastening on a fatal termination by doing tracheotomy by reason of the food going down the trachea, which it already showed some signs of doing? The patient was in a rather pitiable state. He was at present able to earn his own living and talk a little, and when it was explained to him that even if operative measures were taken he would be able to talk no better than before, and would probably not be able to continue earning his living, he did not naturally seem inclined to undergo any operation. If anyone had any experience of a case of this sort in which tracheotomy had been performed, he would be very glad to hear of the results.

In reply to the President, Dr. THOMSON said the anæsthesia, though present, was not very marked.

CASE OF EXCRESCENCES OR INCRUSTATIONS OR CHALKY DEPOSITS LOW DOWN IN THE TRACHEA.

Shown by Dr. EDWARD LAW. The patient, a lady æt. 36, came under observation three days ago. She brought a letter from her doctor in South Africa, stating "she has suffered from ozæna, and has, to a great extent, recovered under various methods of treatment. She knows her ailment, and is anxious to get quite well if possible; she has recently lost her sense of smell."

She had first noticed nose trouble as a child with an occasional disagreeable odour from the nostrils. She had employed various nasal solutions with a syringe or douche, but gave those methods

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up some years ago on account of the discomfort which they caused at the back of the nose and throat. For some years she had sniffed the nasal solution through the nose. Formerly the voice was very husky and hoarse, but not recently. She now complained of a constant short, hacking cough, loss of smell, indifferent taste, and a slight discharge from the nostrils. There was no history of a foreign body, no dyspnœa nor expectoration, and the general health was satisfactory. An uncle died of cancer of the throat. On examination no atrophic changes were found in the nose, pharynx, or larynx, and nothing abnormal beyond some little catarrhal trouble and a small crust in the neighbourhood of Luschka's tonsil, thus verifying her doctor's statement that she had to a great extent recovered from the ozænic trouble. Low down in the trachea a number of papillomatous excrescences, or crust-like or cretaceous deposits, were seen, a large one with ragged edges on the right side, and a number of smaller ones dotted in an annular or crescentic arrangement around the trachea. There was little or no irritation of the tracheal mucous membrane, but pressure over the windpipe, just above and behind the upper border of the sternum, caused slight pain and discomfort.

The diagnosis was, in Dr. Law's opinion, very uncertain. He had thought of papillomatous excrescences, ozænic incrustations, herpetic crusts, keratosis, ulcer, enchondromata, and chalky deposits.

Dr. Law and the members had to thank Mr. Waggett for his very interesting drawing of the case. Suggestions were solicited in reference to the ætiology, diagnosis, prognosis, and treatment.

Dr. Wm. Hill said that to see this case well a better light was necessary than that afforded, and he suggested that as the paucity of light was so frequent a source of complaint, some steps should be taken with a view to remedying this very serious defect.

Mr. Waggett had had an opportunity of looking at this case for an hour under a very strong light when making the drawing, and he said that with regard to the presence or absence of crusts, a point upon which considerable doubt existed, he was persuaded that there were no crusts, and for the reason that the upper part of the trachea was perfectly healthy in appearance, and in the texture of its mucous lining. On the other hand, those little excrescences had very definite forms; there was the larger mass of a trilobed shape, and there were

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about fourteen other little masses which were arranged in an annular manner corresponding to the rings of the trachea; and although the drawing which they had seen might not be absolutely correct, it erred in the omission rather than in the fictitious introduction of masses which were not to be seen with a good light—a strong electric light and a four-inch condenser. He ventured to make a diagnosis that these excrescences were of a papillomatous nature, although he knew opinions on that point differed very widely. There was no true atrophy of the intra-nasal structures. He thought it might be of some interest to add that these little masses did not move during respiration, and that their appearance was absolutely identical now with what it had been twenty-four hours previously.

The PRESIDENT asked Dr. Law whether there was any history of a foreign body having been in the trachea at any time.

Dr. LACK suggested that the growths in the trachea might really be crusts, a view also expressed by other members. The fact that the appearances had not changed in twenty-four hours, in his opinion, in no way militated against this view. They might remain stationary for a week. He suggested that Dr. Law might clear up the diagnosis as to this important point by syringing or spraying the trachea.

Sir FELIX SEMON added his own opinion to the same effect. What induced him to take this view was the co-existence of crusts in the naso-pharynx and (what could not be seen well with the light at their disposal in the adjoining room, but could very well with an oxygen light) the greenish colour of the little protrusions in the trachea, which was quite different from anything with which he was acquainted, either of tracheal excrescences or of a papillomatous nature. As to remaining stationary for twenty-four hours or a week, he would like to mention a little experience of his own. When *in statu pupillari* he observed on a certain occasion an extraordinary (as he thought) excrescence on the right vocal cord of a patient in the Throat Hospital which he could not account for, and so after having it under observation for about a week, he took the patient to Sir Morell Mackenzie, and asked his opinion about this extraordinary growth. Sir Morell Mackenzie, after examining it for a moment, took a dry laryngeal brush, introduced it into the patient's larynx, and having withdrawn it, invited him (the speaker) to look again. He looked, and there was no growth to be seen.

Dr. LAW, in reply to the President, said there was no mention of the presence of a foreign body at any time in the trachea. He would like to suggest that the Council should make some arrangement by which members might be provided with a better light at their meetings for the examination of tracheal cases, for every member who had looked at his case had told him it was almost impossible to do so properly because of the wretched light. With reference to the diagnosis, he was sorry it was still a matter of doubt, as the patient came from South Africa, and was leaving London the following day. He would try and persuade her to return to town for the next meeting. Having carefully examined the condition, he was somewhat opposed to the diagnosis of ozænic crusts. At first the impression made upon him—and he did not at first see the excrescence or deposit

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with ragged edges on the right side, but only the somewhat annular arrangement of a number of the projections which were whitish in colour—was that they were a sort of chalky deposits. Afterwards he thought of papillomatous excrescences, of keratosis, of a possible herpetic condition, of ozænic crusts, of an ulcer. But he considered the diagnosis very doubtful. Dr. Thomson had suggested there might be a breach of surface due to an ulcer; he would point out there was some tenderness over the affected part of the trachea.

Case of Removal of Epiglottis for Tuberculous Disease.

Shown by Mr. R. Lake. The patient, a man æt. 30, was sent to him by Dr. Bennett, of Leicester, with the following history:—He was working in a laboratory when the next man, in performing some experiment, produced a very thick cloud of nitrous vapour which irritated the patient's throat. A few days later, as he was suffering with dysphagia, he consulted Dr. Bennett, who diagnosed laryngeal tuberculosis, and found slight crepitations in one apex. He came as an in-patient to Mount Vernon Hospital two weeks later, and after being treated for a week and getting worse, his epiglottis was removed with the galvano-cautery snare. The stump is quite healed and healthy, but the arytænoid regions are still slightly swollen. His lungs now are apparently healthy.

Tuberculous Perichondritis; Case shown at the Society's Meeting, February 7th, 1902.

Shown by Mr. R. Lake. In this case the larynx had been exposed by a large flap incision on March 8th, and on incising the perichondrium a yellowish-white semi-transparent mass was found separating the perichondrium from the cartilage; it was roughly $\frac{3}{16}$ of an inch in thickness. This was carefully removed, and a small spot of disease was found in the mid-line of the cartilage, which was cleared out. Mr. Lake said, had it not been for the advice of his colleague, Mr. F. Spicer, he would have excised the larynx, but he was glad he did not, the man being now in good health and working at his trade, that of a baker. The mass removed was an organised product of inflammation, and was full of giant-cells, with bacilli in most of them.

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Case of Geographical Tongue.

Shown by Dr. Pegler. This patient was a boy æt. 4, and he had been subject to "wandering patches" on the tongue since birth. They were more or less circular, and varied in size from a quarter of an inch to an inch in diameter. At present they were fewer and less marked than usual; they often disappear altogether for a few days, and then a fresh set succeeded them. The centre of each patch was red and raw-looking, the edges raised, reddish yellow towards the centre, and white at the periphery. The boy was brought to the hospital for nasal obstruction, which turned out to be due to membranous rhinitis. A quantity of the membrane was removed from the septum in the left fossa under an anæsthetic, with considerable benefit, but traces were still visible.

Case of Syphilitic Necrosis of Intra-nasal Structures, exposing to View the Opening of the Sphenoidal Sinus on each side, and of the Posterior Ethmoidal on the left.

Shown by Mr. Hunter Tod. The patient was an old woman, who came to the London Hospital Out-patients, complaining of headaches and dimness of sight. The nose was filled with crusts, removal of which showed present condition. The eyes were reported by the ophthalmic surgeon to be normal.

Dr. StClair Thomson said that no doubt the openings led into the sphenoidal sinus, but he thought it was quite open to question whether they were the natural ostia sphenoidalia. They appeared to him to be on too low a plane altogether, for the natural openings were more commonly higher up, and it was rare for them to be close against the septum. The natural opening in this case was occluded by granulation and cicatrisation tissue higher up, and the opening now seen was due to the front wall having partly necrosed away.

Dr. Hill said that he had measured the distance of these ostia from the vestibule in this case, which was not more than 2½ inches, and he thought that was one inch anterior to the real sphenoidal openings and lower down. He had seen a similar case in which he had made the mistake of thinking he was dealing with the sphenoidal sinuses when he was not. On measuring he found openings too far forward, and he attributed the abnormality to the formation of

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adhesions, but why they should form in this region and simulate the sphenoidal ostia was most curious and inexplicable.

Dr. WATSON WILLIAMS took the same view of this case as Dr. Hill, and did not think that these were openings into the sphenoidal sinuses. Without measuring it was, of course, difficult to judge distances, but it certainly seemed to him that they were too far forward, and he thought that there was no doubt that the syphilitic changes, which evidently had been very pronounced indeed, occurring in the posterior portion of the nasal passages, would be quite enough to distort the posterior ethmoidal cells and to produce the conditions in this case. Under the existing circumstances it would be very difficult indeed without actual measurement to make up one's mind whether they were ethmoidal cells or sphenoidal sinuses. These openings did not appear to be natural openings, being too large and not situated in the normal situation.

The PRESIDENT regretted he had not seen this case. He did not think there was usually difficulty in recognising the opening into the sphenoidal sinus when it was visible.

Mr. TOD, in reply, said he certainly thought that they were sphenoidal sinus openings, as they were very symmetrical and so central. On the left side they could see above and behind the middle turbinate bone an opening which he took to be the posterior ethmoidal cells. On feeling with a probe between the openings it was quite hard to the touch, but around the openings it was membranous. He was able to pass in a probe on the right side nearly an inch; on the left to a less extent. When the patient first came to hospital he passed a cannula into the openings and pus was washed out, and it came out from each opening separate, showing absence of communication between the two sinuses. He agreed with Dr. Thomson the openings led into the sphenoidal sinuses, although the anterior wall had probably become necrosed and been replaced by membrane.

CYSTIC ADENOMA OF PYRAMIDAL LOBE OF THE THYROID.

Shown by Mr. WAGGETT. This occurred in a woman æt. 43, who first noticed a lump in the neck six years ago. A fortnight ago it had become painful, and increased to double its former size. At the present time a firm tumour, the size and shape of a bantam's egg, occupied the subhyoid region of the neck a little to the left of the middle line. Evidently a hæmorrhage had occurred in a cyst.

Dr. GRANT considered this a cyst connected with the thyro-lingual duct.

Mr. WAGGETT said he thought Dr. Grant and himself merely differed on the question of terms. The pyramid lobe of the thyroid gland was the lower part of what was called the thyro-lingual duct.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

Seventy-fifth Ordinary Meeting, *June 6th*, 1902.

E. Cresswell Baber, M.B., President, in the Chair.

Charles A. Parker, F.R.C.S.(Ed.), } Secretaries.
James Donelan, M.B., }

Present—25 members and 3 visitors.

The minutes of the preceding meeting were read and confirmed.

The President called upon Mr. Charters J. Symonds to open the discussion on

THE DIAGNOSIS AND TREATMENT OF MALIGNANT STRICTURE OF THE ŒSOPHAGUS.

Mr. Symonds said—

Mr. President and Gentlemen,

To put the subject of this debate briefly, it may be said that the diagnosis of malignant stricture of the œsophagus resolves itself into the passage of a bougie to ascertain the

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presence of an obstruction, and the treatment in deciding the best way to introduce food. One sees, however, so many cases treated for dyspepsia that it is necessary to consider a few of the early symptoms. In speaking to an audience of experts, I will limit myself to what appear to me to be essential points, and endeavour not to weary you with unnecessary details.

A gradually increasing dysphagia is the common history in most cases. In by no means a small number the onset is sudden, *e.g.* at a particular meal; a man choked over a mouthful of meat, and from that moment had difficulty. Another, after shouting himself hoarse in welcoming the men from the *Powerful* in the City, had choking the same evening, and developed cricoid obstruction. In one instance a loathing for food, so great as to require feeding by a tube, was the leading sign for some weeks. In another the man complained of pain as the food passed the centre of the gullet.

I have seen one instance where there was no dysphagia; the man was anæmic and was thought to have cancer of the stomach, and when his evacuations were black this view was strengthened. At the autopsy we found the greater portion of the œsophagus occupied by an ulcerating carcinoma, which had enlarged and not constricted the lumen at any point.

Before a bougie is passed a good many patients are treated for dyspepsia, and much valuable time may be lost. One sees such patients losing flesh, not so much on account of inability to swallow, but because the diet has been restricted, on the view that the disease was gastric. It must be remembered that so-called "dyspepsia," *i. e.* loss of appetite, "tightness at the chest," water brush, some pain and distension, with irregular bowels, may be the result of œsophageal obstruction. The restricted diet usually prescribed tends to increase the symptoms. A diagnosis can generally be made by asking the patient to swallow liquid. This when marked is characteristic; he makes one ordinary effort, followed by one or more smaller ones; these are accompanied by certain peculiar movements of the neck. Then he brings up a little gas, often hits his chest, and says now it has gone. Kussmaul's sign, viz. listening to the back to hear the fluid arrested at the stricture and then trickling through, is always interesting, and when the observer does not

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pass a bougie is sometimes valuable. I am sure from what I see that an unnecessary fear exists in the minds of many as to the danger attending the use of a bougie. Provided that a fair size be employed, and no force used, and especially that no pressure be made when the patient strains to extrude the instrument, there is no danger. The bougie should be advanced in a deep inspiration or on an act of deglutition, held still on any expulsive effort, and again advanced on inspiration. That there are dangers with fine bougies, and in advanced disease, one cannot deny. In passing the cricoid one must wait for the inspiration which follows the first glottic closure, or make the patient regurgitate by passing the left forefinger far back on the tongue. To press at this moment in close cricoid stricture may send the bougie into the trachea. Once more it may be added that in impermeable cricoid obstruction, where the patient is particularly tolerant, there is special risk of entering the trachea. It is remarkable to note how a patient will bear the presence of a large bougie in the windpipe for some time without coughing. In any doubt we must pass the bougie not more than twelve inches, and examine its position with a laryngoscope. These special points refer rather to treatment; it seemed but right to refer to them here.

With these general remarks, I will next ask you to consider the diagnosis of the disease as it affects the three situations, viz. the upper third and cricoid orifice, the lower end and gastric orifice, and the central region.

1. *Upper third.*—Stricture at the cricoid or beginning just below the ring is, in my experience, always malignant. It begins at 8½ to 9 inches from the teeth, and usually involves 2 or 3 inches. The chief peculiarity is the tendency to cicatrise and contract; so marked is this feature that a specimen may be indistinguishable to the naked eye from a chronic syphilitic or other ulcer. If the margin, however, of such a specimen be examined microscopically, squamous epithelial growth will, I believe, always be found. The contraction is irregular, so that a bougie in passing may have to turn several corners. In the diagnosis of disease at the cricoid I have found three conditions give rise to confusion:

a. The one most closely resembling organic disease is

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dysphagia, occurring in elderly people. In the first instance that came under my notice, the patient was a woman æt. 70; there was dysphagia for solids, and fluids caused trouble; a bulb passed with difficulty, there was a streak of blood, and altogether I thought gravely of the case, and gave a serious prognosis. The symptoms soon disappeared, and the patient, after some years, is still well. A similar instance came before me again in a woman over 70, and another in a man over 80. In the persistence, in the indefinite obstruction to a bougie, and in the age of the patient, there is sometimes a close resemblance to malignant disease. There is also an absence of the nervous symptoms seen in younger people. The condition suggests some organic change, giving rise to temporary interference with deglutition. I have thought that possibly an excessive cricoid ossification, or some bony outgrowth interfering with movement, might explain these cases.

b. The nervous form, especially when occurring in men, and in medical men above all others, can only be settled by time. Suddenly such a patient has difficulty at a meal over a mouthful of food, and later cannot swallow a pill or a crust of bread. He has to be more careful in eating than before. It is well known that such is often the history of the early stages of malignant stricture. The passage of a bougie is not easy, a little blood may result to further confuse the issue, or one may fail to pass the bougie beyond the cricoid without undue force. Where such symptoms occur in a man of forty-nine or fifty, the diagnosis is not easy. In both affections the freedom of swallowing varies, in both soft solids are better dealt with. I would say, however, that in malignant disease the patient almost always permits the passage of a bougie, and that there is found irregularity of the surface indicating disease of some standing. Practically in the majority there is no great difficulty, but in a few cases—especially if they happen to be medical friends—it may give rise to no small anxiety. In most cases it is best, I believe, to give a positive opinion as to the simplicity of the case and wait with your own secret fear.

c. The third condition is that of a pharyngeal pouch. When well marked, the symptoms of this complaint are so defined as to quickly clear up any difficulty. The subject has been so well

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dealt with before this Society that I need only refer to Mr. Butlin's communications.

Malignant disease of the lower end of the pharynx, involving the arytænoids, cannot be excluded from a discussion upon œsophageal stricture, and as the same treatment is required, I must refer to it here. The main distinctions are the pain accompanying dysphagia; the voice early has the peculiar sound produced by the presence of œdematous arytænoids; again, the growth can usually be seen in the early stages. It appears first as a pale cushion below the arytænoids, and gradually advances, giving rise to early œdema of one or other arytænoid. These patients often continue to swallow fairly well, and can, so far as I have seen, always be relieved by a soft tube. The direct extension to the larynx is the special feature of disease in this situation. Those who have seen many of these cases will have observed the greater frequency in women, and in many at an age nearer thirty than forty. I may add that in one instance—a woman also—the early mass seen below the arytænoid disappeared under iodide of potassium. I have not myself encountered syphilitic disease lower than the pharynx. I have one patient with slight obstruction just above, or at the cricoid, who had originally—some thirty years ago—syphilitic ulceration involving the larynx.

2. *In the middle third* a sarcoma and a myoma may occur, and give rise to obstruction. In one of my cases a sarcoma was found as a localised tumour, but clinically it was indistinguishable from the ordinary carcinoma. With such rare exceptions as these, all obstructions of any moment in this section of the œsophagus are due to carcinoma. It is very noticeable that aneurysm and mediastinal growths rarely give rise to serious dysphagia. Once only have I passed a bougie in a case of aneurysm, and the sensation communicated to the hand was, I thought, diagnostic of the disease. The case was sent to me with a diagnosis that mediastinal pressure was absent. The bougie passed over a convexity and smoothly descended without any difficulty.

Œsophageal pouches occurring in the middle and lower sections are sometimes very difficult to detect. In one patient, æt. 72, symptoms of obstruction had existed for several years; a

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bougie was arrested 14 inches from the teeth; on one occasion it slipped past, and there seemed abundance of room. Under chloroform, the largest bougie was several times guided past the orifice. At this time he regurgitated a good third of his food. For another two years he went on much the same, and died somewhat suddenly from another malady. There was no doubt a pouch in this case. The long duration was a strong point against malignant stricture; the second, that he could always take solids.

In another instance a man was sent to me for pyloric vomiting; without going at length into his case, I may say that the symptoms pointed to obstruction low in the gullet, and the large quanity of food retained to the existence of a pouch. He was fed by a tube, and the vomiting ceased. I thought it better that the man should learn to feed himself in this way than undergo a gastrostomy. After a year of such treatment, he is in good health and able to do his work.

3. The *lower end, i. e.* a point 15½ inches to 17 inches from the teeth, is, in my experience, the only locality where we find a simple obstruction. One is justified in saying that, as the obstruction is in this situation, the cause may be simple, and that the mechanical difficulty being overcome, the future carries more hope than does obstruction in any other situation. I have notes of five such cases, two with pathological evidence, while three are clinical. In the first two the symptoms were those of obstruction only, and they died unrelieved. One of the three living cases has had symptoms for some years, and is relieved from time to time by the passage of a coudé bougie; another has swallowed well since a gastrostomy was performed over a year ago, never having required to use the artificial opening; while the third has had symptoms for twenty years, and requires a bougie from time to time. I will again refer to the use of the coudé bougie in obstruction at the lower end; let me here, in referring to diagnosis, insist upon its great value. When a small, straight bougie will not pass, a large coudé may slip through easily. The two specimens referred to showed a simple fibrous thickening, allied, no doubt, to that seen in the pylorus.

Slighter degrees of obstruction occur in this situation, which may be called spasmodic. I have seen only one marked case, a

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lady æt. 30, who, when I saw her, had had obstruction for twenty-four hours. A bougie encountered resistance, which yielded as would a tight sphincter. The obstruction was definite, not a purely nervous form. This brings one to the whole question of "spasmodic stricture," so called. Personally I must express a disbelief in such a complaint, apart from the hysterical cases. Of these latter, the two worst occurred, the one in a boy æt. 7, and the other in a man æt. 35, both hospital patients, and both greatly emaciated. The boy was cured by the temptation of a penny currant bun, the man took a pair of the largest bougies. All the cases brought to me for spasm, except the hysterical, have a basis of malignant growth. I have mentioned before that in a growth in any situation there may be, in the early stages, much difficulty from added spasm and varying mechanical alterations in the growth itself, permitting the taking of solids on one day, and of fluids only with difficulty on another.

When the stomach is infiltrated by malignant disease, and so reduced as to hold but a couple of ounces—the so-called leather-bottle stomach—the resemblance to obstruction at the cardiac end of the gullet is very close. In one instance the patient could retain about 1½ ounces, any larger quantity being rejected. But this amount, taken frequently, was retained, and the diagnosis thus established. This was confirmed by operation.

In another, with obstruction at the cardiac orifice, I found, on performing gastrostomy, only a small portion of the stomach free and available for establishing a fistula. I have no doubt that we had entered the stomach through the œsophagus, and that the inability to retain fluid was due to the reduced capacity. After the operation we were never able to introduce more than two ounces at a time.

Of œsophagoscopy I have no personal experience. Its value was recently demonstrated to me by Professor Mickulicz, of Breslau, who showed me a case of actinomycosis recognised by this method. A piece of growth was removed by forceps and examined.

I may summarise the diagnosis in the following way:

1. Among early symptoms we may base so-called "dyspepsia,"

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nausea, and repulsion for food; pain alone when the central district is affected.

2. That the passage of a bougie is the only way to clear up the case, and that its employment need not be feared.

3. That extra-œsophageal disease rarely gives rise to serious dysphagia.

4. That spasmodic obstruction, apart from the hysterical form, has always, when decided, an organic cause, and that this would be better called intermittent dysphagia.

5. That with regard to the three special districts it may be said—

a. That all organic obstruction in the upper third is malignant, and has a special tendency to cicatrise.

b. That in the central half of the gullet, a sarcoma or a myoma, both rare diseases, may cause fatal obstruction; that here, also, a pouch may give rise to difficulty in diagnosis, but can generally be excluded.

c. That in the lower end alone does simple stenosis occur, and that here there may be difficulty in distinguishing from cancer of the stomach causing great reduction of the cavity (leather-bottle stomach).

Finally, that in estimating the extent of the disease, the special value of the steel bulb is noted, and also the use of the coudé bougie in obstruction at the lower end.

Treatment.—Speaking generally, it may be said that we can relieve by mechanical means only, and that two methods are available, one to overcome obstruction by inserting a tube of some kind, and the second to open the stomach below the obstruction, *i. e.* perform gastrostomy.

I would put the general question of treatment in the following way, as applying to all cases:

1. While the patient can swallow fluids and semi-solids, and while a bougie can be passed and plenty of nourishment taken, he may be left, so long as—

a. He can swallow well;

b. A small bougie, No. 12 (catheter gauge), can be passed.

2. If the dysphagia increases, even though a bougie can be passed, then a tube must be inserted or gastrostomy performed. These conditions are seen in the soft fungating forms.

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3. If a bougie cannot be passed, or goes with difficulty, then the same course must be followed, as we know that complete closure may occur at any time.

4. If both conditions arise, *i. e.* the patient cannot swallow and a bougie cannot be passed, then immediate mechanical treatment is required.

Probably most have summarised their treatment in some such fashion.

I have not advocated the passage of bougies with a view of dilating the stricture. It is injurious in that it irritates and leads to increase of obstruction; it may split a hard stricture and set up rigor and fever from absorption. In my own practice I have abandoned this method in all malignant cases. The object of the small bougie to which I have referred is simply to secure the route so that at any time a tube can be passed for feeding purposes, or the time fixed for gastrostomy. More than this has, in my experience, proved injurious. As applying to all cases, I would here again refer to the advantage of attempting the passage of a tube after a night's rest and a dose of opium.

Turning next to each region, in the upper third we have to note the great tendency to rapid closure and to the certainty of complete obstruction sooner or later. Two methods are available here: (*a*) the long feeding-tube, and (*b*) gastrostomy. Though I have successfully employed a short tube, it does not, as a rule, rest comfortably unless the highest part of the stricture be at least 1½ inches below the cricoid. Of the long tubes, the best is that made from rubber drainage-tube, introduced by the whalebone director. When this cannot be passed, the retention of a silk-web tube for a few days will so enlarge the passage as to enable the other to be inserted, or an ordinary urethral catheter will answer, and sometimes the coudé variety will pass. If the patient be fairly tolerant, the method is a useful one. The tube will last a long time, so much as nine months. If it comes out, it can always be replaced if the attempt be made at once. Should the tube, when rejected, be soft and have lost its elasticity, then a fresh piece must be used. It should never be removed for cleaning, as re-insertion may be difficult. I have conducted many cases to the end with this tube; the main

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objection is that saliva cannot as a rule be swallowed, though some patients will sip fluid by the side of the tube.

Another objection is that it does require some dexterity, perhaps, to insert in difficult cases, and much patience, but not more of either than does the passing of a catheter in stricture of the urethra. The form I have for many years used is, as you see, somewhat roughly made, the end of a piece of ordinary No. 10 drainage-tube .being sewn up with silk, and a big eye cut above. Note that the end of the introducer is passed into the eye, and a small plug of wool is inserted into the closed end to prevent the introducer slipping through. The proof that the thinnest walled rubber tube would keep a malignant stricture dilated was first pointed out by Mr. Berry. We must contrast this method with gastrostomy, and I would say that where the patient is low and unable to bear abdominal section it is our only plan. As an alternative, I find it has sustained life in comfort equal to the most successful gastrostomy, and greater by far than when the stomach contents escape and cause excoriation. When the patient is intolerant and objects, then we can offer only gastrostomy. The longest time I have known one of these rubber tubes remain unchanged was thirteen months. The obstruction was at the cricoid, and great difficulty was encountered in passing the first long feeding-tube. The rubber form was easily introduced after a few days' residence of the silk-web tube. From time to time small pieces of the rubber tube had to be removed, as it split near the silver cannula. The patient died with the original tube in position. Others have worn it for varying periods. In two cases patients have also worn tracheotomy tubes. One now under treatment has had a rubber tube in eleven months and a tracheal tube four and a half months. The same method answers admirably in disease of the pharynx. In this form the obstruction to a bougie is never very great, and I have had cases fed by a member of the family three or four times a day. Its application is limited. After many trials, I have no doubt that the best tube is the gum-elastic silk-web, with a closed end and two large eyes, and that the best sizes are Nos. 10, 12, and 14; smaller ones are of little use for permanent wear, and dilatation up to 12 is best conducted by the long

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tube. The vulcanite pattern introduced by Renvers I have found of no value; it is too hard and too short. The most suitable cases for this method are those where the stricture is short, and has a tendency to contract; then a four-inch tube answers admirably. The position and length of the stricture are ascertained by a steel bulb. As the disease progresses it may be necessary to use a six-inch tube.

In the *central portion*, *i. e.* for obstruction occurring from a point 10 inches from the teeth to 14½ inches, we can use a short tube in addition to the long one. When introducing this method in 1884* I said I hoped it would give relief in a certain number of cases, and it has fulfilled this forecast and no more.

The experience published in two former papers† represents very well the use and value of the short tube, and later experience has confirmed it. Of recent cases I may cite the following:

A man æt. 55. Dysphagia began early in 1898.

February 24th, 1899.—A short tube was inserted, the stricture, a short and contracting form, being 14 inches from the teeth.

April 21st.—The tube removed at patient's request; great difficulty in inserting another.

May 2nd.—A tube inserted.

July 28th.—A new tube introduced by Mr. Steward.

March 3rd, 1900.—The tube was still in and acting well, *i. e.* over seven months.

Some time later he showed signs of extension to the lung, and died on June 3rd, 1900.

Duration before tubage, twelve months; duration under tubage, sixteen months. Of these certainly thirteen were passed in comfort; and he attended to his business.

In another case the short tube acted perfectly up to the time of death, the treatment covering a period of more than a year.

Disease involving the *lower end* and *cardiac orifice* I have found difficult to treat by tube. I admit that occasionally one has been successful with a short tube or a long one, but as a rule it is rejected on account of the contraction of the diaphragm. Early gastrostomy seems to me the best advice. I advise that this be done while the patient's general condition is

* 'Clin. Soc. Trans.,' vol. xviii.

† 'Brit. Med. Journ.,' April, 1887; 'Lancet,' March and April, 1889.

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good. One very strong point in favour of this course is that, as I have said earlier in this paper, simple stenosis may occur in this situation. Given, therefore, a successful gastrostomy, life may be indefinitely prolonged. Moreover it may be possible, especially with the coudé bougie, to dilate the obstruction after the gullet has had a rest. We may at least anticipate some return of swallowing.

Of course, as in other situations, operation would not be undertaken so long as a bougie could be passed and the patient could swallow freely.

Early gastrostomy applies especially to malignant disease in this situation.

I must mention one remarkable case referred to before. A woman with great dysphagia, emaciation, and obstruction at the lower end. A coudé bougie could be passed. As she lived in the country, and as dysphagia was increasing, I performed gastrostomy. From that moment the power to swallow returned, and the second stage of the operation was completed. It has not been necessary to use the stomach opening. The woman remains so well—now more than a year from the operation—that I think the case must have been one of simple obstruction. Dilatation could not have been effected by suturing the stomach to the abdominal wall, and the only other suggestion one can offer is that a tortuosity has been straightened.

In view of the occasional occurrence of simple stenosis at the cardiac orifice, it seems to me our duty to press operation upon our patients when the dysphagia is marked.

The use of chloroform to facilitate the introduction of a tube is a question for discussion. Personally I have always had an objection to it, but I must admit that in cricoid strictures it has been of great service, and deserves a wider employment. So easy is it, however, to pass a small bougie or tube into the trachea, that I make it a rule, after passing a tube for 12 inches, to examine with the laryngoscope to see that it is really in the œsophagus. In one case, when this precaution was omitted, after waiting some time and there being no spasm or cough, milk was poured down and passed into the lung with disastrous consequences.

In another the tube passed through a tracheal fistula.

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Reviewing the whole question of treatment and contrasting tubage and gastrostomy, one may say as regards the latter that it at once disposes of all difficulty as regards swallowing; that in obstructions at the cardiac end it should be performed early; that in all patients intolerant of the tube and bougie, time should not be wasted. In advanced cases, where leaking can be prevented and immediate feeding undertaken, the operation may be successful, and there is reason to expect that such a method has been found.

Unfortunately, many cases among the poor are obtained in too advanced a stage for operation to be considered, and there are others who decline operation. It, therefore, is necessary to perfect, as far as possible, the alternative method of tubage. With regard to cricoid strictures and disease in the lower part of the pharynx, I am quite satisfied with the rubber tube, and believe it to be superior to gastrostomy. We want a tube so constructed that it will not easily be regurgitated, and I believe this will be produced. Once a tube has been retained it is never wise to dispense with it, even for a day. I have several times yielded to the patients' wishes in order that they may enjoy the luxury of a solid meal and been unable to re-insert another tube. The insertion of the new tube should immediately follow the withdrawal of the old one, be it a short or a long tube.

The short tube has, as I said, a limited use, being of little service in disease of the two orifices. But in the central section I still find it valuable. It is open to the objection that it is liable to get blocked, and that, again, some skill is required to insert it. With cases where there is no cough I have known it remain unchanged for ten months, and in another three months. There is no necessity to remove these tubes for cleansing purposes; the silk, protected as is now done by fine rubber tubing, will last for months, and the security of the silk is the only anxiety.

When cough arises from extension of growth, or hæmorrhage occurs, the tube will get blocked, and then a long feeding-tube must be used—either a silk-web or a rubber. It is unnecessary on this occasion to go into details, so I will put the question of tubage thus:

The short tube is useful in strictures occurring from a point

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10 inches to a point 14 inches from the teeth. It is no use when there is cough on swallowing, indicating perforation. It is of little value when the growth occupies a long stretch of the gullet. It is seldom of use in strictures involving the cardiac orifice, and cannot, as a rule, be borne in disease involving the cricoid level.

In suitable cases it has, however, given good results up to the time when perforation occurs, and then, as a rule, a long feeding-tube answers for the few weeks that remain.

A word must be said as to the dangers of intubation. One has had accidents, fortunately in only one was life much shortened. In one case a tube was passed, under chloroform, through a perforation into the trachea. This showed the danger of chloroform.

In another a soft and ragged œsophagus was perforated, the man being in the last stage of the disease.

In another a tube in the tight cricoid stricture passed into the trachea; the man did not cough, and gave no sign that such an accident had occurred until signs of pneumonia developed.

These accidents occurred some years ago, when one was endeavouring to improve the method of treatment. Since one has systematically used the laryngoscope to ascertain the position of the tube in cricoid strictures, several similar accidents have been avoided. It is essential to use this check when operating under chloroform.

Summary of Treatment.

1. In cricoid obstruction the long rubber tube gives excellent results. When not well borne, gastrostomy, if selected, should be performed early.

2. In disease of the central portion the short tube is serviceable in a fair number of cases, and, when it acts well, is superior to any other method. It must be replaced by the long feeding-tube when pulmonary symptoms arise.

3. In disease of the cardiac orifice tubage is so uncertain that gastrostomy should be performed when dysphagia becomes serious.

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Dr. Herbert Tilley: I think that most members will agree with me that the term "classical" is one which might well be applied to the address that Mr. Symonds has given us on the subject of the diagnosis and treatment of malignant stricture of the œsophagus. His experience in this class of cases is so unique that anything which others may say on the matter can only be in the nature of accentuating facts which Mr. Symonds has already brought forward. I will not attempt to do more than this. I wish only to bring before the notice of the Society two cases which seem to illustrate the apparent simpleness of some of the symptoms which are so easily overlooked in the early stages of malignant stricture of the œsophagus, and to which Mr. Symonds has referred in the early part of his address.

The first case was seen some four years ago in University College Hospital. A middle-aged man was admitted to a medical ward suffering, or supposed to be suffering, from ulcer of the stomach. The patient had been brought in complaining of acute pain in the stomach, and on three or four occasions he had vomited large quantities of blood. He was very anæmic, and in the absence of any physical signs in the chest or stomach, it was very difficult to say what organic lesion was present. He took food well, and had no difficulty in swallowing; these were puzzling features of the case. I was given an opportunity of examining the patient, and found that although the voice was fairly clear, yet the left vocal cord was paralysed. Of this, there were no symptoms so far as the voice was concerned. On further examination I saw, about three inches down the trachea, a small, pale, nodular mass projecting into the lumen of the trachea. On the strength of this observation I made the diagnosis of malignant disease, probably of one of the mediastinal glands, the enlargement of which had obstructed the trachea. As to whether that gland was a secondary growth no one could say, for the simple reason that there was no evidence of any primary growth in the œsophagus or elsewhere. In the course of a few days the man died from another attack of severe hæmorrhage. At the *post-mortem* examination a malignant ulceration of the lower end of the œsophagus was found, which, as already stated, at no time had caused any obstruction, and the gland I had seen projecting into the trachea was a secondarily infected mediastinal gland. The case is extremely interesting as illustrating (1) how frequently such symptoms may mislead as to the true nature of the case, and (2) the light which may be thrown on an otherwise obscure case by means of a laryngoscopic examination.

The second case was seen about two months ago. The patient, a man aged fifty-one, had lost his voice for two months, and complained of certain stomach symptoms, *e. g.* flatulence, anorexia, inability to swallow solid food, because it immediately induced sickness, etc., and his illness had been attributed to "gouty œsophagitis," whatever that might mean. For some twelve months he had been complaining of a feeling of sickness after taking food. On examining the larynx, I found complete bilateral recurrent paralysis; the patient could only speak in a whisper, and had a very distressing and ineffectual cough. On examination of the chest, no evidence of aneurysm could be found.

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Attempts were made to pass œsophageal bougies, but the smallest one could not be passed beyond the level of the lower end of the manubrium sterni. I therefore took this to be a case of malignant disease of the œsophagus. A fortnight later I saw the patient again, and on further examination found above the manubrium sterni and in the region of the left lateral lobe of the thyroid a stony hardness, and many small enlarged cervical glands above the clavicles. The patient died a few days after the consultation, and unfortunately no *post-mortem* was obtainable, and it was therefore impossible to be sure as to the situation of the primary growth, *i. e.* whether it was in the thyroid gland and involved the gullet, or *vice versâ*.

These two cases illustrate the fact that sometimes one may get invaluable information as to the cause of the patient's symptoms by the use of the laryngoscope. In both the cases briefly outlined, the suspicion raised by finding the vocal cords paralysed was the main factor in the formation of a correct diagnosis. My experience has been very much in accordance with that of Mr. Symonds with reference to an apparent œdema of the upper end of the œsophagus, which occurs most commonly in young females suffering from malignant disease of the œsophagus in the neighbourhood of the cricoid cartilage. I remember seeing two young women, one aged twenty-one, the other aged twenty-eight, in which this curious œdema of the upper end of the œsophagus was followed very shortly afterwards by death from malignant disease in the situation referred to.

Sir Felix Semon: I am sorry I was prevented from being present at the beginning of Mr. Symonds' admirable paper, and, therefore, do not know whether he referred to two points, the absence of which rather struck me. In speaking of the differential diagnosis between malignant and other forms of œsophageal obstruction, I heard him say nothing about laryngeal paralysis, nor about the question of the enlargement of the cervical lymphatics. Both these points I have often found to be of considerable importance with regard to the diagnosis of doubtful cases. Dr. Tilley has just quoted a case in which the discovery of a laryngeal paralysis gave the first reliable sign of existence of organic obstruction. I may say that I have seen quite a number of similar cases, and more than once have I found that patients who came to me for laryngeal symptoms, apparently limited to that organ, such as hoarseness and loss of voice, later on developed the ordinary symptoms of malignant disease of the gullet.

In connection with this point, I should like to say that œdema of the neighbouring arytænoid cartilages, if the disease is situated in the cricoid region, is by no means the only laryngeal symptom of œsophageal cancer in that situation. When malignant disease affects the posterior aspect of the cricoid cartilage, it eats its way by no means rarely into the substance of the posterior crico-arytænoid muscles, and causes a true myopathic paralysis of one or both of these muscles. The symptoms resulting from this when the disease affects both sides are stenosis of the glottis and great respiratory difficulty, often enough of greater urgency than the difficulty of swallowing.

I need hardly mention that laryngeal paralysis is by no means limited to cases of cancer of the œsophagus when the latter is situated

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in the cricoid region, but that it may also accompany instances of that disease occurring much further down,—that is, one or both recurrent laryngeal nerves are caught in the furrow between the trachea and the œsophagus by a new growth starting from the latter.

With regard to the enlargement of the cervical lymphatic glands, this sign has several times been of considerable value to me, particularly enlargement of those glands which one can feel on pressing hard immediately behind the clavicle when standing behind the patient; but one has to press sometimes very low down to feel these glands enlarged.

With regard to the treatment, I speak with considerable diffidence, for I think we may say we all sit at the feet of Mr. Symonds, who has shown not only this country, but the whole world, how to treat a number of these cases, particularly by the employment of the smaller tubes which he has introduced. In Germany the credit of this is often given to Professor Renvers, although the last-named gentleman himself, when first introducing the method into Germany, acknowledged his indebtedness to Mr. Symonds. Personally I must confess I have not much opportunity of trying the short-tube treatment, and I have been rather unfortunate in those few cases in which I have tried it, for my patients were quite intolerant of the tubes for any length of time, and I had, therefore, to remove them; but in several cases which, later on, I sent to Mr. Symonds considerable relief was given, in two of them for a long time, by the employment of this method.

Should gastrostomy be required, I entirely agree with Mr. Symonds that the operation should not be performed at too late a stage of the disease.

Concerning the introduction of bougies, I have learnt from experience the wisdom of his advice to give in difficult cases the patients a night's rest and a dose of opium previous to the introduction of the tubes. One may succeed by following this simple advice where one has previously failed. Should an anæsthetic be indispensable, the dangers of chloroform in such cases should not be under-rated. I have had a very sad experience of this. About a year ago a lady consulted me on account of difficulty in swallowing. She was thirty-four, and in otherwise excellent state of health, but had lost flesh in consequence of this difficulty. There were no signs of organic disease anywhere in the chest or in the throat, but when I proceeded to introduce a bougie, I did not succeed. The same difficulty was encountered by Mr. Makins, whom the patient had also been advised to consult. He and I agreed that it was desirable to repeat the examination under chloroform. A few days later this was done, the anæsthetic being administered by one of our most experienced and most skilful anæsthetists. When the patient was deeply under the influence of the drug—as in a case of this sort ought to be the case, to exclude all reflex action—I endeavoured to introduce a big bougie, but without success, nor did Mr. Makins have any better fortune. I then tried a smaller one and still failed, and Mr. Makins' attempt met with the same result. The bougie having been withdrawn, the patient showed signs of coming to. The chloroformist said, "Let me give her a whiff more," and proceeded to do so, when the patient died suddenly. Every effort

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was made to resuscitate her but all was fruitless. No *post-mortem* examination took place, and to this day I do not really know what was the nature of the disease, but both Mr. Makins and myself concurred in the belief that it was organic.

A propos of the distinction between organic and functional stricture of the œsophagus, I remember having seen two or three quite distinct cases in which, after some initial difficulty, the bougie could be passed quite easily, and in which, after this had been repeated two or three times, the stricture was found to have disappeared. I cannot say that these were not examples of "hysterical" stricture, but then, what is hysterical stricture? Is it not what one would usually call spasmodic? I do not think the existence of such a form of œsophageal stricture can be denied.

In conclusion, I wish to congratulate the Society upon having had so excellent an *exposé* of an important and difficult question as that to which we have just been listening.

Dr. Clifford Beale: I should like to make one small contribution to this debate, and it is in reference to the question of diagnosis by the means of the X rays. The opportunities have not occurred very frequently since more powerful apparatus was introduced, but a good many cases have been examined, and my friend, Dr. Hugh Walsham, handed to me this afternoon four plates which he has made of such cases, two of them being confirmed by a *post-mortem* examination, and these two show certain definite characteristics which may ultimately turn out to be trustworthy in diagnosis, but, of course, with the evidence so slight as it is at present, one can only take things as one finds them. But the important point is this, that in these cases of œsophageal cancer there is a very well-defined shadow thrown on both sides of the normal mediastinal shadow, whereas in the case of enlarged glands at the root of the lungs, the shadow, although something similar in form, is undefined at its edges. As one would expect, a well-defined morbid growth will give a sharp shadow, and a mass of glands with inflammatory thickening round about them will be represented by indefiniteness. [The plates were then shown.] One point with regard to this method of examination by the Röntgen rays is that it gives us more information as to the amount of thickening and growth that may be present. I think we shall all bear out Mr. Symonds when he says that it is the bougie which masks the diagnosis after all; but the bougie only tells us that there is an obstruction and not how extensive the cause of obstruction may be.

As regards the treatment, one cannot help being struck with the fact that cases are recorded (and Mr. Symonds has mentioned one) where, after gastrostomy has been performed, and where, presumably, the patient has been kept quiet for a few days and fed *per rectum*, it is found that the power of swallowing is perfectly restored. In the cases in question that I have heard of—for I have not yet come across one myself—the power of swallowing is apparently as good as ever. Now, when one comes to think of what it is that gastrostomy does for the patient, one finds that it is nothing more than freeing the growth from irritation, and giving it absolute rest. Therefore, this leads one

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to think that in the early stages of such a condition one might do a good deal in the same way by keeping the œsophagus as free as possible from irritation, and by giving it rest. I have carried out this idea in the case of a patient who is under treatment now. By getting him to swallow a certain amount of hot water after every meal to wash down the œsophagus, and at the same time giving a small amount of sticky mixture of opium, *i. e.* Liquor Morphiæ combined with glycerine and gum acacia, the result is altogether satisfactory, affording, as far as one is able to judge, both cleanliness and rest. I can also quite confirm what Mr. Symonds says as to the absence of dysphagia in cases where there is pressure from intrathoracic growth and aneurysm. I think the absence of dysphagia may sometimes be a rather striking feature in certain cases of cancer of the œsophagus where the stricture is not complete. As an old Guy's man, I rather expected Mr. Symonds to tell the story that was in vogue there in our student days, of Astley Cooper, who after going through the medical wards at Guy's to see some special cases, had his attention called to an old man, sitting up in bed, whose face, so far as appearances went, was obviously suggestive of cancer. Astley Cooper was told that none of the physicians could find out what was the matter with the old man, and he instantly replied, "Then he must have cancer of the œsophagus; he obviously has cancer, and this form of it is the only one which may give no symptoms."

Cases crop up like this every now and then, which are proved by *post-mortem* examination to have extensive malignant ulceration of the œsophagus, and yet during life, though these patients obviously have cancer somewhere, there is no regurgitation, no difficulty in swallowing, and nothing to call attention to it. I do not know how frequent such cases may be, but still one must always bear in mind the possibility of their occurrence.

Mr. H. B. Robinson: I should like to emphasise a point which was made by Sir Felix Semon, and that is, the great importance of the enlargement of the cervical glands in the diagnosis of malignant stricture of the œsophagus. Its importance struck me forcibly in a case I saw a little time ago. The patient was a man I saw in private practice, who had a mass of enlarged glands just above the right clavicle; he had great pain down the arm, but there was no suspicion whatever of his having any œsophageal disease at all, but when one went into the question and made a few inquiries and passed a bougie, there was undoubted contraction of the œsophagus. His œsophageal symptoms had been of so slight a character that the enlargement of the glands had never been thought to be in any way connected with a growth in the œsophagus.

Another interesting case of œsophageal obstruction which is worth bearing in mind perhaps, although the obstruction was not in the œsophagus itself, but was caused by pressure outside it, was that of a man sent to me with very marked dysphagia. He was about forty-five. The only thing one could see that probably had relation to the dysphagia was the fact that there was some enlargement of the left lobe of the thyroid gland; but still, from what one was able to feel, one did not at the time think it could exert any great pressure on the

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œsophagus, though it was the only apparent cause of the difficulty in swallowing. Thinking there might be something deeply placed exerting pressure, I operated and found in the deep part of that gland a cystic adenoma, which was pressing right down between the trachea and the œsophagus and indenting the anterior wall of the œsophagus. I removed it by shelling it out, and the man did perfectly well and has had no further symptoms of dysphagia from that day to this.

Dr. J. DONELAN: I should like to ask Mr. Symonds whether he regards as absolute strictures those in the neighbourhood of the stomach, in the lower part of the œsophagus, where it is impossible to pass a tube and keep it in position for any length of time. I remember the very first case I ever saw of this kind as a qualified man was a case which illustrates the point brought forward by Sir Felix Semon, namely, the early occurrence of laryngeal paralysis. It was a case under the care of a distinguished specialist here in London, and laryngeal paralysis had existed for six months. After a time I saw the patient, who said that four days previously he suddenly lost the power of swallowing and had had no food since. I remember I tried to pass several kinds of bougies, but without success, and the only thing I was able to pass was the third string of a violoncello, which is very small, much smaller than any sound. This served afterwards as a guide for the passage of a straight feeding-tube. I kept this in position for some days; the obstruction was sixteen inches from the teeth. The tube I used for this man was a thin one—I don't know now whose name was attached to it—but it was a French tube and very fine; it was much the shape of a Symonds tube, but much thinner. During the six months that the patient lived afterwards it was retained in position. It was taken out on one occasion and there was very great difficulty in putting it back, but ultimately it was replaced and remained in position until the death of the patient. The second introduction was facilitated by the use of cocaine, by passing the tube down as far as possible and then pouring a little cocaine solution through it.

I should like to ask Mr. Symonds whether the similar use of a solution of adrenalin might not be of some use in reducing the turgescence and facilitating the passage of a bougie or tube.

We have lately had some three or four cases examined by means of the Röntgen rays, but in these the lower part of the œsophagus was the seat of disease, and whether in that situation it will be possible to arrive at any more definite conclusion than that already afforded by the passage of a bougie must be a doubtful matter on account of the greater size and number of the intra-thoracic structures that are present. It does not appear to me that the Röntgen rays in this situation can throw more light on the subject than the *bougie.*

Dr. DUNDAS GRANT: I should like to add my tribute of indebtedness to Mr. Symonds for the way in which he has marshalled so many points. I have selected from my memory some of the difficulties which I have experienced.

The following occurred very early in my experience of general practice. The patient was a man of middle age who had increasing

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difficulty in swallowing. This difficulty varied a little in its intensity. The man was certainly getting thinner. I had then a consultation with the late Sir Andrew Clarke, who asked me to pass an œsophageal bougie, which I did without any very great difficulty; but he discovered the presence of malignant disease in the abdomen.

In another similar case which I have had more recently under observation, the patient had all the appearances of cancer of the œsophagus. I was unable to pass a bougie through it. Without examining the patient very much further I handed him over to a general surgeon who was anxious to perform gastrostomy. On examining him with a view to that operation he found carcinoma of the liver. In these two cases the contraction of the œsophagus seems to have been reflex in origin; perhaps my experience with regard to these cases has been very exceptional, but I put it forward, and I shall be glad to know whether this is a frequent condition simulating carcinoma of the œsophagus. Again, whether in this second case of mine the administration of chloroform would have helped to clear up the difficulty is an important question, because if it would, I think it is a great argument in favour of administering an anæsthetic in these cases. There was under my care some time ago a patient on whom I failed entirely to pass an œsophageal tube. He was fortunate enough to come into the hands of Mr. Symonds, and I understand that it was under an anæsthetic that he succeeded in introducing a tube, which gave the patient very great comfort for some time. Naturally the objection to chloroform is the risk incurred by its use, and this is a serious factor which has to be reckoned with. I should suppose it was a coincidence in this particular case of Sir Felix Semon's, which had such an unfortunate termination. But whether some involvement of the cardiac nerves makes chloroform more dangerous in cases of œsophageal cancer is a point on which I think there is room for reflection.

In another case I was able to pass a large bougie with perfect facility, and ventured to give the opinion that there was no disease of the œsophagus, but the patient died a few months later, and was reported to me to have been certified as dying from carcinoma of the œsophagus. In another case, which I showed to this Society as one of primary malignant disease of the thyroid gland, there was a general consensus of opinion that it was such. The patient died afterwards at Reading Hospital, and on *post-mortem* examination was found to have extensive disease of the œsophagus certified as carcinoma of the œsophagus, though, indeed, this may have been secondary to the disease of the thyroid gland.

With regard to those cases of spasmodic stricture of the œsophagus, I have seen several cases where a considerable amount of dysphagia has arisen from defective dentition, and I remember well the case of an old gentleman (a medical man) who came to me on account of what he thought to be carcinoma of the œsophagus. On examination, I found that he had lost almost all his teeth, and I recommended him to get some artificial substitutes. Within a few weeks' time after obtaining them there was complete recovery of the power of swallowing.

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With regard to the Röntgen rays, I saw a case some little time ago in which a radiograph was taken; the question for decision was whether there was by any chance aneurysm, but there was no pulsation as reported by Dr. Mackenzie Davidson, who made the radiogram. A few weeks afterwards the patient died from a sudden enormous hæmorrhage, and at once the question arose whether this was not after all a mistaken diagnosis, death resulting from rupture of an aneurysm. I do not think it a very rare thing for œsophageal cancer to end fatally from hæmorrhage, but I should be glad to know what is the experience of members with regard to that.

There is one little therapeutic point which I have never had an opportunity of carrying out, but in case it should have its value, I venture to reproduce it for consideration. It was invented by the late Michael, of Hamburg, and is a kind of Hahn's tampon tracheotomy tube, in which the sponge is covered with very thin india-rubber, and some glycerine is introduced between the rubber and the sponge, so that it may dilate and be kept for a long time in the trachea without its getting sodden and soaked with decomposing foods. He states in a paper of his that for a year a patient with a fistula between the upper part of the trachea and the œsophagus was kept alive after the introduction of this tube into the trachea. It remains to be questioned whether in a case of a fairly obvious fistula of this kind it is not a good treatment to do a tracheotomy, and introduce some such dilating tampon cannula.

Mr. President and Gentlemen, I have purposely selected my most unsatisfactory results, and I should be glad to hear how I may avoid them for the future.

The President: Gentlemen, I am sure we are all very much indebted to Mr. Symonds for the able way in which he has brought before us our subject of discussion. His experience of the treatment of these cases of malignant stricture of the œsophagus is, of course, much larger than ours has been. There are one or two points, however, to which I would like to refer. He has mentioned "œsophagoscopy." I do not know, and I should doubt, whether it is of any particular value from the diagnostic point of view, but there is no difficulty in introducing a straight metal tube fitted with a rubber point down to the obstruction. Before using the tube I am in the habit of letting the patient sip some solution of cocaine. Cocaine thus applied also facilitates the introduction of bougies.

In regard to the Röntgen rays, I had a case a short time ago under my care in which a skiagraph was taken, but, unfortunately, the rays did not give any very definite information. The case was confirmed *post mortem* as one of malignant œsophageal stricture.

The dangers of anæsthetics in these cases have been mentioned by Sir Felix Semon and Dr. Dundas Grant; I cannot help thinking that there is some peculiar danger in this class of case from anæsthesia. I remember a case a good many years ago where I was giving chloroform for gastrostomy and the patient very nearly died. Fortunately, we were able to bring him round, but the operation had to be stopped. I think possibly there may be some special liability to

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danger in these cases, or the danger may be due to the weak and exhausted state of the patient at the time of operation.

I should like to ask Mr. Symonds if he has any experience of radical treatment in cases of disease of the upper portion of the œsophagus. What are the results of œsophagectomy? Mr. Symonds, in bringing to our notice the subject of cancer of the upper part of the œsophagus, has included the same disease of the lower portion of the pharynx. There was a case under my care recently, a woman æt. 52, who came to the Brighton Throat and Ear Hospital. On depressing the tongue, the top of a growth the size of a walnut could be seen at the lower back part of the pharynx. On examination with the finger, the growth appeared to be pedunculated. Thinking it a suitable case for external excision, I passed her on to Mr. Buck, at the Sussex County Hospital. Under chloroform, laryngotomy was performed and the growth was ligatured round the pedicle and came off easily. It was found to be a squamous-celled epithelioma. Subsequently an external operation was performed on the left side, the pharynx exposed, and the growth excised with scissors, all the disease apparently being removed. The growth was found to extend just to the left arytæno-epiglottidean fold. The patient did perfectly well, and except for a slight attack of bronchitis after the operation there were no complications. The wound healed admirably, but since her discharge from hospital she developed on the right side of the epiglottis a further deposit of epithelioma, which did not spread from the original growth but started as an entirely fresh nodule. The patient declined further operation.

I have not had a large experience of the use of tubes, but I feel more inclined to employ them since hearing Mr. Symonds' very elaborate description of the method of employment. I should have been glad to hear from him a few more particulars about the risks of gastrostomy. Patients always ask what are the risks involved in this operation.

Mr. C. J. Symonds, in his reply, said: I am much obliged for the kind attention the Society has accorded my paper. I have to thank Dr. Tilley and Sir Felix Semon for raising the question of laryngeal paralysis and its value as an early diagnostic sign of œsophageal stricture. On collating my experience for this paper, I found in most of my cases I was able to settle the question of diagnosis in other ways, but I have seen cases, though not similar to those related by Sir Felix Semon, where laryngeal paralysis has helped in diagnosis, and has been the symptom from which the patient has sought relief. I am much interested in the cases referred to by members, and by Mr. Robinson's especially, though certainly I have not come across a case similar to his. Of course, I may have missed them, but I do not, speaking off-hand, recall any case where the enlargement of cervical glands has led me to diagnose malignant stricture of the œsophagus, and I am glad to learn of this case.

The only point of opposition I have had relates to the "spasmodic" type of case. And here let me explain that as I was opening a discussion, I purposely spoke somewhat positively, as I thought it would increase the interest of the debate. The only case I have had which

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resembled Sir Felix Semon's was that of a woman who had had obstruction for some hours when I saw her, and it was only on several similar occasions that she experienced it, and in her there was a distinct spasm of the sphincter at the lower end of the œsophagus. I wanted to ask Sir Felix Semon at what part of the œsophagus he found his cause of obstruction. [Sir Felix Semon: "Middle."] That I certainly have never found.

With regard to the X rays I have no experience whatever to offer, and I was glad to hear Dr. Beale's answer to my suggestion, which confirms me in my experience that intra-thoracic diseases do not give rise to this trouble.

I would suggest to Dr. Grant, who has asked for any means of assistance which would help him to clear up the difficulties which he has formerly experienced, that he should use the steel bulb. I most certainly would have missed more than one case of malignant disease of the œsophagus if I had not used it. This form* I introduced some years ago for my own convenience more than anything else, and for use in the out-patient room. It answers, I find, very well indeed in diagnosing those soft strictures which will certainly hardly give any signs of their presence to the ordinary conical bougie.

I was glad to hear Dr. Donelan refer to cases of stricture at the lower end of the œsophagus. The position I hold in regard to these cases I put very strongly, because I have been so disappointed with the treatment usually adopted. A long tube such as he described will answer the necessary purpose. Solis Cohn sent me an interesting paper giving a successful case of treatment by short tubes in a stricture at the lower end of the œsophagus, but it is unsatisfactory so far as my experience goes; and so I advise such patients to have gastrostomy done early.

With regard to the President's case of epithelioma, that was not quite what I was referring to. I referred to cases where your only view of the epithelioma is as it creeps up below the arytænoids directly in the middle line. It is so characteristic, being quite different from cases of pharyngeal carcinoma, which begin on one side and creep round in the epiglottic folds. I doubt whether it is worth while excising these growths; they are very unsatisfactory, as they always recur. I think the patient has a better chance if he is left alone. Although I have done these very big operations, one's experience tends to make one put them on one side.

The coudé tubes are passed in the ordinary way; they are most valuable for stricture at the lower end.

As to the question of the danger of gastrostomy which I am asked to answer, I am not prepared to do so at the present time. If performed at an early stage, it should involve very little risk indeed. I have been trying a plan lately, but whether or not it is going to prove sufficiently valuable I do not know yet. My object is to make a better sphincter out of the rectus.

* The elastic stem form with vulcanite bulb at each end was exhibited.

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OFFICERS AND COUNCIL

OF THE

Laryngological Society of London

ELECTED AT

THE ANNUAL GENERAL MEETING,

JANUARY 9TH, 1903.

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P. McBRIDE, M.D., F.R.C.P.Ed.

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PRESIDENTS OF THE SOCIETY.

(*From its Foundation.*)

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1893	Sir George Johnson, M.D., F.R.S.
1894-6	Sir Felix Semon, M.D., F.R.C.P.
1897–8	H. Trentham Butlin, F.R.C.S.
1899–1900	F. de Havilland Hall, M.D., F.R.C.P.
1901–2	E. Cresswell Baber, M.B.
1903	P. McBride, M.D., F.R.C.P.Ed.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

SEVENTY-SIXTH ORDINARY MEETING, *November 7th*, 1902.

E. CRESSWELL BABER, M.B., President, in the Chair.

CHARLES A. PARKER, F.R.C.S.(Ed.), } Secretaries.
JAMES DONELAN, M.B., }

Present—35 members and 1 visitor.

The minutes of the preceding meeting were read and confirmed.

The following gentleman was nominated for election as an ordinary member of the Society:—Donnellan, John Nicholas, M.B., B.Ch., R.U.I., Bromsgrove, Upperton Road, Eastbourne.

The following cases and apparatus were shown:

A CASE OF TERTIARY SYPHILIS OF THE LARYNX IN A MAN ÆT. 26.

Shown by Mr. DE SANTI. The man originally attended Mr. de Santi's Clinic in October, four years ago, with secondary syphilis. At that time the patient had a well-marked rash and the usual ulceration of the tonsils, soft palate, and buccal

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mucous membrane. He also had a hoarse voice, and on examination was found to have well-marked laryngitis, the latter presenting the usual mottled discoloration of secondary syphilitic laryngitis. He was put under mercury, and topical applications made to the larynx. The patient attended irregularly for some nine months, and although the skin eruption and ulceration of the tonsils soon disappeared, the laryngitis remained obstinate. He had been advised to give up smoking and over-use of the voice, but did not observe these instructions.

The patient was lost sight of until October, 1902, when he again returned to the Westminster Hospital. He stated he had always had a hoarse voice since October, 1898, and that he had been under treatment at various hospitals, especially Golden Square. At the last-named institution he had been under Dr. Powell, who had put him on iodide of potassium gr. 40 three times a day, and had applied various paints and sprays to the larynx. Dr. Powell had also on six or seven occasions tried to use endolaryngeal forceps.

At present the patient complained of a hoarse voice, some difficulty in breathing, and slight pain. Examination of the larynx showed both cords chronically inflamed, especially the left. On the left cord was a large, firm, red outgrowth or excrescence; in the interarytenoid space was a large swelling which presented cicatricial changes. The cords could not be properly approximated owing to the growth on the left vocal cord.

The patient was brought before the Society on the question of treatment. He had had a long course of large doses of iodide of potassium, topical applications to the larynx, and even attempts to remove endolaryngeally some of the outgrowth from the cord, but without any apparent benefit. He was now getting both pain and difficulty in breathing, and bearing in mind the course these cases of tertiary syphilis of the larynx are apt to follow, the question arose as to the advisability of performing a thyrotomy, and removing the diseased intra-laryngeal area.

Dr. Dundas Grant said that this case presented the appearance of pachydermia laryngis. There was an elevation on one side of the larynx, which lay in a depression, and a swelling on the other side. The growth was redder and somewhat more irregular than the very

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typical pachydermia, though for all that he considered it to be of that nature.

Dr. FitzGerald Powell said this patient had been under his care for some time, when he thought there was possibly a syphilitic history, although he diagnosed the case as one of pachydermia laryngis. He endeavoured on one or two occasions to remove portions of the growth, but he found them very tough, and they could only be taken away with a considerable amount of force. The size of the growths was nothing like that now seen. At the beginning of the case there was evidently pachydermia laryngis, but the growth which was now coming out from the ventricle looked of doubtful origin.

Dr. Lack thought that one of Mr. de Santi's cases was an instance of pachydermia laryngis. The other was a syphilitic overgrowth which he thought might be treated by removing pieces through the mouth.

Dr. Milligan suggested the inunction of mercury. This course was usually followed in primary and secondary conditions. Assuming this to be tertiary syphilis of the larynx, he considered it might be very advisable to put the boy through a course of inunction over the larynx if this had not already been done.

Mr. F. J. Steward asked if a formalin spray had been used for this boy, as he had had good results from its employment in a somewhat similar case.

In answer to the remarks of Dr. Dundas Grant, Mr. de Santi thought he was mixing up his first and second cases, the second case being probably one of pachydermia laryngis. In answer to Dr. Powell, Mr. de Santi was surprised that he should have put the patient whilst under his treatment on such large doses of iodide of potassium if he thought the case to be pachydermia. In answer to Dr. Milligan, he agreed with his suggestion of inunction of mercury, but had already tried it, and apparently without benefit. Altogether Mr. de Santi was disappointed that members had not brought forward any suggestions as to treatment.

Case for Diagnosis: Man with Growth on Left Vocal Cord.

Shown by Mr. de Santi. This patient came to Westminster Hospital Throat Clinic in May, 1902, with a history of hoarseness, sore throat, and pain in left chest anteriorly. He had had these symptoms about six months. Dr. Hebb, Mr. de Santi's colleague, had examined the patient's chest, but found no physical signs of disease. Examination of the larynx revealed marked thickening and reddening of the posterior third of both vocal cords, and a tumour, pyramidal in shape, with its base attached to the left vocal cord posteriorly; also a well-defined swelling in the interarytenoid space. The cords moved freely,

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examination of the chest, harsh breathing, prolonged expiration, and increased vocal resonance were found over the left apex, but no adventitious sounds could be heard. There was some difficulty of deglutition, the patient being unable to take solids.

Subsequent to admission to hospital a tracheotomy had to be performed for the relief of dyspnœa. The sputum was twice examined for tubercle bacilli, with negative results, and a large bougie was passed without difficulty, except that it seemed gripped about the level of the cricoid. The inequality of the pupils varied, for a few days the right being the larger, and then for a few days the left. After tracheotomy deglutition improved, the patient shortly being able to take solids.

Mr. Parker brought the case forward for diagnosis. At first he had been doubtful whether it was a case of fixation or paralysis of the cords, and, if the latter, whether it was due to a central nervous lesion or to pressure on the recurrents by a malignant growth of the œsophagus. At the present time the arytenoids were more œdematous, and the condition suggested tubercular mischief with fixation of the cords.

Case of Removal of the Epiglottis for Tuberculous Disease in a Male æt. 35.

Shown by Mr. Richard Lake. The prominent symptom in this case had been intense dysphagia, for which reason the epiglottis had been amputated over four weeks ago by means of the galvano-cautery snare. When removed it was found to be nearly half an inch thick where cut through, and the posterior or pharyngeal surface was deeply ulcerated. The rest of the larynx was diseased, and had not yet yielded entirely to treatment, but the stump of the epiglottis was soundly healed, and of normal thickness. Dysphagia ceased immediately after the operation and did not recur. The general condition of the patient was markedly improved since he had been able to take his food in comfort.

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Pedunculated Laryngeal Growth, probably dating from Birth, in a Boy æt. 15 Years.

Shown by Dr. Donelan. There were two growths present. The large one probably began as a papilloma arising from the upper surface of the anterior growth of the left vocal cord, and had, in the course of years, become fibrous and pedunculated. The smaller tumour was sessile, subglottic, and situated immediately below the anterior commissure. The mother thought the affection dated from birth, as from the first he had had a peculiar hoarse cry, and in voice had always been hoarse. The large growth and its peduncle in each inspiration were drawn through the glottis, which they momentarily filled almost completely. The influence of this respiratory obstruction acting through so many years showed itself in the stunted and anæmic appearance of this youth, while the other members of his family were healthy and well grown.

The President thought the case looked like one of papilloma.

A readily Improvised Working Model to demonstrate the Air Channels and Currents in the Nasal Cavities in Normal and Impeded Nasal Respiration.

Shown by Dr. Scanes Spicer. This apparatus had been contrived from objects which would probably be in the possession of most rhinologists. It consisted of a Betz plaster model of the half-head as seen on medial sagittal section, the septum nasi having been removed; a soft, flexible, perforated metal Asch's nasal tube splint; 12 inches of india-rubber tubing ($\frac{5}{8}$ inch in diameter); some plasticine modelling composition; and a sheet of clear glass 10 by 8 inches. The flexible metal tube was moulded to represent accurately the form and dimensions of the vestibule and rima naris, and then puddled on to the alar region of the plaster model with plasticine; the rubber tubing was similarly affixed to the lower end of the pharynx of the model. A cord of plasticine, $\frac{1}{3}$ inch in diameter, was then

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accurately affixed to the margins of the nasal and naso-pharyngeal cavities of the model, and the sheet of glass pressed down so as to allow no leak anywhere. The model was now filled with smoke from a cigarette through the rubber tube.

On inspiring or expiring air through the rubber tube, the passage of the entering or outgoing current of air through the dense smoke could be easily traced. The normal inspiratory current in quiet breathing was seen to issue from the rima and spread out like a fan to impinge on the front part of the middle turbinated body and adjacent parts. It then swept rapidly round the roof of the nose and naso-pharynx, passing chiefly through the upper two thirds of the nasal cavity. A vortex was also seen to be formed by a current becoming detached from the main stream just in front of the posterior nares, which impinged downwards and forwards on to the floor of the nose, and then curled round the front end of the inferior turbinated body. The inspiratory current did not normally pass through the inferior meatus.

The normal expiratory current in quiet breathing passed chiefly through the lower two meatuses, and a vortex was formed in the fore-part of the nasal cavity in a reverse direction to that of the preceding.

The glass could be removed, and any pathological condition, such as spurs, deflections, polypi, adenoids, etc., could be represented in size and position by lumps of plasticine, and on replacing the glass as before their effects in diverting the normal currents could be easily studied and the conditions varied.

Mr. Spicer thought it might with reason be objected that the anatomical conditions were not exactly reproduced, and that the ala did not move as in normal respiration; but the approximation must be fairly accurate, for it was remarkable how the results agreed with Paulsen's and Franke's researches on the cadaver, and Parker's deductions from his lycopodium powder experiments.

The full results of observations made would be deferred for a future communication, but in the meantime, considering how readily the apparatus could be arranged and worked, doubtless many rhinologists would test it and compare the results with their previous ideas on the subject.

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Left Antral Empyema, followed by Abscess of Hard Palate and of Septum Nasi.

Shown by Mr. Hunter Tod. The patient was a medical student, who three months ago had had a severe attack of toothache on the left side, followed, on the second day after the onset, by swelling of the face, and, on the fourth day, of the hard palate on the same side also. On the sixth day an abscess of the palate had burst into the mouth; at the same time he had noticed his nose had become swollen and obstructed. Two weeks after onset a dentist extracted the second incisor, canine, and first bicuspid tooth. The swelling of the face gradually diminished. Mr. Tod saw him three days later. He then had an obvious abscess of the septum, which blocked both anterior and posterior nares. The left antrum was dark on transillumination. The abscess of the septum was incised; much offensive pus escaped, and the nose was kept clean by a simple wash. A month later the nose appeared healthy but for great thickening of the septum, seen by posterior rhinoscopy; and there was a drop of pus in the middle meatus of the left side of the nose. The second molar was extracted, and the antrum, which contained much pus, was drained through the alveolar arch. The patient was now practically well. There was no necrosis of bone, and no perforation of the septum.

The President suggested that the teeth had caused inflammation on the palatal surface and inside the antrum, producing a palatal abscess and an abscess on the septum, and at the same time one in the antrum.

Mr. C. A. Parker said he had recently had a rather similar case, as far as the septum was concerned, in a child seven years old. There was a considerable amount of necrosis of the alveolar process above the right central and lateral incisors, and a well-marked abscess showing on either side of the septum.

Mr. Hunter Tod said the onset was so very sudden. He was not sure whether the antrum was first affected or not, but the history of the case had its commencement in tooth trouble.

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Double Antral and Frontal Sinus Disease; Left Side cured by Radical Operation; Question of operating on the Right Side.

Shown by Mr. Hunter Tod. The trouble in this case probably dated from an attack of influenza in 1897, since which the patient had suffered from headaches, gradually increasing in severity, and had noticed much purulent discharge from right side of the nose. The headaches had incapacitated him from working since onset.

About Christmas, 1901, there was an abscess over the left eye. This was scraped twice at a provincial hospital. On admission to the London Hospital the left eye was nearly closed from œdema and infiltration of the supra-orbital tissues, and there was a tiny fistula leading into the frontal sinus. The nasal cavity on that side was normal. The right side was filled with polypi, and there was much pus. The anterior half of the right middle turbinate and the polypi were removed. A week later, after cleansing the nose, the antrum was explored with a fine trocar; it contained pus. Similarly a cannula was passed into the fronto-nasal duct, and pus was washed out of the frontal sinus. Exploration of the left antrum proved it full of pus, although the nasal cavity appeared normal.

A radical operation, consisting of removal of all the anterior and inferior wall of the left frontal sinus, which was filled with polypi and pus, was performed, and a passage made into the nose. The patient was practically well on the seventh day, and left the hospital on the tenth. A tube was worn in the fronto-nasal duct for two months. Since then there had been no recurrence.

The antra were drained *viâ* the alveolar arch. The left side was now cured. There was still pus in the right frontal and antral sinuses, proved by repeated washing out of the sinuses. The patient, however, since the operation on the frontal sinus, had had no further headache, and felt and looked well. He had not been seen for two months before being shown to the Society. He had now so greatly improved that the question of

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operation on the right side hardly arose. There was considerable flattening over the right frontal sinus, but to this the patient did not object.

The PRESIDENT said there seemed to be a free exit for the discharge from the right frontal sinus, and as Mr. Tod was able to syringe it out easily and the man had no particular symptoms, he thought it was well to leave that sinus alone, save for syringing at regular intervals. It would be useless operating radically on the right antrum till the right frontal sinus was better, since it might be emptying itself into the antrum.

Dr. HERBERT TILLEY congratulated Mr. Tod on the result of the operation on the left frontal sinus, and thought that a similar operation on the right side would be the only means of curing the headaches from which the patient suffered, and which was obviously due to the suppuration in that sinus. If the headaches were not very severe the operation was not urgent, because very little pus was present in the right nostril.

Mr. TOD said the patient was not subject to very severe headaches, but only to occasional slight attacks which were removed by washing out the right frontal sinus.

A CASE OF OBSCURE LARDACEOUS-LOOKING VARIABLE INFILTRATION OF THE UVULA, SOFT PALATE, AND RIGHT ARYTENOID CARTILAGE IN A LADY ÆT. 30.

Shown by Sir FELIX SEMON. The patient was first seen on July 12th of the present year, with a history of long-standing throat trouble, and occasional difficulty in swallowing. She had been seen by various medical men, all of whom, according to her statements, had considered the affection as rather serious, but had apparently not known what to make of it.

On examination an almost lardaceous condition of the uvula was seen; that was to say, the uvula and the adjacent parts of the soft palate were considerably infiltrated, and at the same time quite smooth to sight and touch, whilst the most characteristic point consisted in the peculiar yellowish colour of the affected parts, reminding one of nothing so much as of the appearance of a kidney which had undergone lardaceous degeneration. In the larynx there was a similar condition of the mucous membrane over the right arytenoid cartilage. The left looked slightly more œdematous, reminding one of the ordinary

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pseudo-œdematous infiltration of tuberculosis; still, although more transparent than its fellow, it had a similar yellow colour to the right arytenoid.

There was no evidence of kidney trouble, but on examination of the legs there was slight pitting on pressure, particularly over the external malleoli.

Her voice was normal. There was no pain, and no difficulty in breathing. The organs of the chest were normal.

The urine had been examined later, and found perfectly normal. On July 14th, 1902, the local condition of both pharynx and larynx was much better than three days previously. The patient was given an arsenic and iron mixture.

On July 29th, 1902, the swelling both of the uvula and of the right arytenoid cartilage was much more marked than on the occasion of her last visit, and the colour was much more that characteristic lardaceous yellow which had been observed on the occasion of the first examination. The condition apparently varied from day to day.

On November 6th, 1902, the patient was found to have been distinctly better since last seen, and had only occasionally had slight difficulty in swallowing. The uvula as well as the right arytenoid cartilage now looked much less infiltrated than they were in July.

Remarking on this case Sir Felix Semon said: "This is the third case of the kind which I have ever seen, and I am not aware that the condition has ever been described.

"My first case, which I saw very many years ago, occurred in the wife of a practitioner in the Midlands; the lady's age was about thirty. In her case the condition was much more marked and general than in the present one, and I at first thought that it was a case of tuberculous infiltration, distinguished only from the ordinary cases by the peculiar yellow colour of the affected parts, as the infiltration involved not only the uvula and the soft palate, but also the epiglottis and both arytenoid cartilages. In that case the general discomfort and the difficulties in swallowing were much greater than in the present case, and no method of treatment had any effect whilst the patient was under periodical observation, which extended over nearly two years. I was, therefore, not a little surprised when again, about two

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years afterwards, the patient called on me to show me that there had been a return to perfectly normal conditions. There was as little known cause for the restoration to health as there had been for the original affection.

"The third case, which also occurred in a lady, æt. about 40, I only saw once. In that case the conditions were very much as in the patient now shown.

"I cannot make the least suggestion as to the pathology of these cases, and bring my case forward with the double purpose of giving the members of the Society the opportunity of seeing these most unusual conditions, and of possibly obtaining some help with regard to its pathology and treatment."

The PRESIDENT asked if any member had seen a similar case; if so it would be interesting to hear his experience.

Dr. FITZGERALD POWELL suggested that a portion of the uvula should be taken off and submitted to microscopical examination.

Sir FELIX SEMON replied that he would follow Dr. FitzGerald Powell's advice if the lady consented.

A Case of Ulceration of the Left Tonsil with Acute and Considerable Enlargement of Numerous Cervical Lymphatic Glands on Both Sides of the Neck; (?) Malignancy.

The patient, a clergyman, æt. about 70, was first seen on October 28th, suffering from ulceration of the left tonsil, which had remained behind after an attack of what appeared to be peritonsillitis about six weeks previously. There was no general cachexia, and hardly any pain or discomfort in the throat.

On examination the left tonsil was seen to be moderately enlarged, and in part superficially ulcerated. It was not excessively hard. Not only on the left, but also on the right side of the neck, numerous enlarged cervical lymphatic glands were present, those on the left side being particularly enlarged. Almost all of them on both sides were slightly tender on pressure. The interior of the pharynx, with the exception of the ulceration of the left tonsil, was quite normal.

Whilst the occurrence of ulceration of a tonsil, coupled with enlargement of the cervical lymphatic glands, in a man of 70,

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pointed of course *primâ facie* to malignancy (there being no evidence whatever of tuberculosis or syphilis), the unusual features in this case were—

1. The very rapid development of the enlargement of the cervical lymphatic glands;

2. The comparative smallness of the affected tonsil in proportion to the number and size of the affected glands;

3. And, above all, the fact that the cervical glands were enlarged on both sides, whilst only the left tonsil was affected.

A piece had, therefore, been removed, on the exhibitor's advice, with punch forceps by the patient's regular medical attendant, and sent to Mr. Shattock for examination, whilst at the same time iodide of potassium had been given internally, and a thick belladonna paste applied externally.

Mr. Shattock's report was as follows:—"I have carefully studied sections of the two pieces of tissue removed three days ago by Dr. T—, one from the swelling of the tonsil, the other from the anterior pillar of the fauces. They both show the same changes. I regard the tissue as inflammatory, rapidly growing granulation tissue. It consists of polyhedral connective-tissue cells distributed amongst fibroblasts and capillaries, the last well formed and distinct from the surrounding structures. A certain number of polymorphonuclear leucocytes occur. The epithelium over the pillar of the fauces is intact, but a considerable number of leucocytes are migrating into it from the subjacent inflammatory tissue.

"In the tissue from the tonsil considerable areas have undergone necrosis. Tuberculosis may be excluded histologically, as it may doubtless also clinically. I should not, therefore, class the lesion as sarcomatous. You recollect the notorious swelling of the tonsil that was cured by the violets, *i. e.* disappeared."

When the patient was again seen to-day there was found to be a decided diminution of the size of the cervical lymphatic glands on both sides, but they were still somewhat tender, and undoubtedly both the size and the ulceration area of the left tonsil had not inconsiderably increased since the patient was seen ten days ago. In spite, therefore, of the unusual clinical features, and of Mr. Shattock's favourable report, Sir Felix Semon did not consider that all cause for anxiety was over, and

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he had therefore brought the patient before the Society to hear the opinions of its members.

Mr. de Santi looked upon this case as one presenting many difficulties as regards diagnosis. Looking at the age of the patient, the general appearance of the tonsil, and the condition of the glands, he considered the ulceration to be epitheliomatous. He had not felt the growth with his finger, but the tonsil was probably hard to the touch. The condition of the glands and the rapidity of their enlargement was unusual in epithelioma, but in his experience one could never quite be certain of the course lymphatic infection in malignant disease might take in various individuals. He had seen glands secondarily involved from epithelioma of the lip on the opposite side to the malignant growth, and he had seen cases in which for some time no lymphatic enlargement was noticeable, and then almost suddenly extensive involvement of the glands had occurred. Of course the rule was to get the glands affected on the same side on which the original growth existed, though later the glands on both sides might and did become involved. Although bearing in mind the pathological report, and that it had been given by so eminent an authority as Mr. Shattock, Mr. de Santi looked upon the case as malignant from its clinical aspects; indeed, he could not see what else the condition could be. At all events, if it were malignant he was strongly of opinion that it should be left alone from an operative point of view. No operation with such glandular involvement would be of any use or justifiable. He understood iodide of potassium was being given, and he would be very interested to hear the subsequent history of the case.

The President understood that the appearance of the tonsil had changed considerably since the piece referred to by Sir Felix Semon was punched out.

Sir Felix Semon.—Yes.

Dr. Dundas Grant said that the removal of one of the glands could be easily accomplished, and its examination might give further valuable information.

Sir Felix Semon said he by no means fought against the possibility of this being a case of malignant disease. It was, in truth, at first his own idea of the case.

With regard to Mr. de Santi's remarks, however, he would like to mention the following points :—(1) The appearance of the tonsil at the present time might be more suggestive of malignancy because only six days ago a fairly big piece had been punched out by forceps, and there was of course a good deal of inflammatory change following this operation. (2) He quite agreed that one saw cases in which the cervical glands were affected on both sides, but this, in his experience, was as a rule only found in advanced stages of the disease. In the present case, however, there was extensive enlargement of these glands on both sides, whilst the whole duration of the disease, including the peritonsillar inflammation, was only six weeks. This was certainly most uncommon if the affection was really of malignant character. (3) So competent an observer as Mr. Shattock had made a micro-

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scopic examination and expressed a very decided opinion that the changes were of inflammatory character, and not of the nature of new growth.

He did not, in reply to Dr. Grant, consider himself justified in removing one of the enlarged cervical glands, for if the case after all were malignant, as Mr. de Santi thought, this was certainly no case for radical operation. In all probability it would be impossible to remove all the enlarged glands, and even if one succeeded in this, recurrence in no time would be practically certain.

He would not fail to report to the Society on the further course of the disease, and would only add that, in spite of complete absence of any antisyphilitic antecedents, antisyphilitic treatment had been tried; the patient had had iodide of potassium for two weeks and perchloride of mercury, but with little effect.

Case of Cyst of the Epiglottis in a Male Æt. 40.

Shown by Dr. FitzGerald Powell. The patient complained of nasal obstruction and ear trouble, but had incidentally remarked that he felt a "stickiness in the throat," which had existed for about two years. On making an examination of his throat with the laryngoscope, a bluish translucent growth was seen on the upper surface of the epiglottis. It was about the size of a marble, and vessels were seen coursing over its surface.

Case of Epithelioma of Tongue in a Single Woman Æt. 24.

Shown by Dr. Hamilton Burt. Patient first noticed a depression under the right side of tongue in February last, about the size of a pin's head. It appeared as though the part had been punched or sucked in. On the flow of depression she noticed a small white deposit. She took little or no notice of it. It grew very slowly, and was painless. She sought advice about three months ago, and was advised to have some stumps and bad teeth in the vicinity of growth removed. This was done, but no improvement was noticed. Dr. Burt had first seen patient about four weeks ago; the growth was then the size of a small cherry, and occupied the right side and upper part of the middle of the tongue; the base was indurated, and the surface smooth, not ulcerated, with a few tiny yellow spots

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scattered here and there, out of which, when squeezed, a yellowish fluid escaped. No enlarged glands could be felt. Taking into consideration the age of the patient, the appearance of the growth, and the absence of enlarged glands, she was put upon iodide of potassium and mercury, the iodide being increased to ʒss three times a day. Under this treatment the growth became considerably reduced at first, but in spite of the increased doses of iodide it had increased rapidly during the past ten days. The patient had not lost flesh.

Mr. de Santi considered the diagnosis to rest between malignant disease, tubercle, and syphilis. The situation of the growth on the side of the tongue, its hardness, the fact that it had arisen from irritation of a tooth, its general appearance of infiltration, were all points in favour of malignancy. On the other hand, the age of the patient was only twenty-four, and the sex female. Moreover there was an absence of glandular infection, and there was the history of almost total disappearance of the growth under iodide of potassium. Mr. de Santi, however, had seen a case of epithelioma of the tongue very similar to the case under discussion in a girl still younger, namely twenty-one; the ulceration was considered to be syphilitic though there was no history or other symptoms past or present of that disease. The patient for a short time improved under iodide, but eventually the ulceration extended rapidly and the glands became involved. Removal of one half of the tongue and of the enlarged glands was performed, but within four months the patient died of a recurrence in the glands,—in fact, the case was very rapid in its malignancy. Mr. de Santi did not think the case one of tubercle, nor was it probably syphilitic; it did not resemble a chancre, and it was almost certain that it was not gummatous; he had seen many gummata of the tongue, and they invariably affected the dorsum in its mid-line. He would advise excision of a piece of the growing margin and its examination microscopically. If malignant the earlier the case could be dealt with radically the better.

Dr. FitzGerald Powell said in his opinion the growth was an epithelioma, and was to be felt beginning to dip down deeply into the floor of the mouth. He understood that the growth had almost disappeared under antiseptic treatment, but had again grown rapidly, the treatment having been continued. He thought no time was to be lost before operating.

Dr. A. H. Burt said that under treatment by iodide of potassium the growth had almost disappeared, but within the last five days it had again come up suddenly and had spread very much more into the substance of the tongue. He had come to the conclusion that it could be nothing but malignant disease.

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Case of Recurring Ulceration in Pharynx and Larynx, thought to be Herpetic, in a Woman æt. 56.

Shown by Dr. Furniss Potter. The patient had come under observation about three weeks previously, and stated that she had been troubled with attacks of "ulcerated throat" almost continuously for the last six years, never having been free for more than ten days at a time.

On examination two small erosions were seen, one on the right posterior faucial pillar, punched-out looking and saucer-shaped; the other between the left posterior pillar and the pharyngeal wall, about a quarter of an inch in diameter and with a flat surface. The voice was husky. During the time the patient had been under observation the ulcer on the right anterior pillar had completely healed, while the one on the left side had almost disappeared. In the meantime several others had made their appearance—one on the palate, another on the edge of the epiglottis, and a third in the interarytenoid region.

The patient stated that the "spots" sometimes came on the gums, and inner surface of the lips and cheeks. She said that their appearance was generally preceded and accompanied by pricking, burning pain, a feeling of malaise, and discomfort in swallowing.

There was a history of four miscarriages and loss of hair. Between the ages of sixteen and twenty-one she had suffered from exactly similar attacks, and had been an in-patient at the Westminster Hospital for "ulcerated throat."

The appearance of the throat when first seen, together with the history, had led to a suspicion of the possibility of syphilis; and mercury and potassium iodide had been prescribed, but had been discontinued after ten days, since which the only treatment had been a mouth-wash of boric lotion, and occasional touching of the ulcers with a solution of chromic acid (30 per cent.).

Dr. Lack said he did not think this was herpes, as the individual ulcers were much too large. To him it appeared more like pemphigus.

Dr. Milligan said that the same idea had struck him as to its being pemphigus. The ulceration on the pharynx was rather large for herpes,

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but, on the other hand, the traces of small isolated areas in the larynx were rather suggestive of herpes. He asked the patient, when she first noticed the rash, what the condition was, and she said the spots were as big as the little finger-nail—which was rather against herpes.

Dr. FURNISS POTTER thought the size of the vesicles at the commencement was against the pemphigus theory; they were quite small. He had watched them from the beginning, and had observed that the surface of the ulcer was very much larger than the initial vesicle. In pemphigus one would expect to see a large bleb or bulla, but in none of these cases had there been any bleb corresponding at all to the size of the fully developed ulcer. The ulcers spread till they covered a patch about a quarter of the size of a postage stamp. They healed with great rapidity, leaving no cicatrix.

CASE OF VASCULAR NASO-PHARYNGEAL FIBROMA OF EXTENSIVE ORIGIN FINALLY REMOVED BY A COMBINED OPERATION THROUGH THE SOFT AND HARD PALATE, AND EXTENSIVE REMOVAL OF ANTERIOR WALL OF LEFT SUPER-MAXILLARY BONE.

Patient and specimen shown by Dr. HERBERT TILLEY. F. S—, male æt. 14, came to the hospital November 19th, 1901, complaining of complete nasal obstruction associated with a blood-stained discharge from the left nostril of five months' duration. For the last three weeks the discharge had been offensive, and for seven to eight weeks the right nostril had been completely occluded. It was noted that the patient was weak and anæmic. The lower half of the nose was much broadened, and the left nostril distended by a grey sloughing mass which bled freely when touched with a probe. The discharge from the left nostril was very offensive, while the right was completely occluded by marked deviation of the nasal septum. By posterior rhinoscopy the left choana was seen to be filled by a reddish mass, which passed insensibly on to the mucous membrane of the naso-pharynx. Digital examination revealed a smooth-surfaced elastic swelling which seemed to spring from the basi-sphenoidal and ethmoidal regions. There was no displacement of the left eye. Transillumination showed opacity of the left antrum.

First Operation, November 20th, 1901.—Having made an inverted ∪-shaped incision over the sides and root of the nose, the nasal bones were divided in the line of incision with a saw and the nose turned downwards on the face. This brought the growth well into view, and procured easy access to the ethmoidal

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region. The growth was seized in strong forceps and some half of it torn and cut away, but it was soon obvious that the base of the tumour was too extensive for removal through the opening. The hæmorrhage was very profuse, and could only be kept in check by compressed marine sponges forced into the nasal cavity. Respiratory difficulties arose owing to blood escaping into the larynx in spite of the post-nasal space having been plugged.

The nose was finally replaced and sutured in position; it healed by immediate union. Dr. Horne reported the growth to be an angeiofibroma, and free from any elements of malignancy. The iodoform gauze packing which was used to plug the nasal cavity at the end of the operation was removed through the nostril in forty-eight hours. The patient made a rapid recovery from the shock of the operation, and three weeks later it was determined to attempt the removal of the remainder of the growth by a different method.

Second Operation, December 7th, 1901.—Having inserted a laryngotomy tube and placed a sponge above the larynx, a Whitehead's gag was employed to keep open the mouth. With the patient's head hanging slightly backwards over the end of the table, the soft palate was completely divided in the middle line, the incision being carried forwards to the alveolar border, immediately behind the incisor teeth. The mucous membrane was stripped from the left half of the hard palate, and the latter completely removed by chisel and mallet. The growth was thus brought fully into view, and its base was seen to be attached to the left basi-sphenoidal and ethmoidal regions. Its base was seized in an ovariotomy clamp, and the greater part of the growth removed by scissors. Other smaller portions were removed by means of strong wire snares and cutting forceps. The hæmorrhage was free but under good control, and it was checked by marine sponges on holders. As far as the eye and finger could ascertain allthe tumour was removed. The patient, although only thirty-five minutes under the anæsthetic, had at the end of the operation a weak, rapid, and intermittent pulse, which quickly recovered under the influence of a rectal injection of $1\frac{1}{2}$ oz. of brandy and strychnine gr. $\frac{1}{30}$ administered hypodermically.

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The long strip of iodoform gauze which was packed into the naso-pharynx at the end of the operation was removed in forty-eight hours, and the nasal cavity subsequently irrigated three times daily with a warm alkaline wash.

The patient made a rapid recovery, but after an interval of three weeks the growth was seen to be recurring, and in the course of six to eight weeks it was obvious that further intervention would be required.

March 15*th*, 1902.—A third operation, identical in all details with the last, was carried out, but possibly a more thorough clearance of the growth was made.

A month later recurrence was visible in the region of the middle meatus, and every week during the months of May, June, and July the patient attended as an out-patient, the treatment consisting of piercing the growth in many places with the galvano-cautery. This seemed at first to retard its growth, and produced a number of puckered scars, but latterly it became increasingly obvious that the growth was increasing in size. Towards the end of July it projected through the cleft of the palate, and nasal obstruction again became complete. The lad was anxious that yet another attempt should be made to eradicate the growth, a request which received some encouragement from the report of the pathologist, viz. that there were no signs of malignancy in the piece of tumour which he had examined (*vide supra*). Since the recurrence seemed to spring from the middle meatal region, and the left antrum was very opaque on transillumination, it was decided to explore that cavity.

July 31*st*, 1902.—With the preliminaries, as in the preceding operations, an incision was made in the gingivo-labial furrow from the level of the left molar tooth across the middle line to the corresponding position on the right side. The cartilage of the nasal septum was divided along its floor by strong scissors, and the nose and soft parts of the face on the left side turned upwards, so as to fully expose the anterior surface of the left maxillary bone. The front wall of this was then completely removed, and the antral cavity found to be filled with the growth, which was very vascular and firmly attached to the whole of the posterior and upper walls. To gain more room the lower half of the ascending (nasal) process of the maxillary

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bone was removed by means of strong bone forceps. The portion of the growth extending into the mouth was then removed by a strong wire snare, the remainder was seized in a pair of powerful tonsil forceps and torn away from its attachments, leaving completely bare the left side of the basi-sphenoid, ethmoidal, and maxillary antral regions. Hæmorrhage was checked by means of marine sponges. The after treatment consisted of syringing out the nose and left antrum three times daily for three weeks with warm boracic lotion.

The patient made a rapid recovery, and left the hospital fourteen days after the operation. At the present moment (November 7th) there is no sign of recurrence, no nasal discharge, the parts appear perfectly healthy, and the patient is in robust health, having grown two inches since the first removal of the growth. It now only remains to close the cleft in the soft palate.

The PRESIDENT wished to know if there were any signs of recurrence when the young man was last seen. It was an extremely interesting case.

Dr. FITZGERALD POWELL congratulated Dr. Tilley on the result of his operations. He hoped he would be able to place the patient's mouth in a better condition, by bringing together the divided soft palate. He understood Dr. Tilley to say this was the first case recorded of a growth of this nature springing from the antrum, but he had exhibited a patient at a previous meeting of the Society from whom he had removed a fibroma through the nose which had arisen in the antrum from the under surface of the floor of the orbit and the outer wall. He had also exhibited the growth at the same meeting.

In answer to questions Dr. TILLEY pointed out—(*a*) the great value of a preliminary laryngotomy and the placing of a sponge above the larynx, in that these measures (1) prevented blood getting into the larynx, (2) they relieved the anæsthetist from anxiety, and at the same time placed that individual out of the way of the surgeon; (*b*) by dividing the soft and hard palate these growths were brought splendidly into view, and the free hæmorrhage which occurred during their removal was under absolute control.

CASE OF COMPLETE ADHESION OF SOFT PALATE TO POSTERIOR WALL OF PHARYNX.

Shown by Dr. LAMBERT LACK. The patient was a woman æt. about 30. There was complete union between the soft palate and posterior pharyngeal wall; not even the finest probe could

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be passed up from the mouth into the naso-pharynx. This was evidently the result of tertiary syphilis, although it was the only lesion, and there was no active disease. The patient had trouble in swallowing at times, occasional shooting pain in the ear but not severe, and much mucus collected in the post-nasal space, and had to be syringed away through the nose. Dr. Lack asked was operation for this condition successful, and would this patient, in view of her slight symptoms, be well advised to undergo one.

Mr. DE SANTI had had operative experience of two exactly similar cases—cases quite as complete. In the first case there was considerable pain in one ear and mastoid region, and his colleague, Mr. Spencer, bearing in mind the fact that the ordinary operations for relief of this condition were unsatisfactory, had separated the adhesions with a knife and passed stout silver sutures through the detached though short remains of the soft palate, and sutured the soft palate to the muco-periosteum of the hard palate. In fact, the stump of the soft palate was sutured tightly up—rolled up—to the hard palate, and it was left to nature to allow the sutures to cut their way out. The result was good, although later a good deal of recontraction took place. There was also very severe hæmorrhage at the time of operation. Not long after a quite similar case came under Mr. de Santi's care, and he performed the same operation. In this case there was luckily but little hæmorrhage, and the eventual result was very good. Some years had elapsed since the operation, and the patient remained well with a free passage between the naso-pharynx and the oro-pharynx, and dilatation was unnecessary. He could with confidence recommend the operation to Dr. Lack.

CASE OF PERSISTENT EPISTAXIS IN A MAN ÆT. 42.

Shown by Mr. CHARLES A. PARKER. The patient complained of epistaxis, which had lasted over twelve months and had entirely incapacitated him for work. During this period there had been constant slight hæmorrhage, and three or four times a week most severe attacks of bleeding. The bleeding came from first one nostril and then the other, but more often from the right. When first seen, in August, 1902, he was anæmic, breathless, and exhausted. On removing a plug which had been inserted into the right nostril, blood spurted from a small vessel on to the septum. The mucous membrane covering both sides of the septum as far back as could be seen was soft and boggy, and bled profusely on the slightest touch of

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a probe. Since then the condition had been treated by the constant use of the electric cautery, but without much success. The hæmorrhage could be controlled by its use for the time being, but after a day or two it recurred from other spots, and sometimes from the floor of the nose as well as the septum. A blood-count has been kindly made by Dr. Emery, who reported that the findings suggested a moderate grade of secondary anæmia, which might be due to the repeated hæmorrhages, and did not raise the suspicion of a more serious form of anæmia.

Mr. Parker raised the question of the best method for further treatment. He asked the members whether they would think it a suitable case for trying the method recently recommended by Mr. Hunter Mackenzie, namely, of denuding the septum of mucous membrane; or whether, seeing that both sides of the septum were affected, it would be justifiable to remove a portion of the septum itself.

A Case of Paralysis of the Abductors of the Vocal Cords and of the Palatal Muscles, and Slight Paresis of the Tongue, in a Man æt. 25.

Shown by Dr. Dundas Grant. J. W—, æt. 25, was first seen in March, 1900, on account of cough and groaning sound when in bed. The condition had lasted two or three months, and had come on after an attack of hiccough lasting on and off for about ten days. He had had a cough on and off for about one year, especially when drinking quickly. For six months he had occasional stridor on inspiration. Examination of the throat revealed slight paresis of the right half of the palate, but no abnormality in the movements of the tongue. The vocal cords approximated during phonation, but on inspiration the vocal processes did not move from the middle line. There was, however, an elliptical slit between the cords. The case was obviously one of paralysis of the abductors and internal tensors of both cords and paresis of half the palate, and the lesion was, therefore, in all probability one of the vagus nerves in or near the medulla oblongata.

In seeking for a cause, especially for any signs of syphilis, there were found enlarged post-cervical glands of about six months' duration, and a flat ulcer on the scalp on the parietal

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region, with slightly indurated edges. This was asserted to have been in existence for nearly three or four months, but it seems more probable that it preceded the enlargement of glands. There was also general enlargement of the lymphatic glands over the body. The pulse almost disappeared during inspiration; the knee-jerks were normal. An antisyphilitic course of treatment was instituted, and when seen a fortnight later it was reported that there was less noise in sleep since the second occasion on which the mercurial ointment was rubbed in; the vocal slit appeared to be rather wider during inspiration. There was some degree of mercurial stomatitis.

The patient disappeared from the observation of the exhibitor, but returned again a fortnight ago—namely, more than two years after being first seen—on account of great difficulty and marked inspiratory stridor, also such a degree of paralysis of the palate that fluids usually regurgitated through the nose when he drank, while his speech was so indistinct that he was obliged to pinch his nostrils in order to make himself understood at all. The protrusion of the tongue into the right cheek was not quite so strong as into the left; he was unable to channel the tongue, but was not aware of ever having been able to do this. He stated that under the previous course of treatment he recovered sufficiently to be able to attend to his work as a butcher; he was at present, however, unable to do so. He was again placed on antisyphilitic treatment, and when seen a week later reported slight improvement in the breathing and greater ease in speaking. He yesterday drew attention to the fact that he had a difficulty in raising his left arm, but he had left the out-patient department before an investigation of this symptom had been made. It remained to be seen whether or not this was due to paralysis of the muscles supplied by the spinal accessory. The reporter would be glad to have suggestions as to the possible source of infection, as there was nothing to give colour to the idea that it was hereditary, and there was no history of genital infection. It seemed possible that the ulcer on the head was developed at the site of the primary sore, but the early development of the nervous symptoms would, in that case, be remarkable. Dr. Grant hoped to show the case at the next meeting of the Society.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

SEVENTY-SEVENTH ORDINARY MEETING, *December 5th*, 1902.

E. CRESSWELL BABER, M.B., President, in the Chair.

CHARLES A. PARKER, F.R.C.S.(Ed.), } Secretaries.
JAMES DONELAN, M.B., }

Present—23 members and 4 visitors.

The minutes of the preceding meeting were read and confirmed.

The ballot was taken for John N. Donnellan, M.B., B.Ch., R.U.I., and he was declared unanimously elected.

The following cases, specimens, and experiments were shown:

CASE OF NASAL DEFORMITY IN A WOMAN.

Shown by Mr. W. R. H. STEWART. This case was shown to the Society in February, 1894. She had then suffered from a bad smell from the nose for eight years, and more recently the nose had become blocked and sore, followed by falling-in of the sides of the nose. She had been treated by Mr. Stewart by the application of an 80 per cent. solution of lactic acid and the

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passage of bougies, which was followed by some improvement. The patient then became pregnant and was lost sight of until a month ago. At the present time the alæ had quite fallen in, and there was considerable contraction in the vestibule, and the septal cartilage was bent over. The case was shown in the hope of obtaining suggestions as to treatment, operative or otherwise.

Case of Strumous Ulcers of the Mouth and Tongue.

Shown by Mr. W. R. H. Stewart. The patient, a domestic servant æt. 30, had suffered from ulcers on the tongue, lips, and cheeks for about four years, recurring at intervals and lasting for three weeks to a month. She had been under treatment for two years. Anti-specific treatment made them worse. For the last twelve months she had been taking from one to two grains of sulphide of calcium three times a day, and Angier's petroleum emulsion. At the present time she did not have so many ulcers, and they did not last more than one week. Mr. Stewart wished to know if anyone could suggest a better line of treatment.

Mr. W. G. Spencer said he thought it was a pity to apply the term "strumous" to the conditions here seen, for that term was generally understood to mean tuberculous. They were herpetic ulcers —or, rather, vesicles, for they could scarcely be called ulcers—and as such kept on recurring. They were very easily treated by some strong astringent. Mr. Butlin's treatment was 10 per cent. solution of bichromate of potassium, but even with this they reappeared in three weeks. They were attended by stinging pains.

The causes were not known, but the condition was due to something more active than nerve lesions and neuralgic pains.

Dr. Furniss Potter thought this case was like the one he had shown at the last meeting, and he should accordingly feel inclined to agree with the previous speaker in calling it a case of herpes. In his own case he had tried touching the ulcers with a 20 per cent. solution of chromic acid, but without any effect. He was of opinion that these cases were identical with those mentioned by Osler as "stomatitis neurotica chronica Jacobi."

Specimen of Malformation of the Œsophagus.

Shown by Mr. F. J. Steward. The specimen was taken from a baby who was admitted into the Hospital for Sick Children at

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the age of five days with a history that, after taking the breast, apparently the whole of the milk taken was regurgitated in about five minutes.

Examination demonstrated a complete obstruction in the œsophagus five inches from the gums.

Gastrostomy was accordingly performed, and feeding commenced at once.

The child did well at first, but sank and died nine days after operation.

The specimen would be seen to belong to the most common variety of malformation of the œsophagus.

The upper portion of the œsophagus was dilated, and ended in a blind extremity about one inch above the bifurcation of the trachea. The lower portion of the œsophagus communicated at its upper end with the trachea immediately above its bifurcation. The opening into the trachea admitted a No. 8 catheter. The actual gap in the œsophagus would be seen to be about half an inch in extent.

The other organs were healthy, with the exception of the lungs, which contained some milk presumably regurgitated.

Laryngitis Hypertrophica in a Girl æt. 21, following Prolonged Nasal Trouble.

Shown by Mr. Hunter Tod. The patient had suffered from nasal obstruction, due to continuous nasal catarrh, for five years. For the last four years she had been hoarse, and had been troubled with a severe cough and continued hawking up of mucous secretion from the throat.

She came to the London Hospital three months ago, and was found to have marked hypertrophic rhinitis, with much muco-pus trickling down the pharynx into the larynx. The larynx showed marked hypertrophy of the interarytenoid region, and also of the vocal cords, which latter were very thick, irregular, and of a red beefy appearance, and there was considerable muco-purulent secretion to be seen.

The nose was first treated, the hypertrophic tissue being removed by the snare. The nose and pharynx were now

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practically normal; there was no longer any nasal obstruction, and no muco-purulent secretion in the pharynx.

Mr. Tod said he brought forward this case in order to obtain advice as regards the further treatment.

Dr. HERBERT TILLEY advised that the interarytenoid mass should be removed by cutting forceps, and nitrate of silver frequently applied to the cords. He had completely restored the voice in a similar case by these means. The hoarseness was mainly due to the fact that the heaped-up epithelium and subepithelial connective tissue formed a wedge which prevented adduction of the vocal cords.

Mr. STEWARD said, *à propos* of Dr. Tilley's remarks, that this girl had been under his care for a great many months. He had removed large masses on four or five occasions, and she had, as in Dr. Tilley's case, recovered her voice, but for a short time only, when the trouble had all recurred. Therefore he would like to know whether Dr. Tilley's case had been watched for any length of time, and, if so, whether the improvement had been permanent.

Dr. TILLEY, in reply to Mr. Steward, said the case he had referred to had kept free for five months.

Dr. FITZGERALD POWELL thought the condition might be very much improved by daily washing the larynx with an alkaline antiseptic solution, with a view to getting away the tenacious mucus. Possibly the insufflation of alum in addition would be of benefit. The chronic condition was possibly the result of nasal obstruction and the septic discharge from the nose.

Dr. DUNDAS GRANT had described such cases as "post-rhinitic pseudo-pachydermia." He remembered a case of old standing in which rapid improvement was obtained by repeatedly washing out the nose and applying a solution of salicylic acid to the laryngeal swelling.

Mr. TOD, in reply, said he would follow Dr. Tilley's advice, and remove the interarytenoid mass.

A LANTERN DEMONSTRATION SHOWING THE NORMAL FLUCTUATIONS OF AIR-PRESSURE IN THE UPPER RESPIRATORY TRACT, BY DR. SCANES SPICER.

This demonstration was given to bring to the knowledge of those members of the Laryngological Society present some of the results of his recent investigations on the normal fluctuations of air-pressure in the upper respiratory tract, and the effect on these fluctuations of experimentally induced alteration in calibre of the nasal channels in himself. He also showed charts with observations automatically recorded on persons who did not know what was expected of them, and he invited the

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members present to repeat these experiments on themselves there and then, and test the accuracy of his conclusions. He suggested that a naturally wide rima, with the consequent diminution of normal pressure fluctuations and lessened rhythmical stimulus to circulation in the blood-vessels, leading to diminished nutrition of the walls, was the long-sought explanation of the origin of so-called atrophic rhinitis. His researches would shortly be published in detail.

The PRESIDENT thought that the Society was much indebted to Dr. Spicer for describing to them these experiments, which had extended over so long a period. In order to criticise them one would need to be a physiological physicist as well as a rhinologist. He would like to ask Dr. Spicer whether he had found the apparatus of any practical value in the diagnosis, prognosis, and treatment of cases. He understood Dr. Spicer to say that he was able to determine by the results of these experiments whether the patency of the nasal cavities was normal. He would like to know how this was done. Dr. Spicer's remarks as to the causation of atrophic rhinitis were extremely ingenious and suggestive, and lent themselves to discussion.

Dr. DUNDAS GRANT said he thought there would be no great difficulty in accepting Dr. Spicer's views, in so far as they related to physical facts, even if some members might dispute his interpretations of them. He thought the occurrence of negative pressure—if they understood what each of them meant by the use of that term in physical science—was beyond dispute. He himself was quite prepared to accept these experiments exactly as Dr. Spicer had given them; his little knowledge of physical science would have led him to anticipate such results. He suggested that they should be performed quietly before the Society, either at a special meeting or before a specially appointed sub-committee of the Society with power to add to its numbers, and that, in order to make them still more convincing, they should be carried out upon individuals who did not know what results were expected or—might he go the length of saying—desired to be obtained.

He had himself, with a roughly made manometer, tried a similar experiment to those of Dr. Spicer. By watching the rise and fall of a coloured liquid he had, in this rough way, obtained results which confirmed those of Dr. Spicer. There was also during the moment of swallowing a distinct dip in the manometer tube, much more marked if the nose was obstructed at the same time. He had also made a model in which were placed manometer tubes corresponding to the two Eustachian tubes, and he found that, in the one on the side of the nostril which he had blocked, there was, during inspiration, a more distinct dip than in the other. He allowed, however, that it was dangerous to apply to biology results derived simply from physical materials. It had always seemed a little difficult to explain why expiration did not exactly neutralise what was effected by inspiration;

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this was made very clear by Dr. Spicer. In Donders' experiment the difference in the negative pressure during inspiration and in the positive pressure during expiration was very marked, but he thought Dr. Spicer had made it more clear to them when he showed them that it was only when obstruction was present that the difference between these two was so marked as Donders found it.

He hoped that these experiments would receive the careful attention they undoubtedly deserved.

Dr. LAMBERT LACK thought Dr. Spicer's experiments were quite unreliable, and that his instruments would give any desired result. That there was a negative pressure in the upper air-passages during inspiration and a smaller positive pressure during expiration were surely facts that needed no further proof. Of necessity also these pressures were increased by any obstruction to the air stream. The unreliability of the instrument or of the method of using it had been demonstrated that afternoon by the fact that two observers found quite different effects on the air-pressure resulting from the act of swallowing. Again, Dr. Spicer demonstrated that there was no variation at all of the air-pressure in the nose when the nose was completely obstructed and mouth breathing was resorted to, although a little consideration would show that this result was absolutely at variance with all the laws of physics. There must be a negative pressure during inspiration, not only in the direct path of the air stream, but in every column of air in direct connection with it. If this were not so Dr. Spicer's instrument would not record any variations at all.

Dr. HILL thought the subject ought to be thoroughly discussed in order that they might arrive at the general opinion of the Society as a whole regarding it. Some members might discredit Dr. Spicer's interpretation of the experiments, as Dr. Lack had done; others might endorse his conclusions; and others, again, might think there was some truth in Dr. Spicer's position without exaggerating the clinical importance of negative pressure. They ought to endeavour to thresh the subject out before the forthcoming discussion on nasal obstruction in reference to some forms of middle ear disease.

Dr. SCANES SPICER, in reply to the President as to whether these experiments would have any practical value, said he thought that in doubtful cases the use of his naso-manometer, under the conditions he had stated, would afford a test of the presence or not of obstruction, and would so become a clinical stenosimeter. The apparatus afforded absolute physical evidence of the normal fluctuations of air-pressure, and also how these fluctuations were altered by obstruction. It was not necessary even to insert the tubes in the nose, for readings taken in the mouth—always, be it understood, with the precautions he had mentioned—accurately indicated the pressure conditions in the nose, and therefore whether the nasal passages were sufficiently patent, other conditions being similar. Fluctuations of the column in excess of the normal indicated stenosis. Provisionally he would suggest +7 mm. and −7 mm. of water as the limits of physiological fluctuations of pressure for ordinary quiet breathing at rest, whereas the normal appeared to be −5 and +4 respectively. Dr. Dundas Grant thought that it was hardly necessary to have experiments and physical

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measurements on these matters, for the clinical evidence of the ill effects of nasal obstruction was so overwhelming. He quite agreed we should be quite justified in all other practical work of life in acting on much less conclusive evidence than we had in clinical proofs here, but he thought that experiments and physical measurements were also necessary to remove any shadow of doubt, and to place the subject on a scientific basis. He had shown them a number of charts, the results of investigation upon persons who had no idea of physics or physiology, or what was expected of them, and the results in essentials were the same as those in himself. With reference to Dr. Grant's observations on the effect of swallowing, and on the more marked fluctuations of pressure if nasal obstruction were present, he had not observed these phenomena; but had found that, in himself at all events, there was no fluctuation of pressure in the naso-pharynx at the moment of swallowing, but a positive fluctuation during the expiration which followed. Dr. Lack would find that he could not manipulate the results at will. If he would consent to be tested with the apparatus, and allow the speaker to obstruct the former's nose, he would soon find the limits of voluntary and intentional manipulation.

A Series of Anatomical Preparations demonstrating the Artificial Production of Œdema of the Larynx.

Shown by Dr. Logan Turner. Injections of *carmine gelatine* were made into the loose submucous tissue in various situations in fresh specimens of healthy larynges. In some cases moderate, in others forcible injections under considerable pressure, were made, and in this way both the amount of development and the limitations of the loose areolar tissue were defined. The results thus obtained closely simulated the conditions met with clinically. The injection was allowed to cool and set, and the preparations were then hardened in Jores' fluid and preserved in glycerine. In this way the spread of œdema from the tonsil and lateral wall of the pharynx was demonstrated, also œdema of the glosso-epiglottic fossæ, ary-epiglottic folds and pyriform sinuses, the false cords, true cords, and subglottic region.

Specimen of Abnormal Narrowing of Larynx and Trachea, probably Congenital.

Shown by Dr. Logan Turner. This specimen was removed *post mortem* from a man æt. 70. He was markedly alcoholic,

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but apparently suffered from no respiratory difficulty during life.

The *post-mortem* examination, which was carried out by Dr. Harvey Littlejohn, from whom the specimen was obtained, showed the body to be well nourished; the thorax was markedly barrel-shaped, and there was drawing-in of the lower costal cartilages. There was considerable emphysema of the lungs and some old pleural adhesions. The pericardium was universally adherent to the heart, the aorta was dilated, and there was hypertrophy of the left ventricle.

There was no glandular or other enlargement in the neck or mediastinum.

The specimen showed the epiglottis of the infantile type being curved backwards, and there was considerable narrowing of the upper laryngeal aperture. The trachea was flattened from side to side throughout its entire length, the lumen of the tube being considerably narrowed.

The two main bronchi presented a normal contour.

Mr. W. G. Spencer wished Dr. Turner to tell them about the thyroid, as the trachea was scabbard-shaped. He asked whether there had been any hypertrophic change, followed by atrophy, which would be likely to produce a result of this kind, the isthmus acting like a strap between the two lobes.

Dr. Logan Turner, in reply to Mr. Spencer, said that at the time of the *post mortem* examination there was nothing found in the neck or the posterior mediastinum to account for the condition. There were no enlarged thyroid or lymphatic glands.

Specimen of Malignant Stricture of the Upper End of the Œsophagus.

Shown by Dr. Logan Turner. The patient was a woman æt. 58, with a history of pain and difficulty in swallowing for six months before death. She refused any palliative operation, and died after rapid emaciation. The case had additional interest from the fact that it was one of three cases of malignant disease of the œsophagus occurring in women and seen within a comparatively short period of time.

The specimen showed a stricture measuring one inch vertically, and with a diameter of 2—3 mm., lying behind the cricoid

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cartilage and upper two rings of the trachea. There was a chain of enlarged glands on the right side. The right recurrent laryngeal nerve was involved in the tumour mass. The microscope showed the tumour to be a squamous-celled carcinoma.

Case of Advanced and Inoperable Epithelioma of Epiglottis with Secondary Infection of Cervical Glands. Exhibited to illustrate Relief obtained by Removal by "Morcellement" of Primary Growth through the Mouth.

Shown by Dr. Herbert Tilley. The patient was a man æt. 52. He sought relief for fits of suffocation at night, which had become frequent and distressing. In addition he could only swallow small quantities of liquid food, and even these often caused violent fits of coughing, not uncommonly ending in regurgitation of the food. His breath was very foul, and he was losing weight rapidly. Examination revealed a fungating, sloughy mass, the size of a small hen's egg, occupying the lower half of the pharynx.

The patient was seen in consultation with Mr. Symonds, who agreed that a radical operation was inadvisable, and advised removal of the primary growth through the mouth in order to relieve symptoms.

This had been carried out in the course of several sittings by means of Krause's and Watson Williams' cutting forceps.

The relief to symptoms had been extraordinary. The patient's breathing was perfectly easy, and he could eat any food without the slightest difficulty.

His weight had increased since September (when the treatment was undertaken) by 1½ stones.

The President said that undoubtedly this man had greatly improved as regards swallowing by removal of a portion of the epiglottis.

Dr. Furniss Potter fully endorsed what Dr. Tilley had said as to the desirability of "doing something" in inoperable cases of malignant disease of the larynx where the epiglottis was involved and there was distressing dysphagia. He had had a similar case under his care last May, and he had removed about five sixths of the epiglottis with very marked relief indeed; before this the patient had suffered greatly from dysphagia, could only take liquids, and any attempt at swallowing gave great pain. The operation was performed with the galvanocautery snare, and three or four days afterwards the man was able to

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eat quite comfortably a meal of beef, potatoes, bread, etc. He would like to ask Dr. Tilley why he preferred to punch out the epiglottis (which necessitated a number of sittings) in preference to using a snare and completing the removal by one operation. In the case he referred to he had removed the epiglottis quite easily at one sitting.

In answer to Dr. Potter, Dr. TILLEY stated that it was impossible to remove the whole growth at once by a snare, because it was not sufficiently pedunculated.

CASE OF LARYNGEAL GROWTH IN A MAN ÆT. 50.

Shown by Dr. WYATT WINGRAVE. This patient, a dock labourer, æt. 50, was exhibited in April last, when there was some hesitation in expressing definite opinions as to the nature of the lesion. At that time he was somewhat hoarse, and had suffered slight dyspnœa on exertion. There were three myxœdematous-looking swellings overhanging the right half of the glottis, together with some slight œdema of the uvula.

During the interval his symptoms had greatly improved, but the growths had distinctly increased in size. He had been treated with Pot. Iodid., as he gave a dubious specific history.

He had no dyspnœa, no swallowing difficulty, and a good voice and no loss of flesh. The tendency to œdema had prohibited the removal of portions for examination.

CASE OF PARALYSIS OF THE ABDUCTORS OF THE VOCAL CORDS IN A YOUTH (SHOWN AT LAST MEETING)..

Shown by Dr. DUNDAS GRANT. The patient's palate was still in a highly paretic condition, but somewhat less than before, and in the larynx there could be now distinctly seen, during inspiration, a linear extension forwards and backwards of the elliptical slit, which alone was present between the vocal cords on the last inspection. This seemed to indicate a slight increase in the action of the abductors.

The exhibitor thought it unlikely that this could be accounted for by increasing paralysis of the internal tensors, although he was convinced that only time would settle this question.

The patient was still under treatment by means of mercurial inunctions and iodide of potassium internally.

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It should have been added to the former report that sensation on both sides of the body was practically normal, both for touch and for temperature.

Dr. Grant would like to bring the case before the Society again.

Mr. W. G. SPENCER thought this case made an interesting comparison with others of a similar character that had been shown to the Society. The man's heart-rate was very quick, being 120—130; he had doubted whether it was in excess of its normal rate, for this patient did not seem to be nervous under examination. He suggested that the lesion in this instance was bilateral and in the fourth ventricle somewhere underneath the inferior fovea on each side. He thought it was a local lesion, and it might be syphilitic; but it was also quite as possible that it was an obscure lesion of progressive muscular atrophy. It corresponded to other cases of this disease shown to the Society. There was no paralysis of the sterno-mastoid and trapezius belonging to the spinal accessory proper coming from the spinal cord, and there was, in addition, no indication of any involvement of the hypoglossal with the nerves which are usually involved about the base of the skull in syphilitic inflammation round the foramina, nor was there any sign of carious disease in the occipitals. He had not stripped the man, but the patient had evidently a weakness of the left arm, caused by the involvement of the serratus magnus, and so possibly this was a case of progressive muscular atrophy.

CASE OF COMPARATIVE HEMIANÆSTHESIA IN A YOUNG FEMALE, WITH SUBJECTIVE NASAL OBSTRUCTION ON THE AFFECTED SIDE.

Shown by Dr. DUNDAS GRANT. The patient, a female, unmarried, æt. 30, was first seen a few days ago on account of pain and noises in the right ear, attributable to chronic suppurative otitis. She complained further of the air not passing through her right nostril. On examination no obstruction sufficient to occasion this symptom was present, but the mucous membrane was found to be in a comparatively anæsthetic condition. There was found to be diminished pharyngeal reflex, increase of knee-jerks, comparative hemi-anæsthesia on the right side, and erroneous localisation of spots touched, too low on the arm, too high on the leg. Under these circumstances he looked upon the alleged nasal obstruction as being purely subjective, explainable by the patient (owing to the anæsthesia of the mucous membrane) not feeling the passage of air through the nostril, consequently not

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believing that it did pass. The foundation was probably hysterical.

Dr. FitzGerald Powell said that frequently there was some nervous trouble in these cases, and probably it existed in this woman. This subjective obstruction might be due to a choreic or spasmodic condition of the soft palate. Probably the opening was not sufficiently large to allow the patient to breathe properly, the palate being drawn up against the pharynx. When the patient exerted her will she could breathe easily through the nose.

The President did not have an opportunity of seeing the nasal cavity, but he would like to ask Dr. Grant on what grounds he based the diagnosis of subjective nasal obstruction in this case.

Dr. Pegler said this was a case in which he should have hesitated to apply the term subjective nasal obstruction, as on the right side there was slight inspiratory insufficiency due to displacement of the lower lateral cartilage and a narrow lumen.

Dr. Scanes Spicer thought that in this case the rima was obstructed by the inferior turbinals.

Dr. Dundas Grant said he had stated that there was really no obstruction at all. The only obstruction was that which existed in the patient's own mind, and the term "subjective obstruction" was most legitimately applied to such a case. Obstruction produced by contraction of the palate was not "subjective," but "objective;" it might be simply due to spasmodic action of the muscle, but then it became objective obstruction, and the word "subjective" was not applicable. He had first found out the subjective obstruction when asking the patient if she could breathe freely through the nose; she answered that she could not breathe with the right nostril, whereas in reality she was doing so at the time.

Case of Increasing Dysphagia of Six Months' Duration in a Middle-aged Man (for Diagnosis); probably Pharyngeal Epithelioma.

Shown by Dr. Dundas Grant. The patient, æt. 35, was first seen on November 20th, 1902, on account of difficulty in swallowing, which had come on gradually during the last six months. He stated that when endeavouring to swallow potato or meat he could hardly get it down at all, and when lying down in bed the saliva did not go down the throat. There was no pain. He had a thickness of the voice like that of a person with very large tonsils. On examination there was seen a projection from the wall of the pharynx, which concealed the posterior part of the ary-epiglottic folds with the cartilages of

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Santorini. The growth was so far down that it was impossible to reach it with the finger; it was seen to be bathed with a fluid which was probably saliva. There was no tendency to consumption in the family. There was just a little doubt with regard to the gland behind the left angle of the jaw, but practically at the present time there were no enlarged glands. As regards the question as to whether, by any possibility, it was a tertiary specific affection, there was no history to bear that out, but it was decided to try him with iodide of potassium, and since taking it in 10-gr. doses thrice daily for a week, he expressed himself conscious of some relief; there was, however, no change in the objective appearance.

Dr. Donelan said there was some obstruction of the œsophagus, the dysphagia was progressive, and there was now frequent regurgitation, even of fluids. He thought it a case of œsophageal stricture, probably malignant. There was some enlargement low down on the right side of the neck.

Dr. Dundas Grant said that in this case there was a projection on the posterior wall of the pharynx just above the level of the posterior margin of the larynx, which overhung the cartilages of Santorini. He took it to be the upper margin of either an epitheliomatous or a gummatous ulcer. It was situated in the lowest part of the pharynx, not in the œsophagus.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ANNUAL GENERAL MEETING, *January 9th*, 1903.

E. CRESSWELL BABER, M.B., President, in the Chair.

Present—the Honorary Officers and 15 members.

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

Mr. H. B. Robinson and Mr. Dennis Vinrace were appointed scrutineers of the ballot, and the following officers were appointed for the year:

President.—P. McBride, M.D., F.R.C.P.Ed.
Vice-Presidents.—A. A. Bowlby, F.R.C.S.; J. Dundas Grant, M.A., M.D., F.R.C.S.; Percy Kidd, M.D., F.R.C.P.; Charters J. Symonds, M.S., F.R.C.S.
Treasurer.—W. R. H. Stewart, F.R.C.S.Ed.
Librarian.—StClair Thomson, M.D.
Secretaries.—James Donelan, M.B.; E. Furniss Potter, M.D., M.R.C.P.
Council.—Felix Semon, M.D.; E. Cresswell Baber, M.B.; C. A. Parker, F.R.C.S.Ed.; W. Permewan, M.D., F.R.C.S.; Rd. Lake, F.R.C.S.; L. A. Lawrence, F.R.C.S.

The report of the Council was then read and unanimously adopted:

REPORT OF COUNCIL.

The Council has the pleasure to report that the Society continues in a most prosperous condition. During the year six new members have been elected and seven members have retired, whilst the Council has to announce, with great regret, the death of one honorary member, Professor Gerhardt, and two ordinary members, Dr. F. A. N. Bateman and Dr. Caldwell Stephen.

There has been an average attendance of thirty-two members, which

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is exceptionally large, and there has been a very abundant supply of clinical material.

The Ordinary Meeting on June 6th was devoted to a discussion on "The Diagnosis and Treatment of Malignant Stricture of the Œsophagus," introduced by Mr. Charters J. Symonds. There was a good attendance and full discussion.

The Council has made arrangements for a fuller report of the Society's proceedings in the 'Lancet' and 'Medical Press and Circular.' They have also come to a most satisfactory arrangement with the Royal Medical and Chirurgical Society with respect to the Society's Library, a matter which will be fully dealt with in the Librarian's report.

The financial position of the Society continues satisfactory, as will be seen from the Treasurer's report.

The following report of the Treasurer was read and adopted:

Our receipts this year have been £161 17*s*. 6*d*. This, with £19 18*s*. 1*d*., the balance brought forward from 1901, gives a total of £181 15*s*. 7*d*. Our expenses have been £148 9*s*. 8*d*. We thus have a balance of £33 5*s*. 11*d*.

The sum of £151 3*s*. has been received in subscriptions. Of this amount, however, no less than £23 2*s*. has been paid for arrears, one member not having paid since 1898. All these back accounts have now been collected, and only twelve members, all country ones, remain who have not paid for 1902.

The Balance-sheet, duly audited and found correct by the auditors, Mr. H. B. Robinson and Dr. F. Willcocks, is appended.

BALANCE-SHEET, 1902.

INCOME.				£	*s.*	*d.*	EXPENDITURE.	£	*s.*	*d.*
Subscriptions:							Rent	31	10	0
1902	£127	0	0				Adlard—Printing	77	18	2
1901	16	16	0				Arthur—Tongue-cloths	1	1	8
1900	4	4	0				Smith—Reporting	21	9	3
1899	1	1	0				Baker—Microscope	1	15	0
1898	1	1	0				Pulman—Binding	1	9	9
1903	1	1	0				Clarke—Indexing	1	13	0
				151	3	0	Annual Dinner	6	6	0
Entrance Fees				5	5	0	Bank charges	0	0	8
Sale of 'Proceedings'				1	9	3	Receipt Book	0	7	6
Discount (Arthur's)				0	7	2	Christmas-boxes (Porters)	0	15	0
Interest on Deposit				3	13	1	Mathew (Porter)	2	0	0
Balance from 1901				19	18	1	Secretaries' Petty Cash	1	10	5
							Treasurer	0	13	3
							Balance	33	5	11
				£181	15	7		£181	15	7

Deposit at Bank, £200.

Examined and found correct,

HY. BETHAM ROBINSON, } *Auditors.*
FREDERICK WILLCOCKS, }

W. R. H. STEWART, *Hon Treasurer*

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The Librarian's report was then read and adopted :

Owing to the regrettable failure of health on the part of our librarian, Dr. StClair Thomson, I have, at his request, undertaken to continue the duties of his office in the meantime.

I have to report to you that he has effected certain arrangements with the Royal Medical and Chirurgical Society, which our Council have approved of and consider of great advantage to our members. The terms of the arrangement are, that in return for our according to the members of the Royal Medical and Chirurgical Society the use of our library for consulting and borrowing purposes, our books, marked with distinguishing labels, are conveniently placed on the shelves of the Royal Medical and Chirurgical Society's library. Their librarians will undertake the duty of giving out and recalling our volumes, which can be borrowed whenever the library is open. We have, however, had to meet the expense of arranging and marking the books, and the Council has further sanctioned the initial expense of a typed card catalogue. I have no doubt you will authorise me to convey to Dr. StClair Thomson the expression of your thanks for the excellence of the arrangements, for which you are indebted to him. I am pleased to be able to state that his health is improving, and I am sure I may be allowed to add to my communication the expression of the hope on the part of all members of the Society that he may speedily recover and again be among them.

I have only to add that the "Exchange" periodicals have come with regularity, and that the work of binding the completed volumes is in progress.

The report of the Curator of the Morbid Growths Collection was then read and adopted :

The Curator of the Morbid Growths Collection of the Society has pleasure in presenting to the Annual Meeting a copy of the catalogue of the microscopical preparations now in the possession of the Society, and wishes to thank those members who have kindly assisted his efforts to render the cabinet as representative as possible with reference to the Society's pathological work since the date of its formation. The preparations cover a considerable field in the realm of laryngology and rhinology, but many valuable slides of great importance are absent from the collection, which it is to be hoped are yet available for its enrichment. The catalogue is divided into two portions, the first and most important of which consists of microscopic sections referred to in the 'Proceedings,' and many of which have been reported upon by the Morbid Growths Committee. The second part consists of slides bearing upon the normal and pathological histology of those regions of the head and neck with which this specialty is concerned, and which are therefore valuable for purposes of reference and comparison. A list of the normal tissue preparations, together with one or two others, was published by Dr. Dundas Grant in the January number for 1900, vol. vii, of the 'Proceedings.' These, for the most part, were contributed by the Curator in order to start the cabinet, and many others have now been added. As at present constituted the cabinet contains

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sufficient material to render a study of it worth the while of every member who is interested in the fundamental science of the specialty, and the Curator hopes the members will avail themselves of the opportunities that obtain for so doing. Aided by efficient microscopes, a complete set of the bound volumes of the 'Proceedings,' and an amply indexed catalogue containing full reference to the 'Proceedings' and 'Reports' of the Morbid Growths Committee in every instance, he trusts the members will find an inducement for visiting the collection, either at the Society's rooms or at his own residence, as they may desire.

REFERENCE CATALOGUE OF PATHOLOGICAL SECTIONS IN THE CABINET OF THE LARYNGOLOGICAL SOCIETY OF LONDON, CHRONOLOGICALLY ARRANGED, JANUARY, 1903.

I. *Nose.*

1. Papilloma of Septum, P. de Santi, November 18th, 1894, vol. ii, p. 13.
2. Regeneration of Inferior Turbinal, W. Hill, October, 1895, vol. iii, pp. 15, 42.
3. (M.G.C., No. 4.) Tuberculous Degeneration of Inferior Turbinal, W. Hill, March, 1896, vol. iii, p. 70.
4. Lupus of Inferior Turbinal, W. F. Bennett, January, 1897, vol. iv, p. 82.
5. Recurring Degeneration of Inferior Turbinal, H. Pegler, April, 1897, vol. iv, p. 75.
6. Lymphoid Hyperplasiæ of Septum, H. Pegler, December, 1897, vol. v, p. 16.
7. (M.G.C., No. 11.) (2) Recurrent Fibro-angioma of Septum, Scanes Spicer, December, 1897, vol. v, p. 19.
8. Papilloma of Septum, McL. Yearsley, April, 1898, vol. v, p. 78.
9. Hypertrophy of Septal Tubercle, A. Cheatle, November, 1898, vol. vi, p. 6.
10. Rhinoscleroma, D. Grant, April, 1900, vol. vii, p. 85.
11. Alveolar Epithelioma of Nose and Antrum, D. Grant, November, 1900, vol. viii, p. 7.
12. Squamous Papilloma of Vestibular Septum, W. Wingrave, April, 1901, vol. viii, p. 2.
13. (M.G.C., No. 28.) (2) Alveolar Epithelioma of Nose, D. Grant, April, 1902, vol. ix, p. 108.
14. (M.G.C., No. 29.) Cystic Growth of Septum (? Meningocele), H. Pegler, April, 1902, vol. ix, p. 103.

II. *Naso-pharynx.*

1. Naso-pharyngeal Cyst, A. Cheatle, November, 1898, vol. vi, p. 6.
2. Naso-pharyngeal Sarcoma, H. Pegler, January, 1900, vol. vii, p. 54.
3. (M.G.C., No. 30.) Columnar-celled Carcinoma, B. Baron, January, 1903, vol. x, p. 54.

III. *Mouth and Tongue.*

1. Fibroma of Tongue, Morley Agar, November, 1897, vol. v, p. 4.
2. (2) Epithelioma of Tongue, November, 1902, vol. x, p. 16.

IV. *Pharynx.*

1. Growth from Supra-tonsillar Fossa, A. Cheatle, April, 1898, vol. vi, p. 78.
2. Papilloma of Left Faucial Pillar, H. Sharman, May, 1898, vol. v, p. 86.
3. Papilloma of Left Tonsil, H. Sharman, May, 1898, vol. v, p. 86.
4. Epithelioma of Tonsil, L. Lack, April, 1901, vol. viii, p. 55.
5. Round-celled Sarcoma of Tonsil, McK. Johnston, June, 1901, vol. viii, p. 142.
6. (M.G.C., No. 27.) Lipoma of Pharynx, W. Milligan, January, 1902, vol. ix, p. 41.
7. Fibro-angioma of Tonsil, W. Wingrave.
8. (M.G.C., No. 31.) Inflammatory Growth from Tonsil, L. Lack, January, 1903, vol. x, p. 51.

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V. *Larynx.*

1. Angioma of Larynx, P. Kidd, January, 1894, vol. i, p. 63.
2. (M.G.C., No. 6.) Spheroidal-celled Carcinoma of Larynx, W. G. Spencer, November, 1896, vol. iv, p. 10.
3. (M.G.C., No. 5.) Carcinoma of Cricoid and Larynx, W. G. Spencer, November, 1896, and June, 1897; four slides, larynx, neck, lung and liver.
4. (M.G.C., No. 13.) Recurrent Growth of Larynx (? Epithelioma), J. W. Bond, June, 1897, vol. iv, p. 104.
5. Malignant Growth of Right Vocal Cord, F. Potter, November, 1897, vol. v, p. 35.
6. (M.G.C., No. 15.) Carcinoma of Epiglottis, W. G. Spencer, February, 1898, vol. v, p. 49.
7. (2) Malignant Growth of Left Vocal Cord, C. A. Parker, January, 1899, vol. vi, p. 43.
8. (M.G.C., No. 19.) Fibro-angioma of Left Vocal Cord, F. Potter, November, 1899, vol. vi, p. 1.
9. Syphilitic Stenotic Mass from Larynx, W. G. Spencer, February, 1900, vol. vii, p. 62.
10. (M.G.C., No. 21.) (2) Round-celled Sarcoma of Larynx, F. Potter, November, 1899, vol. vi, p. 1.
11. (M.G.C., No. 20.) Glandular Sarcoma of Larynx, R. Lake, March, 1900, vol. vii, p. 71.
12. Squamous Papilloma of Larynx, W. Wingrave, November, 1900, vol. viii, p. 11.
13. (M.G.C., Nos. 22, 23, 24.) Benign Papilloma of Larynx, M. Hovell, May, 1901, vol. viii, p. 120.
14. Subglottic Polypus, W. G. Spencer.

VI. *Thyroid Gland.*

1. Fibrosis of Thyroid Gland, W. G. Spencer, October, 1894, vol. ii, p. 24.
2. Parathyroid Tumour, P. de Santi, June, 1899, vol. vi, p. 104.
3. Sarcoma of Thyroid Gland, D. Grant, November, 1900, vol. viii, p. 9.

It was proposed by Dr. Vinrace, and seconded by Dr. Donelan, "That this meeting give the Council permission to approach the Council of the Otological Society with a view of the two bodies jointly nominating a Committee, which shall practically investigate the question of the results of intra-nasal operations in chronic non-suppurative middle ear disease." This was carried *nem. con.*

The meeting then adjourned.

SEVENTY-EIGHTH ORDINARY MEETING, *January 9th*, 1903.

E. CRESSWELL BABER, M.B., President, in the Chair.

CHARLES A. PARKER, F.R.C.S.(Ed.), }
JAMES DONELAN, M.B., } Secretaries.

Present—32 members and 2 visitors.

The minutes of the preceding meeting were read and confirmed.

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The following gentlemen were nominated as Honorary Members of the Society:

Professor G. Killian, Freiburg-im-Breisgau.
Professor Lermoyez, Paris.
Dr. P. Schech, Munich.
Dr. E. Schmiegelow, Copenhagen.

As Ordinary Member:

Arthur Stanley Cobbledick, M.D., B.S.Lond., 402, Brixton Road, S.W.

The following cases, specimens, and instruments were shown:

Sequel to a Case of Ulceration of the Left Tonsil, with Acute and Considerable Enlargement of Numerous Cervical Lymphatic Glands on Both Sides of the Neck. ? Malignancy.

Shown at the Meeting on November 7th, 1902, by Sir Felix Semon. The case was shown again as affording a valuable lesson to the effect that not every ulceration of a tonsil in old people, accompanied by enlargement of numerous cervical glands, must be looked upon as necessarily malignant. It would be seen that the ulceration of the left tonsil had quite disappeared, and the tonsil itself had become much smaller, whilst the enlargement of the cervical lymphatic glands on both sides of the neck had also considerably diminished, even more so on the side corresponding to the affected tonsil than on the opposite one. In all probability septic influences had been at work. Malignancy, at any rate, was now completely excluded.

The President congratulated Sir Felix Semon on the successful result of this case.

A New Design for Sphenoidal Sinus Cutting Forceps.

Shown by Dr. Watson Williams.

Dr. Dundas Grant expressed his admiration for the instrument, which he calculated would be extremely useful. It was for use in a dangerous region, and accordingly extra care had to be exercised. He

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had sometimes been able to expose the region without removing normal structures by means of long-bladed nasal specula. There was an illustration of one of these in Mr. Baber's book; the pattern he himself used was devised by Killian, with which, after one had forcibly pressed the middle turbinal to one side, a view of the anterior surface of the sphenoid, large enough for inspection and for the introduction of suitable punch-forceps, was obtained. He had brought with him some sphenoidal sinus cutting forceps, which he would show to the Society and describe later on in the evening if time permitted.

Dr. Bronner thought quite as good results were to be obtained with cutting forceps, and without the danger necessarily attached to pointed instruments.

Dr. Lack considered these forceps very dangerous; it was not safe to open a sphenoidal sinus without a good view of the natural opening. If the opening were first brought into view it could be enlarged quite easily and safely, but any attempt to perforate the anterior wall of the sinus without previously ascertaining its extent or even its existence must be dangerous under any circumstances.

The President said that he was inclined to agree with Dr. Lack, because if one could not see the natural opening it seemed dangerous to push a sharply pointed instrument into the sphenoidal sinus. As regards Killian's specula, which Dr. Grant had mentioned, it occurred to him that they were somewhat like Markusovsky's speculum.

Mr. W. G. Spencer, continuing the line of argument brought forward by Dr. Lack, suggested that it was much safer to operate externally, as for the frontal sinus; a curved incision should be made round the inner angle of the orbit to just a little outside the nasal duct. Then the soft structures should be turned downwards and outwards, when the thin orbital plate of the ethmoid would be exposed, and so render it possible to do what the previous speaker had mentioned, viz. see what was being done. This, in his opinion, was a far safer method than that of opening the sphenoidal sinus as proposed by Dr. Williams.

Dr. McBride asked Dr. Williams how often he had used these forceps and with what result;—that was the important point.

Dr. Powell asked Dr. Williams what was the result from his experience of operations on the sphenoidal sinuses, and whether he had had many cures resulting from operative interference in this locality. Personally, he had a number of cases coming into his hands which had been operated on by other surgeons, where the sphenoidal sinuses had been opened, and he could only say that their last state was considerably worse than their first.

Dr. Watson Williams, in reply, admitted that the instrument was dangerous inasmuch as any operation on the sphenoidal sinuses was dangerous. But it must be remembered that sphenoidal sinus disease was very dangerous also. Everything depended on the care with which the forceps were used, and he presupposed that the remarks which had been made started on these premises. He himself never used any force in entering a sphenoidal sinus, and he did not consider these forceps were dangerous if used with proper care. If an opening had to be made into a sphenoidal sinus, it was easier and safer to make it

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lower down than in the position of the natural orifice, and unless it could readily be seen he never troubled about the natural opening. He had only just recently designed this instrument, and had used it once with entire satisfaction. It was an improvement on those he had been in the habit of using in the few cases he had had under his care. If the sphenoidal sinus did not exist in any case it was because that one had a solid sphenoidal body. Therefore the non-existence of the sphenoidal sinuses robbed such an instrument as this of any real danger, providing care and gentleness were used. These forceps slipped in with the greatest ease through the thin turbinated bone which forms the anterior wall of the sphenoidal sinuses; and it was through this very thin portion that he always entered the sinuses.

Drawing with Notes of a Case of Suppurative Ethmoiditis and Frontal Sinusitis after Radical Operation for Nasal Polypi.

Shown by Dr. Adolph Bronner. In the section of laryngology at the Manchester meeting of the B.M.A., Dr. Bronner had stated that, in his opinion, the so-called radical operation for nasal polypi was not devoid of danger, and that he knew of several cases which had been followed by meningitis and death. He was not at liberty to give details of these cases, as he had heard of them *privately*, and had no permission to publish them. He was very sorry to have now to report a case of his own.

Miss K—, æt. 20, was seen on July 24th, 1900. Both nostrils had been blocked for several years, and there had been a copious, purulent discharge. No pain or special discomfort. Both nostrils were completely filled with polypi and degenerated mucous membrane of the lower turbinated bones.

On September 18th, 1900, both nostrils were scraped with Meyer's ring, and the mucous membrane of the lower turbinated bones removed. Insufflations of iodoformogene and boric acid were ordered. The patient was seen again in June, 1901. There had been extensive recurrence of the polypi from the upper turbinated bone. It was again scraped.

On August 14th the patient was seen again. Numerous polypi were removed by the cold snare. There was, however, rapid recurrence. On October 28th, 1902, Meyer's ring was again used under chloroform. Insufflations of aristol and boric acid were ordered. The patient was seen on November 7th and

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20th. There was no pain, but very slight tenderness over the right frontal sinus. There had been no recurrence of the polypi, but there was very slight purulent discharge from the region of the frontal and anterior ethmoidal cells. On December 2nd the patient was brought into the hospital. For nine days she had intense pain in the nose and head, and there was swelling of the nose and forehead. She was semi-comatose; there was well-marked swelling of the centre of the forehead and bridge of nose, extending into cheek, and slight paresis of the right side. Temperature 104°.

On December 3rd an incision was made above the right eyebrow; much pus escaped, the bone was rough. The right frontal sinus was found to be full of pus. The dura was exposed and bulging; on incision there was no pus. The left frontal sinus was opened; there was very little pus. The dura was exposed and opened, and a large quantity of pus escaped. The opening was enlarged and free drainage established. The patient was relieved for twelve hours, and then became more and more comatose and died.

On post-mortem examination the anterior part of left frontal lobe was seen to be necrosed, and evidences of purulent meningitis were seen commencing on the left side, extending backwards on the base of the brain (well marked over the pons) as far as the medulla. The lateral ventricles were full of sero-pus. The whole of the ethmoid bone was necrosed and filled with pus, and the crista galli was quite loose and detached.

In this case the infection evidently originated in the ethmoid bone.

Sir Felix Semon congratulated Dr. Bronner on his courage in bringing forward such a case, by which frank act one learnt more than from any amount of mere hearsay reports.

Dr. Lack hoped that every one who had such cases would bring them forward with details, so that they might all learn something from them. He would not criticise this case until he had seen a full report of it.

Dr. Bronner said that the fact that there had been recurrence proved that he had not used excessive force; recurrence would not have taken place if he had removed the greater part of the cells. The more one scraped away the greater was the danger of cerebral complications.

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Case of Functional Aphonia in a Man with Unusual Symptoms.

Shown by Dr. Lambert Lack. The patient, a male æt. 58, had lost his voice suddenly six months ago, and had never regained it. He spoke now in a whisper, but with much strain. The expiratory muscles were all tense, and the pulse became more rapid during speech. On examining the larynx the parts appeared to be normal, and the movements were normal until attempted phonation, when the larynx appeared to be tightly closed and to prevent all air escaping.

It was probably a case of spasm of the larynx, but the patient was not able to say even one word in a loud voice, thereby differing from most similar cases, in which one or more words can be loudly uttered at the beginning of each sentence. On the other hand, the patient could sing loudly and naturally. Another point of interest was that he had a similar attack the previous year, losing and regaining his voice quite suddenly. He had not used his voice excessively, although he had shouted at times. He had recently lost a sister with tubercular laryngitis. It was possible that suggestion had something to do with his present condition.

Dr. McBride thought this case one of great interest. It was a case of spastic aphonia. The abdominal muscles were tense when the patient attempted to speak. The interesting point about the case was that the false cords covered the true cords when phonation was attempted. He had observed in certain voice users, who complained of early fatigue of the voice, a similar condition, but to a less marked extent. He wondered if other members had observed it also? The parts during rest were normal, but on attempted phonation there was apparently hypertrophy of one or other, or of both false cords. Whether this was to be looked upon as a "missing" or early stage of spastic aphonia or dysphonia was a point which had interested him for some years.

Sections of Ulcer of Tonsil Showing Tubercles, but which had yielded to Antisyphilitic Remedies.

Shown by Dr. Lambert Lack. The patient, a female æt. 25, had had a large ulcer with clean cut edges and sloughly irregular

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base covering the right tonsil and posterior pillar of the fauces. There was much dysphagia, and the patient was anæmic and rapidly wasting. The glands were tender and enlarged. A diagnosis of tertiary syphilis was made, and the patient placed on large doses of potassium iodide. She had, however, seen other specialists who had considered the case to be possibly malignant or tubercular. By special request, therefore, a small piece of the ulcer was excised for microscopical examination. The sections showed that the mass of the ulcer consisted of granulation tissue with newly-formed capillary loops, but at the deeper part of the ulcer were tubercle-like nodules consisting of giant-cells, surrounded by epithelioid and round cells. This seemed to confirm the cautious diagnosis which had been previously given in the case. In spite of it, however, the ulcer, which at first was as large as a two-shilling piece, had diminished to half its size in a week, and was completely healed in a fortnight under the iodide treatment alone. The patient three months later remained perfectly well. Was the case to be regarded as one of syphilis or of mixed infection? There was no history of syphilis to be obtained.

The specimen was referred to the Morbid Growths Committee.

Microscopic Section of Cyst of Ventricle of Larynx opened when Operating on a Case of Malignant Disease.

Shown by Dr. Lambert Lack. The patient, a male, had malignant disease of the right vocal cord, etc., for which an operation was performed. Previous to operation a smooth, fixed, hard swelling was noticed overlying and apparently attached to the cornu of the hyoid bone. There were no enlarged glands. On cutting across the ventricular band during the thyrotomy there was a sudden gush of creamy fluid, nearly two drachms escaping. The swelling over the hyoid bone disappeared. At first it seemed as if an abscess had been opened, but after consideration and exploration it was considered more likely that the cavity was a cyst-like projection from the ventricle, such as was normally present in certain apes, *e.g.* the orang-outang, and was rarely met with in man. This diagnosis was

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confirmed by sections of part of the wall which was excised, and which showed that the cavity was lined by ciliated epithelium.

Pathological Specimens.

Shown by Mr. Lake. 1. Section of new growth removed from the posterior extremity of the inferior turbinate body (right) of a man æt. 50. The history was one of nasal obstruction of some years' standing, increasing considerably just before the operation. The patient has not been heard of since.

2. From a male shown by Dr. Pegler and Mr. Lake in 1900. This was from a recurrence; both left inferior turbinate and septum were involved.

3. Section of right inferior turbinate from patient æt. 72, who had been under Mr. Lake ten years ago for lupus nasi of thirty-five years' duration. This had been cured after it had penetrated the right tear duct. Two and a half years ago some swelling appeared at the site of the old infection of the tear duct, with nasal hæmorrhage. There was a small ulcer visible on the upper surface of the inferior turbinate. Finsen's rays were employed for a year, when Mr. Lake saw him again. The ulcer was larger, and there was apparently an invasion of the tissues about the nasal bones by what looked like new growth. The inferior turbinate (right) was removed, and pronounced to be carcinomatous by a pathologist. The disease was considered to be too extensive for operation by Mr. Arbuthnot Lane, but X rays had kept the patient comfortable, and appeared to be able to control the spread of the growth, though not to absolutely "cure" it.

Dr. Pegler had pleasure in recommending that these sections, and Dr. Barclay Baron's (*see* page 54), which required careful study, should be referred to the Morbid Growths Committee. Dr. Pegler said he had only been able to give the sections under the microscope a very cursory observation, and had not had an opportunity of examining the patient. He had formed an impression that naso-pharyngeal sarcomata were in certain cases very loosely attached to the surface from which they sprang, and might in early stages be easily mistaken, as they gave little evidence of malignancy. Some three or

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more years ago, a young man of twenty-five came to his out-patient department complaining of nasal obstruction, in whom the usual digital examination detached several loose fragments of tissue feeling like adenoid growths, which were expelled through the nostrils. A short time since, this patient returned to the hospital, and on admission his naso-pharynx and nasal chambers were found to be completely obstructed by the disease. He was shown to the Society ('Proceedings,' vol. vii, Jan. 7, 1899). The masses were removed as thoroughly as possible under chloroform by forceps, and Mr. Lake, who assisted in the operation, was to-day exhibiting sections of the growth. Previous specimens showed all the characters of mixed-celled sarcoma; fortunately examples of those sections were in the cabinet. The patient had been lost sight of since his discharge.

The specimens were referred to the Morbid Growths Committee.

Case of Large Swelling of the Mucous Membrane in the Inter-arytenoid Region (so-called Interarytenoid "Pachydermia.")

Shown by Dr. Herbert Tilley. The patient, a male æt. 48, had not been addicted to alchohol or excessive tobacco smoking. He complained of hoarseness of two months' duration.

The patient was a particularly robust-looking man. In the interarytenoid region was a sessile, red, congested swelling, about the size of a large horse bean, which prevented complete adduction of the vocal cords.

Dr. FitzGerald Powell said he noticed that Dr. Tilley had a note at the end of the title of this case to the effect that this was a case of "so-called interarytenoid pachydermia." He presumed from that that Dr. Tilley did not believe in the existence of interarytenoid pachydermia. He himself had always understood that the heaping up of the epithelium and hyperplasia of the connective tissue on the cords and in the interarytenoid space would be looked upon as pachydermia. Evidently it was not pachydermia in this case, or it would not have disappeared so quickly, but probably just a general swelling of mucous membrane simulating pachydermia.

Sir Felix Semon thought that the observation made by Dr. Powell was perfectly justified. This was not a case of pachydermia. In order to speak of pachydermia, metaplasia was necessary, *i. e.* a change of the epithelium into an epidermal structure. The present case was simply an instance of hyperplasia.

Dr. Herbert Tilley, in reply, said that his reason for putting at the end of the description of his case the words "so-called inter-

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arytenoid pachydermia" was in order to enter a slight protest against the loose way in which the word "pachydermia" was so often applied to any form of hypertrophy of the mucosa in the interarytenoid space. He did not consider this a case of pachydermia, but a localised form of chronic laryngitis. He thought one ought to confine the term "pachydermia" to those cases in which there was an overgrowth of the epithelium and subepithelial connective tissues, such as were most often met with on the vocal cords, where a prominence on the one cord seemed on adduction to apply itself to a corresponding depression on the other cord. In this particular patient there was a very swollen, congested condition of the interarytenoid mucous membrane, and he proposed removing it with Watson Williams' intra-laryngeal "punch forceps."

Specimen of Large Naso-pharyngeal Fibro-myxoma with Prolongations extending to Anterior Nares.

Shown by Dr. Donelan. The patient, a youth æt. 18, had suffered from marked nasal obstruction and defective speech since his second year. When seen he appeared to have a large mucous polypus in each nostril, and a growth about the size of a walnut projected slightly below the soft palate, in pulling or pushing which the polypi were moved. The large growth was sessile, springing from the vault of the pharynx immediately behind the vomer. It was seized with forceps and came away together with the anterior prolongations, leaving the patient's nasal passages perfectly free.

Case of Naso-pharyngeal Malignant Disease.

Shown by Dr. Barclay Baron. The patient, a woman æt. 50 years, had complained of deafness, obstructed nostrils, and discharge of blood and pus, for about eight months. Three months ago a hard, irregular growth had been scraped out of the naso-pharynx, with relief of all the symptoms. Now they had all returned, and there was much pain in the jaw and temple, especially on the right side, which was swollen. The naso-pharynx was filled with growth, which protruded into the nostrils, especially the right one. It was hard and ulcerated. The nature of the growth was uncertain, lympho-sarcomatous

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looking in parts, but with islands of ephithelial cells in others. Dr. Baron asked for suggestions as to treatment; he was not inclined to curette again, but preferred either to leave it alone or deal with it more radically.

The PRESIDENT said the disease seemed to affect not only the naso-pharynx, but also the nasal cavity on that side. Therefore, if any operation of a radical character were performed, it would either have to be through the palate, or an external operation.

Dr. MCBRIDE said this case seemed to him to be one of very great interest. There was, to start with, the growth in the naso-pharynx and also one in the right nostril. He had no doubt that the pathological report was absolutely correct. The one point which struck him forcibly was that in a malignant case one would have expected more marked ulceration and sloughing than had taken place in this case after the removal of the growth. Then another point arising in connection with that just mentioned was that this was probably a lympho-sarcoma; it would be worth while to try large doses of arsenic. He had seen several cases of lympho-sarcoma disappear wonderfully quickly under the influence of arsenic. He called to mind one case with a very large tonsil, which was reduced almost to its normal size by this means. The patient died of malignant abdominal disease within a relatively few months afterwards in the north. She went to a home, but he was unable to hear the details of the last illness, and there was no post-mortem. In connection with malignant disease, he might refer to a case of extreme interest which he had to deal with some time ago. The patient, a gentleman, came to him with a very large ulcer in front of the epiglottis at the back of the tongue, while there was a large, fixed, glandular mass in the neck. It looked specific, and he gave him iodide of potassium and mercurial inunctions, but they had no effect at all. He then tried him with large doses of arsenic, but this also was of no use. He might say he wished to punch a piece out for microscopical examination, but the patient refused to allow him. He went on with the iodide and arsenic for a long time, but without much benefit. Later the patient met a friend in Glasgow, who acted somewhat unprofessionally, but nevertheless for the patient's good. The patient's friend saw his prescriptions, and ordered him, instead of arsenic, cacodylate of sodium—another arsenical preparation. In about five weeks' time the patient was so much better that he said to him, "Go and show yourself to Dr. McBride." He came, and was undoubtedly very much improved. The ulcer had quite healed, but the cervical tumour remained. Later on he died, but the speaker did not know from what cause, and was unable to give any histological history of this case.

Mr. SPENCER said that cases of lympho-sarcoma differed from other forms of malignant disease, inasmuch as a surgeon could operate on them partly and remove a part of the growth with benefit to the patient. He should advise removal piecemeal, or that a large portion should be removed, and that this treatment should be followed by

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giving arsenic and iodide of potassium, which drugs should give considerable benefit for a long time. There were many cases of malignant sarcoma—not only the most malignant and generally considered hopeless cases, but also those moderate forms of the disease—where one could do a partial removal with benefit to the patient. As regards arsenic, undoubtedly there were certain preparations of this drug which were much more valuable than others in their action. He remembered a case which he had seen with Dr. Hall, and in which he had taken away portions of a large mass of lympho-sarcoma from the neck, where they had considerable difficulty in finding the particular preparation of arsenic which was most suitable to the case; in this case it was, so far as he remembered, the hydrochloride. This might explain what had been said of the new one, the cacodylate of sodium.

Dr. Tilley remarked that he had had the opportunity of putting his finger into the post-nasal space, and he found its posterior and upper parts were covered by a large, well-marked, ulcerated surface, which was somewhat hard to the touch. No bleeding followed the examination. He was rather inclined to doubt the probability of its being a lympho-sarcoma. The feel of the ulcerated surface was suggestive of epithelioma. He would suggest that if operative treatment were attempted, a laryngotomy tube should be first inserted, a sponge placed above the larynx, the soft palate divided, and, if necessary, some of the hard palate also removed. Such measures would give a full view of the growth, and hæmorrhage could be readily controlled.

Dr. Baron thought that the method mentioned by Dr. Tilley was the only one likely to do any good. For a case like this a curetting operation was of no value, since the disease was too deeply situated. He had left a section with the Morbid Growths Committee, in case they should care to make use of it.

A Case of Epithelioma of the Larynx in a Man æt. 60.

Shown by Mr. Attwood Thorne. This man was first seen at the London Throat Hospital on December 16th. He had then suffered from hoarseness for six months, and slight pain on swallowing for a few days.

A view of the larynx (which was only obtained with difficulty) showed that the left cord was fixed in the mid-line, and that there was a growth involving the left arytenoid and extending into the ary-epiglottic fold on that side. The larynx was slightly tender when examined from without, and there was a large gland just under the ramus of the jaw on the left side. There was a good deal of pain referred to the left ear, and restlessness at night. The man was of good physique, a

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carpenter still pursuing his trade. He had two healthy grown-up children, and denied having had syphilis.

He was put on fifteen grains of potassium iodide and a drachm of Liq. Hyd. Perchlor., and for the last fortnight had been an in-patient. With the exception that there had been temporary swelling for a few days of the right arytenoid, there had been little to note, except that the enlarged gland had somewhat increased in size.

Mr. Thorne said he would be obliged by any suggestions as to treatment. He personally did not think that any operation would prolong the patient's life, or add to his comfort.

Dr. LACK said there was no epithelioma in the larynx; but there was a growth on the outer edge of the aryteno-epiglottic fold which he should think was epitheliomatous. It would be extremely difficult to remove it, and if an attempt was made, pharyngotomy, not laryngotomy, was required.

Mr. WAGGETT had watched the case for some days. The left side of the larynx was completely fixed, and the left arytenoid region and ventricular band were considerably swollen. Below the level of the vocal cord, which could not be distinguished, there was occasionally to be seen a growth which appeared to be pedunculated. He had no doubt that the disease had commenced within the larynx, both the history and the clinical appearances pointing in this direction. Dysphagia was absent. The question of making an exploratory laryngo fissure in this case was an open one. He would be glad to know the actual experience of surgeons who had performed this operation in cases which proved on inspection to be beyond radical treatment. Did the laryngo fissure seriously compromise the subsequent condition of the patient?

Sir FELIX SEMON said that the left side of the larynx was completely fixed, and this pointed to infiltration of the inside of the larynx itself. The growth had probably commenced in the lower part of the larynx. With regard to the question of operation, he would not directly oppose an exploratory laryngotomy, but his experience was that in such cases the disease was usually found to be much more advanced than had appeared on mere inspection and palpation, and the results usually were not gratifying.

Dr. LACK admitted that there was fixation and thickening of the left side of the larynx, but considered this was due to spreading inwards of a growth commencing on the outside in the pharynx. There was no epithelioma in the larynx.

Dr. GRANT remarked that the interior of the larynx seemed to him to be very definitely affected, and he also should feel disinclined to advise any operation because of the large extrinsic mass.

Dr. MCBRIDE said that probably the disease began inside and passed over the arytenoid.

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Mr. THORNE, in reply, said that hoarseness had come on about six months ago. He himself had been of the opinion that it would be a mistake to undertake any operation, and he was glad to have this view confirmed. There was no pain on swallowing until three weeks ago, when the man first came under his care.

CASE OF INFILTRATION OF PHARYNX AND POST-NASAL SPACE IN A MAN ÆT. 45.

Shown by Dr. FITZGERALD POWELL. The patient had complained of inability to sleep with his mouth closed. He stated about six months ago he found that he woke himself up with a loud snoring; this had gradually become more marked, occurring more frequently. He said that since present trouble began he could fall asleep at any time. He had no pain, and was gaining flesh. There was no interference with deglutition or phonation, and there was no history of syphilis obtainable.

On examination, the whole of the pharynx, more especially the left lateral wall, and the post-nasal space were found to be the seat for considerable infiltration and thickening, giving the appearance of bulging. There was slight swelling of the edge of the epiglottis on the left side.

The tongue was marked with deep fissures and cracks. The uvula was attached along both its free borders to the posterior pillars of the fauces. The arms and wrists and inside of foot showed patches of eruption, apparently dry eczema.

He had been treated with iodide of potassium and mercury.

CASE OF GROWTH IN POST-NASAL SPACE APPEARING BELOW SOFT PALATE IN AN INFANT ÆT. 18 MONTHS.

Shown by Dr. FITZGERALD POWELL. The mother stated the child cried as if it "had a stoppage," and during sleep made a whistling noise. She said that she had noticed it from the time of the child's birth, and that the noise was not any worse now than it was then. There had been no discharge or hæmorrhage from nose. The child was flabby, and backward for its age.

On examination, a reddish-looking growth, a little larger than the uvula, was seen protruding below the margin of the soft

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palate. On seizing it with a pair of forceps and running the finger up along the growth, it was felt to be elongated and pedicle-shaped, growing from the vault of the pharynx. Considerable traction was made on it with the forceps, but it appeared to be tough and resisting.

Dr. Powell proposed putting the child under an anæsthetic and removing it.

The PRESIDENT said that the edge of a growth could be seen behind the uvula. An opinion as to its nature could not be given except after palpation.

EPULIDES OR SYMMETRICAL SWELLINGS OF GUM AT THE POSTERIOR ENDS OF THE ALVEOLAR BORDER IN A FEMALE ÆT. 37.

Shown by Mr. W. G. SPENCER. The patient had worn a plate for seven years, and had noted the swelling for one year, with pain. The dental plate now worn reached back only to the front of the swelling.

Mr. VINRACE ventured to suggest that this case lent itself to a very simple explanation. It seemed to him to be due to a combination of mechanical action and slow inflammatory process. He had ascertained from the patient that she had worn a plate constantly day and night for seven years, and it would be observed that the growth was immediately adjacent and in contact with the margin of the plate; consequently he thought that whatever had been the cause of the swellings, they were largely regulated by the presence of the plate.

Dr. DONELAN asked Mr. Spencer if he considered symmetry an essential characteristic of an epulis, because, from the title of the paper, he inferred this to be the case. An epulis might be symmetrical, of course, but it was not a necessary characteristic. He agreed with Mr. Vinrace as to the possible effect of the pressure of the plate, but he noticed that it was in those parts—both in front and behind—where the plate did not press that these enlargements were present. The swellings behind the plate which were described as epulides were apparently caused by the pressure of food between the lower plate and the upper gums producing a thickening of ordinary fibrous tissue. So far as his recollection went, he was under the impression that an epulis was connected with bone changes, and that there must be some inflammatory disease of the bone to set up an epulis; but there was no evidence of that in this case.

Mr. WAGGETT believed this to be an exaggerated example of the tuberous swelling of the posterior end of the upper alveolus which was very frequently to be seen in the mouths of adults. His attention was

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constantly drawn to these swellings in making sketches of the mouth and fauces, and he believed them to be of no clinical importance.

Mr. SPENCER said he thought the swellings of the gum were connected with the tooth-plate, either directly or indirectly. He did not propose to do anything to the patient, unless suggestions were made that she might get worse if he did not. He did not see the necessity of taking away the swellings, which were simply fibrous hypertrophy; he brought the patient to the Society to see if any member thought the removal necessary. The case had been sent to him as one of epulis, with a swelling of the gum.

CASE OF NASAL TUMOUR IN A MAN ÆT. 26.

Shown by Dr. KELSON. The patient had had a fibrous polypus removed eight years ago, and recurrence had now taken place.

CASE OF LARYNGEAL GROWTH IN A WOMAN.

Shown by Dr. KELSON. The patient (shown at a previous meeting) had suffered from aphonia, due to a rounded growth originating in the left ventricle which had prevented approximation of the cords.

The growth had been removed, and specimens shown under the microscope pointed to its being a fibroma undergoing mucoid degeneration.

CASE OF HEREDITARY SPECIFIC PERFORATION OF THE ANTERIOR PILLAR OF THE FAUCES.

Shown by Dr. DUNDAS GRANT. The patient, a boy, æt. 15, was seen for the first time on January 8th, 1903, on account of pain and difficulty in swallowing. He was found to have an elliptical opening in the left anterior pillar, with thick congested edges covered with a greyish-white slough. Behind it on the tonsil was also a fairly circumscribed excavation with a sloughy floor. The symptoms were of fourteen days' duration, and there was well-marked evidence of a hereditary specific dyscrasia. The exhibitor brought the case before the Society because the opening was very similar to the congenital slit observed in several

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instances by members of the Society. He thought it would be interesting to observe at a later stage to what degree the opening would resemble the congenital malformation.

The **President** considered it to be a case of inherited syphilis. The perforation did not look at all as if it were congenital.

Dr. **Grant** said it was difficult to foresee what the appearance would be after the gummatous disease had been cured. It would probably be very much like what they had seen in the congenital cases (but not symmetrical).

Case of Chronic Laryngitis with Inter-Arytenoid Pseudo-pachydermic Swelling, probably due to Purulent Rhinitis.

Shown by Dr. Dundas Grant. The patient, a girl, æt. 20, was first seen the week previous on account of hoarseness, which was worst in the morning, and which had lasted for two months; similar hoarseness was present during the whole of the previous winter, but had disappeared as that season passed off. There were crusts on the vocal cords and on the summit of a sessile swelling, which interfered with the apposition of the cords. This swelling was irregular, and presented a white, sodden appearance. The patient was the subject of muco-purulent rhinitis, and the secretion tended to dry in the nose. There was deviation of the septum into the right nostril, and the right middle turbinated body was hypertrophied. The exhibitor considered the laryngitic condition to be the result of the inhalation of morbid secretion from the nose, and that the swelling in the inter-arytenoid space, which simulated pachydermia, was the result of proliferation and maceration of the superficial epithelium. He had prescribed a simple nasal wash, and the patient, presented at the Society, stated that the hoarseness had very much diminished during the week that the nasal wash had been employed. The swelling in the inter-arytenoid space had become somewhat smaller.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

SEVENTY-NINTH ORDINARY MEETING, *February 6th*, 1903.

P. MCBRIDE, M.D., F.R.C.P.Ed., President, in the Chair.

JAMES DONELAN, M.B.,
E. FURNISS POTTER, M.D., } Secretaries.

Present—30 members and 2 visitors.

The minutes of the previous meeting were read and confirmed.

The ballot was taken for the following gentlemen, who were unanimously elected as Honorary Members:

Professor G. Killian, Freiburg-im-Breisgau.
Professor Lermoyez, Paris.
Dr. P. Schech, Munich.
Dr. G. Schmiegelow, Copenhagen.

As Ordinary Member:

Arthur Stanley Cobbledick, M.D., B.S.Lond.

The following report of the Morbid Growths Committee was read:

Dr. BARCLAY BARON's specimen (*vide* 'Proceedings,' January, 1903).—The Committee considered that it was a columnar-celled carcinoma, showing the characteristics of the epithelium of the place of origin. Between the infiltrating columns was a large amount of round-celled infiltration.

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Dr. LACK's specimen—tonsil—(*vide* 'Proceedings,' January, 1903).—The Committee considered that there was no sufficient evidence of tubercle. A giant-cell was seen in a lymph-space, and the whole specimen showed evidence of inflammatory change without any special characteristics.

Dr. DUNDAS GRANT's specimen (*vide* 'Proceedings,' April, 1902).—The Committee considered that it was a columnar-celled carcinoma of the antrum, the appearance having been much altered by small-celled infiltration following the operations, and recurrences.

The following cases, specimens, and instruments were shown:

MICROSCOPICAL SECTION OF A TUBERCULOUS PACHYDERMIA FROM THE PROCESSUS VOCALIS.

Shown by Mr. LAKE. The epithelium was thickened, and the subepithelial tissue consisted of a mass of small, round cells.

CASE OF LARYNGEAL TUBERCULOSIS.

Shown by Mr. LAKE. The right vocal cord was thickened and covered with granulations, with ulceration at the junction of its anterior and middle thirds. The left ventricular band was ulcerated, and there was also moderate enlargement of the arytenoids.

Mr. R. LAKE, in reply to a question by Dr. W. Hill, said that the signs in the chest were not very marked, but there was involvement of both bases. The patient was under the care of Dr. Weber.

CASE OF PARALYSIS OF THE LEFT VOCAL CORD DUE TO LEAD-POISONING.

Shown by Mr. CHARTERS SYMONDS. The patient, a girl æt. 18, exhibited the usual paralysis of the limbs seen in this malady, and besides had paralysis of many muscles of the trunk. A blue line on the gums was marked. The left cord lay in the cadaveric position, and did not move on phonation. The rarity of the laryngeal affection was commented upon.

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Sir **Felix Semon** said that the co-existence of abductor paralysis with paralysis of the internal tensors was a very interesting feature in this case. According to modern researches the form of paralysis seemed to vary with every poison. In lead-poisoning, the abductors were most frequently affected. It was well known that for this reason horses working in lead-mills had frequently to be tracheotomised.

Dr. **de Havilland Hall** thought that there was also paralysis of the right internal tensor. It struck him that there was quite as much tensor paralysis on the right as on the left side.

Dr. **Dennis Vinrace** asked whether this was an isolated case, or whether there was an epidemic of lead-poisoning in the neighbourhood.

Septotome for use in Moure's and other Operations for Deflection.

Shown by Dr. Pegler. The instrument was an adaptation of existing patterns of the best design, and could be had in two sizes, differing only, however, in the length of the cutting parts, which measured 1·75 and 2·25 cm. (about $\frac{5}{8}$ and $\frac{7}{8}$ of an inch) respectively. These blades were modified from those of Moure's scissors, but they were narrower, somewhat probe-ended, for the protection of the limina vestibuli; their cutting edges were all but parallel, and they were symmetrical. Moreover their necks or shanks were much less curved or bowed, and at the junction of the latter with the blades there was no bending on the flat. The remainder of the instrument closely resembled the straight-cutting pliers of Asch, but there was an addition of two powerful springs. The result of the combination was a simple and handy septotome, which worked well in practice. The springs ensured the disengagement of the blades after closure upon the septum, an action which expedited operation, whereas strength and precision were secured by symmetry, and the absence of angles in the shanks. Of the two sizes, the smaller was probably the more generally applicable; the slight increase in the length of the blade in No. 2 could scarcely obviate the necessity for extending the primary maxillary incision in osteo-cartilaginous deflections. The septotome was made for the exhibitor by Messrs. Mayer and Meltzer.

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Case of Unilateral (Right) Swelling of the Thyroid Gland in a Woman Æt. 50.

Shown by Mr. de Santi. The tumour had been growing for five or six years, and was an ordinary parenchymatous swelling of the right half of the thyroid gland. The interest of the case consisted in the very great displacement of the whole of the larynx and trachea to the left side. The woman had been for some months lately subject to bad attacks of dyspnœa, due to the pressure on the displaced larynx and trachea, and on the right pneumogastric nerve. Taking this fact into consideration, Mr. de Santi was strongly of opinion that removal of the enlarged half of the thyroid should be performed, and brought the case forward for corroboration of this opinion.

Sir Felix Semon thought that the right lobe of the thyroid gland should be removed, since it both pushed the larynx to the left and also exerted pressure on the laryngeal nerves. This pressure might become dangerous if the tumour were to suddenly increase in size, as by internal hæmorrhage.

Dr. Dundas Grant thought that the operation should be carried out as soon as possible, for if delay occurred both the larynx and the trachea might lose their resiliency.

Mr. P. de Santi said that he would advise the patient to undergo the operation.

Microscopical Sections of Nasal Growths of the type of "Bleeding Polypus of the Septum."

Shown by Dr. Brown Kelly. 1 *and* 2. *Bleeding polypi of the septum.* 3. *Alar polypus.* 4. *Sarcomatoid tumour of the septum.*

The four growths, sections of which were shown, were related histologically, although they differed from the clinical standpoint.

All four were composed of a connective-tissue framework supporting fibro-cellular masses through which numerous blood-vessels coursed. Many of the blood-vessels were dilated to form sinuses. In each case one or other constituent predominated and gave the growth its special character.

1 and 2. The clinical features of these bleeding polypi were

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typical of this class of tumour. The structure of one was that of a soft fibroma; the other was rather that of an angio-fibroma.

3. The alar polypus was about the size of a hazel-nut. It was attached to the left ala, near the anterior angle of the vestibule, by a thin pedicle which sprang from the region where the skin passes into mucous membrane. The microscopical characters of the growth closely agreed with those of the bleeding polypi just referred to.

This case was of interest on account of the unusual seat of attachment. Only one case of bleeding polypus of the ala could be found on record (Masip). The growth from which the section now exhibited was taken had originated in much the same way as a bleeding polypus of the septum; a small "pimple" had been first noticed, this had bled readily, and after each severe hæmorrhage the tumour had seemed to become larger.

4. The sarcomatoid growth illustrated how a serious error in diagnosis might arise. The patient, a man æt. 20, had complained of frequent epistaxis of four months' duration, and of subsequent, gradually increasing nasal obstruction. On examination, a purplish sessile growth was found filling the anterior part of the right nasal fossa.

The whole extent of the growth could not be determined, but it seemed to originate from the bony as well as the cartilaginous septum. In consequence of the pressure exercised by it, the superior lateral cartilage was elevated, causing considerable external deformity, and the cartilaginous septum was deviated so as almost to occlude the other nasal fossa. The tumour was regarded as sarcomatous, and a portion was removed for microscopic examination.

After this the patient passed out of notice, and was not seen again for two years. He then stated that the snaring of the piece of growth had cured him, but having been put in prison he had been unable to report himself earlier.

The only indication now apparent of previous disease in the nose, was an extensive smooth scar at the former site of the tumour, from which a delicate synechia crossed to the anterior part of the inferior turbinate. The deviation of the cartilaginous septum was much less, and the external deformity had altogether disappeared.

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Sections showed the removed portion of the growth to be of a uniformly cellular character in its deeper part, an appearance which, taken in conjunction with the clinical history and aspect of the case, would naturally have led to a diagnosis of sarcoma.

Various writers and several members of this Society, particularly Dr. StClair Thomson and Dr. William Hill, had referred to the misleading histological characters of certain nasal tumours. This case was reported to show that a benign growth of the septum may assume macroscopically, as well as microscopically, characters of malignancy.

In reply to Mr. Waggett, Dr. Brown Kelly said he should be pleased to send the sections to the Morbid Growths Committee.

Case of Tabes with Early and Unusual Implication of various Cerebral Nerves.

Shown by Sir Felix Semon. For the following careful abstract Sir Felix Semon was indebted to Dr. T. Grainger Stewart, House Physician to the National Hospital for Epilepsy and Paralysis, Queen Square:

The patient was a stud-groom, æt. 46, married.

Complaint.—Tightness round waist, difficulty in speech and in swallowing.

Duration of above symptoms, six months; has had lightning pains for two years.

Family history.—Good; married for eighteen years; six healthy children, none dead, no miscarriages.

Previous health.—Good till twenty-four years ago, when he had some *kind of venereal disease*; denies any secondary symptoms. Never had any throat affection.

Present illness.—*Two years ago* "lightning pains" in lower extremities. *Six months ago* "tight feeling" round abdomen at level of umbilicus. *Five months ago* he began to have trouble with his throat, which consisted of a difficulty in swallowing solids; no trouble with fluids. *Four weeks ago* feeling of numbness in inside of left cheek, which later changed into right; now quite free. *Three weeks ago* voice began to get weaker. *Two weeks ago* his wife noticed that he made a peculiar noise when he was asleep. He replied that he was going to turn a "roarer." *One week ago* right eyelid began to droop, and patient had diplopia for one day. *Three days ago* some difficulty in starting micturition.

Never any loss of sight or hearing; no gastric or laryngeal crisis; no difficulty in walking at daytime or night; never any pains in tongue or throat.

Present condition.—A rubicund man with tortuous temporal arteries; general health good; also mental.

Special senses.—*Smell* and *hearing* good. *Taste* slightly affected on left side of tongue. *Sight:* Right, $\frac{6}{8}$; left, $\frac{6}{8}$. *Fields* not contracted. *Optic discs:* Left, normal; right edge of disc soft, not blurred. Condition due to a retinal œdema

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which causes a slight haze. Arteries suggestive of granular kidney, being irregular and "silver-wired."

Cranial nerves.—III, IV, VI. Weakness of right internal rectus; drooping of right upper eyelid; right pupil larger than left; right, no reaction to light; left, faint to strong light. Both pupils react to convergence. V. *Motor,* normal; *sensory,* slight affection left side. VII. Slight weakness right side, general, passing off. XII. Tongue deviates to right when protruded; other movements all good. IX, X. *Soft palate: Volitional movement* abolished; *Reflex irritability* completely abolished; *tactile sensibility* more affected than four weeks ago; *slight* touches not felt on either side; *forcible probing* felt and localised on right, not felt on left; touching on middle line felt on right. Electrical reactions of soft palate: *Faradism,* no response to moderate current; *galvanism,* twelve cells KCC greater than ACC; no polar change.

Larynx: Vocal cords slightly excavated, being, in quiet respiration, 4 mm. apart. *On deep inspiration* not further abducted. *On phonation* come promptly together. *On deep inspiration* following phonation, right vocal cord is moved outward a shade more than left; there are no ataxic movements of vocal cords. During examination had an attack of coughing with characteristic laryngeal stridor—inspiratory.

Motor system not affected; *sensory system,* slight analgesia ulnar sides of both upper extremities, a band across chest, and some change in legs; girdle sensation, numbness in tip of second fingers. *Reflexes, deep, arm*-jerks diminished; *knee- and ankle*-jerks absent; *plantars,* indefinite, flexor; *organic,* some trouble in starting micturition; *swallowing* solids difficult, fluids not unless patient is in a hurry.

General health.—Aortic second sound accentuated; *urine* low sp. gr., with trace of albumen; no hypertonia, no Charcot joint, no perforating ulcer; *nails more brittle.*

Remarks.—The point of interest in the case was, as stated above, the early and unusual implication of various cerebral nerves. It was, of course, well known that laryngeal abductor paralysis sometimes was one of the earliest, if not the earliest, signs of tabes, and might even be present at the time when the patellar reflexes were not yet lost. Sir Felix Semon had demonstrated a case of that kind some years ago at the Laryngological Society, but he had never seen a case in which so complete a paralysis of the soft palate as that witnessed in this case was amongst the early symptoms of tabes; and, indeed, he did not remember, amongst the very many cases of tabes with laryngeal complications which he had seen, a single one in which paralysis of the soft palate had played any *rôle.*

The second point of interest was that, in spite of the complete motor paralysis of the palate, swallowing of fluids did not produce regurgitation through the nose when he drank slowly.

Thirdly, it was very remarkable that, seeing how complete the paralysis of the palate was, the tongue should, until a few days ago, have so completely escaped. As a rule, when there was paralysis of the palate and the larynx, there was a triad, the

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tongue being also, and often enough even preponderately, implicated.

Fourthly, it was remarkable that there were considerable vacillations of the clinical symptoms, the paralytic phenomena in the tongue, the palate, the larynx, and the eyelids being distinctly more marked on some days than on others.

Finally, it might be observed that the patient had had no laryngeal crises at any time of the illness, but that his breathing now at nights was distinctly stridulous and sonorous.

The PRESIDENT said he would like to hear whether members had seen anything approaching the bilateral paralysis of the pharynx. He had had a case which he had shown to Sir Felix Semon in which there were bilateral paralysis of the abductors, unilateral paresis of the palate and tachycardia, without other bulbar symptoms. The condition had remained stationary for years.

CASE OF ANKYLOSIS OF LEFT CRICO-ARYTENOID ARTICULATION IN A WOMAN ÆT. 23.

Shown by Dr. DONELAN. This case was shown on account of one of its less obvious features. The patient, a French lady æt. 23, when twelve years old had been seen by Dr. Landouzy, of Paris, who considered she was suffering from incipient tuberculosis. She, however, had apparently recovered, and had remained in good health until six years ago, when she had what appeared to have been influenza with acute laryngitis. Previously she had had an excellent speaking and singing voice, but at this time had completely lost it for about three weeks, after which it had gradually grown stronger. During the attack she had been treated by her family doctor, but hæmoptysis having occurred a consultation had taken place, when the opinion had been given that the case was one of pulmonary tuberculosis and chronic laryngitis. The hæmoptysis had continued at intervals for over a year, when it had ceased, and except for her defective voice she had been quite well since.

The most obvious symptoms were those of left adductor paralysis. She produced her present voice by compensatory approximation of the right vocal cord. There were no thoracic

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signs, pulmonary, vascular, or glandular, and there were no evidences of former pulmonary lesions or impairment. The paralysis was complicated by ankylosis of the crico-arytenoid articulation, as evidenced by the absence of displacement of the affected cartilage on phonation, and by immobility on the application of a probe under cocaine.

The case was regarded as one of left adductor paralysis occurring in the course of an acute laryngeal influenza, with subsequent bleeding from the laryngeal or tracheal mucus membrane, and in which ankylosis of the inflamed joint had supervened.

The patient had had no treatment of the larynx, except during the acute stage, and as in her present employment a better voice was very desirable, the opinion of the members was asked as to whether at this distance of time it would be advisable to attempt to set free the articulation, and try faradisation.

The PRESIDENT thought that the left arytenoid seemed completely immobile.

Sir FELIX SEMON thought there was hardly sufficient evidence to show that ankylosis had supervened upon the paralysis. There was no tumefaction about the base, nor enlargement of the immobile arytenoid cartilage. Whilst not contesting the possibility of the order of events sketched by Dr. Donelan, he considered it "not proven." Therapeutically, he thought electricity would be harmless, but, on the other hand, it was not likely to be of any benefit. Surgical measures did not appear justifiable to him.

Dr. DONELAN, in reply, said that it was, of course, impossible for him to offer more than a suggestion as to the sequence of events which took place in a case which had occurred so long ago and was not under his observation. As he had previously mentioned, he based his diagnosis of ankylosis on the fact that the arytenoid of the affected side was not disturbed by the impact of the other in phonation, and also resisted attempts to move it with a probe. It seemed to him the natural course that the development of ankylosis should follow, rather than accompany, the changes due to the initial inflammation.

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Case of Polypoid Tumour of the Nasal Septum in a Woman Æt. 33. Three Months' Duration. Microscopical Section Exhibited. Diagnosis (?).

Shown by Mr. Hunter Tod. The tumour grew from the anterior part of the septum, on the left side, and almost protruded from the nostril. There had been several attacks of severe bleeding. The growth was polypoid, with a sessile base. Only a small piece had been removed, in order to obtain a microscopic examination. There was considerable bleeding after this small operation, the nose requiring to be packed for some hours.

Mr. Tod desired particular attention to be given to the microscopic section. He presumed the growth to be of the class known as "bleeding polypus of the septum." The section showed very dilated vessels, around which was a definite tumour formation of cells of the endothelial variety. Dr. Bullock, pathologist to the London Hospital, had suggested the name "hæmangio-perithelioma" or "perivascular endothelioma" to describe the growth.

Mr. Tod wished to know if this growth should be considered benign or not, and if mere snaring off the growth would be sufficient, or would it be desirable to remove part of the septum with it?

The President had had a similar case. The tumour was completely removed on two occasions. The first time it was pronounced by an expert pathologist to be an adenoma. It recurred in a few weeks and was again removed. On this occasion it was pronounced to be a sarcoma, but had never returned.

Dr. Dundas Grant said it would be desirable that these specimens should be submitted to the Morbid Growths Committee. He referred to a similar case of his own, in which the report of a pathologist of high repute had been entirely indefinite. Many of the growths originating in the septum seemed to baffle the histologists.

Dr. Pegler remarked upon the puzzling character of many microscopical sections of tissue from the region of the septum, owing to this so-called sarcomatoid character. A section which he had placed in the Society's cabinet, of a small growth from the vestibular septum, had been pronounced to be a sarcoma by experts from its microscopical appearance, and had been labelled as such, but had shown no evidence of malignancy or recurrence.

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Mr. DE SANTI stated that these simple-looking (from a clinical point of view) tumours occurred not infrequently in the vestibule, and had pathologically—or, at all events, microscopically—all the appearance of sarcomatous tissue, but were absolutely benign in their clinical behaviour.

The PRESIDENT proposed that the matter should be referred to the Morbid Growths Committee. The motion was carried *nem. con.*

Mr. HUNTER TOD, in reply, said he would remove the growth as suggested, and would be pleased to submit sections to the Morbid Growths Committee.

CASE OF LARYNGEAL OBSTRUCTION.

Shown by Mr. W. H. R. STEWART. The patient had been shown at the January meeting in 1897. She then had the following history:—"Breathing badly for eight or nine months, rapidly becoming worse. No history pointing to malignancy, tubercle, syphilis, or injury." The opinions of members at that meeting had varied considerably. One member diagnosed the case as "simple inflammation," another thought there was a foreign body, a third suggested albuminuria, a fourth syphilis, and a fifth tubercle. Tracheotomy had to be performed immediately she entered the hospital, and thyrotomy a few days after. According to the notes, a soft round growth was removed from below the left vocal cord. Unfortunately the pathologist's report had been mislaid, and its import had not been remembered. The patient did well, though there was some difficulty in getting the wound to heal. The voice returned, and she remained well until a year ago, when pain on breathing and shortness of breath came on, and the voice became gradually worse. There was now some subglottic growth on the right side of the larynx. She also complained that when she coughed, something came up and blocked the throat, and she could not breathe until it had gone back again. A month ago she had had a bad attack of bronchitis, and when seen two days ago the whole larynx was swollen and stiff, the left side especially seeming hardly to move.

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Case of Frontal Sinus Disease showing Marked Expansion.

Shown by Mr. F. J. Steward. Alfred G—, æt. 36, was first seen on January 23rd, 1903, and gave the following history:—Towards the end of 1901 he had developed nasal obstruction, and in December some polypi had been removed. In the following May a swelling had formed on the left side of the nose, close to the inner angle of the orbit; this had gradually increased in size, and burst a month later, discharging yellow pus. After about a month the sinus had healed spontaneously. The patient had been well until September, 1902, when the present swelling of the frontal region had commenced and steadily increased, without pain or any other symptom, except occasional discharge from the left nostril.

When seen on January 23rd there was marked swelling in the frontal region, clearly due to expansion of both frontal sinuses, the most prominent part projecting fully one inch beyond the normal surface of the bone. Pus was also seen in the anterior part of each middle meatus. A few small polypi were removed from the left side, and an attempt was made to pass a cannula into the frontal sinus without success. During the past fortnight free discharge had taken place from both nostrils, and the frontal swelling had markedly diminished, although it was still considerable.

The chief points of interest in the case appeared to be (1) the great expansion that had taken place without perforation, (2) the rapidity of the expansion, (3) the rapid diminution of the swelling during the last fortnight, and (4) the fact that the distension of the left frontal sinus did not lead to discharge through the old sinus.

Dr. Dundas Grant said there seemed to be some softening of the bone, apparently periostitis associated with the frontal sinus suppuration. He should be disposed to treat it actively with antisyphilitic remedies. Sometimes in this region one met with tuberculous disease of the frontal bone, but in this case he should first think of syphilis; as far as his experience went, when a frontal sinusitis was pointing to the surface of the bone it did not select that region. He thought there must be some specific condition present.

Mr. Steward, in reply, said that the patient had been treated with antisyphilitic remedies, but with no appreciable benefit.

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Case of Malignant Disease in the neighbourhood of the Right Eustachian Tube in a Man Æt. 69.

Shown by Mr. Waggett. The patient was a man of strong physique complaining of pain and tinnitus in the right ear, of two months' duration. Nose and throat symptoms completely absent. The drum membrane of the right ear was markedly retracted, and its vessels injected. The right Eustachian eminence was involved in a firm, infiltrating, new growth, which extended behind the posterior wall of the naso-pharynx on the right side. The whole mass was not much larger than the yolk of an egg. The history, evidence, and result of anti-specific treatment negatived the probability of syphilis.

Mr. de Santi said that he had not been able to obtain a sufficiently good view of the growth to enable him to make any accurate diagnosis; if Mr. Waggett's diagnosis of malignant disease were correct he did not think any operation would be justifiable.

Case of Disease of both Frontal Sinuses in a Man Æt. 29.

Shown by Dr. Furniss Potter. The patient had been under observation for two and a half years, the only trouble complained of being discharge from the nose. This had not been profuse—the patient not requiring to use more than two handkerchiefs a day,—but was increased by cold weather. The drainage was ample, the fronto-nasal canals being especially patent, a curved probe being able to be passed into either sinus with great ease.

There was marked tendency to the recurrence of polypi in the neighbourhood of the fronto-nasal canals, which had been repeatedly removed by snare and curetting. The patient was a soldier, and had been ordered to a station where it would be impossible for him to remain under observation. The case was shown as one in which the indication was not considered sufficient to justify the performance of a "radical" operation.

Dr. Pegler thought that, in spite of Dr. Potter's asseverations as to much having been done in the direction of clearing away granula-

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tion-tissue from the region of the hiatus, there was still much to be done with the curette, after which a more satisfactory drainage would probably render further radical treatment unnecessary.

Dr. Grant asked if the sinus had been irrigated. Dr. Potter had evidently been passing a probe, and if he could pass a probe he could introduce a cannula. He thought this plan of treatment might be given a trial.

Dr. Furniss Potter, in reply to Dr. Pegler's suggestion, said that both sides had been curetted very freely indeed with Meyer's ring-knife, and there was still great tendency to recurrenee. If the patient were about to continue under his care, he should curette him again, and repeat the operation as often as might be necessary. He had not irrigated the sinuses, but he would like to have an opportunity of adopting Dr. Grant's suggestion. He did not agree with Dr. Hill that the mischief was principally in the ethmoidal region. Having observed the patient very carefully for two and a half years, he felt convinced that the chief trouble was in the frontal sinuses; he did not think there was any extensive ethmoidal disease. There was persistent recurrence of polypi—in spite of frequent curetting—in the neighbourhood of the fronto-nasal canals, the result of the irritation of the discharge. Unfortunately the man had been ordered to a distant station, and he was therefore unable to continue further treatment.

Case of Chronic Œdema of Larynx. ? Amyloid.

Shown by Dr. Dundas Grant. Mrs. I—, æt. 45, was first seen January 8th, 1903, on account of difficulty in swallowing, without pain. This had commenced about twelve months ago. It had been associated with slight hoarseness, most marked in the morning, and the voice had now the tone suggestive of a swelling in the pharynx. The larynx was the seat of a pale, somewhat solid œdema of the epiglottis and both aryepiglottic folds, especially the left; the cords appeared to be normal and mobile, though the left one (which was only partially visible) was somewhat restricted in its excursions. There was no ulceration anywhere, but the palate and pillars of the fauces, especially the left one, were somewhat thickened. The patient had been losing flesh for the last three years, and had become pale, whereas she formerly had had a good colour. The urine was scanty and free from albumen; there was no history of prolonged suppuration; no suppurating gingivitis; no evidence of tuberculous or specific infection; no enlargement of glands. The swelling seemed rather solid for simple œdema, too inactive

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for tuberculosis, and the suggestion occurred that it might be a form of amyloid change; the spleen was perceptible, and probably enlarged. The liver dulness was considerable, but, pending examination by a skilled physician, the exhibitor would not dwell upon this. He would be glad of suggestions in the meantime as to diagnosis and treatment.

Sir FELIX SEMON said he was greatly interested in this case. It was so recently that he had brought a similar case before the Society (November, 1902), when he had also read notes of three other cases, that many of those present would remember that the subject of his first case, whom he saw many years ago, was the wife of a medical practitioner who had come to him with a general infiltration of the uvula, epiglottis, soft palate and larynx. At first sight no one would have doubted but that it was a case of tuberculous disease. The only thing which had struck him as being unusual had been the infiltration of the pharynx and arches of the palate just mentioned. He had examined the chest very carefully, but had found no evidence of tuberculous disease. He had tried various remedies, local and general, for nearly two years without effecting any improvement, and the patient had finally left him. Two years later the patient had come back, and the infiltration had disappeared, although she had been under no treatment in the meanwhile. Dr. Dundas Grant had spoken of the case as one of amyloid disease. He (the speaker) wished to emphasise that he had merely spoken, when bringing his last case before the Society, of a lardaceous *appearance*, as he had no proof that the affection was actually connected with amyloid disease; the look of the parts merely reminded one most of the appearance of a kidney which had undergone lardaceous degeneration—this, they would agree with him, after having seen Dr. Grant's case, was a perfectly justifiable comparison. He hoped sincerely that the sequence of events in this case would be the same as in his own, but the spontaneous disappearance of the infiltration did not help them in the least as to its pathology. Since he had shown his last case he had read the original description of Quincke's disease, and felt sure the cases in question did not belong to that category. Following the suggestion of Dr. FitzGerald Powell, he had removed with his patient's consent the uvula, and had submitted it for microscopical examination to Mr. Shattock, who found no evidence of amyloid disease; the only thing he had so far found at a preliminary examination was an enormous infiltration of round-cells. He was now waiting for a further report. He wished once more to express his pleasure that the Society had had an opportunity of seeing a particularly interesting instance of a hitherto-undescribed and certainly pathologically very obscure case.

Dr. DE HAVILLAND HALL said that the laryngeal aspect of this patient reminded him of the case of a man shown to the Society six or seven years ago, the diagnosis of which had been very doubtful at the time; some members suggested lupus, and others a chronic tuberculous condition. The disease had made gradual progress, and some eighteen

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months after showing the patient Mr. De Santi had performed tracheotomy. He had lived three years after this operation, enjoying a fairly healthy life, but eventually had died of pulmonary tuberculosis. The condition had therefore probably been a tuberculous infiltration; there had never been any ulceration, simply a pale puffy swelling of the epiglottis and aryepiglottic folds, and the mucous membrane covering the arytenoid cartilages. The aspect had been, in fact, much the same as in this patient, but in the case he was relating the pharynx and soft palate had not been involved.

Dr. Brown Kelly had had a somewhat similar case, which he had described two years ago in the 'Lancet' under the name of "sclerotic hyperplasia of the pharynx." He thought the President had had an opportunity of examining the case. The most marked change had been in the pharynx. The uvula had been immensely enlarged, being not only elongated but also generally increased in size; and the lateral parts of the posterior pharyngeal wall had presented great and uniform thickening. The roof of the naso-pharynx had undergone similar changes. Treatment had had no effect on the condition. There was no history of syphilis, and antisyphilitic remedies had given no benefit. The last occasion on which he had seen the patient he had noticed that there was a tendency for the whole condition to grow less. He had cut off a large piece of the uvula and had examined it, but was unable off-hand to give details of the microscopical structure. These, however, together with illustrations of the pharyngeal appearances, might be found in the article referred to.

Dr. Grant, in reply, referred to several cases of amyloid changes in the larynx described in an article in a recent number of 'Münchener Medicinischen Wochenschrift.' He was bound to say that the examination of the rest of the body, which he had described to the Society, rather contradicted the idea of amyloid disease, being negative as far as that was concerned. He thought these cases extremely puzzling, but no doubt as their experience of them accumulated they might be less in the dark than they were at present. He felt very uncertain about the real nature of this one. Quincke's disease was a more sudden thing, which passed off quickly.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

EIGHTIETH ORDINARY MEETING, *March 6th,* 1903.

P. McBRIDE, M.D., F.R.C.P.Ed., President, in the Chair.

JAMES DONELAN, M.B.,
E. FURNISS POTTER, M.D., } Secretaries.

Present—38 Members.

The minutes of the previous meeting were read and confirmed.

The following gentleman was nominated for election as an Ordinary Member of the Society:

J. A. Knowles Renshaw, M.D.Cantab.

The following cases, specimens, and instruments were shown:

SPECIMEN OF COLUMNAR-CELLED CARCINOMA OF THE NASO-PHARYNX FROM A MAN ÆT. 63.

Shown by Dr. BRONNER. The patient was first seen in April, 1898, when he complained of nasal obstruction and discharge from the nose. There was a good deal of hypertrophic rhinitis, and a small, soft tumour could be felt in the naso-pharynx growing from the roof and posterior wall. It bled freely on touch. A piece was removed and examined by the Clinical Research Association, who reported that "the growth from the naso-pharynx is a very soft columnar-celled carcinoma, covered with intact mucous membrane. The character of the growth suggests an origin in the antrum."

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Insufflations and a formalin spray were used, and part of the growth was removed every three or four months, until May, 1902. It was then rather larger than when first seen, but did not project below the soft palate, and only slightly into the posterior nares. From that time the growth spread rapidly, and the patient died in October, 1902.

At the time of death there was well-marked exophthalmos and optic atrophy, with cerebral symptoms. There had never been much pain.

The case was of interest in many respects. Columnar-celled carcinoma in the naso-pharynx was very rare; the growth, although of the soft type, had only slightly increased in size in four and a half years; was it possible that the application of formalin had arrested its growth? The absence of pain was also very unusual.

Sir Felix Semon, in reply to Dr. Bronner's question, said he did not put much belief in the efficacy of the formalin injection; it was the nature of these cases to be of long duration. It was, indeed, well known that malignant disease in the nose took a much longer course than malignant disease in many other parts of the body, and a duration of three or four years for a case of malignant disease of the nose was nothing very uncommon; he had seen several cases where it had existed as long as that. He was not prepared to say off-hand that columnar-celled carcinoma grew more rapidly than the squamous variety, but in this connection he would mention the following case:— He had now under his care a girl æt. 21 years, with a soft growth in the posterior part of the nose, and with enormous infiltration of the cervical lymphatic glands on both sides of the neck. The patient had been seen by various observers, and amongst others by Dr. Dundas Grant, who would perhaps remember that the case had been almost stationary for a period of more than six months; at the present time it was making very little, if any, progress.

Dr. Bronner asked Sir Felix Semon if he had not noticed that the soft columnar-celled carcinoma grew much quicker than the squamous kind. The softer and the more vascular a carcinoma was, the quicker was its growth in most cases.

A Case of Dislocation of Bones of Nose due to Polypi, in a Man æt. 60.

Shown by Dr. Kelson. The patient had suffered from nasal polypi for fifteen years, and nasal deformity for six years. The

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left nasal bone was separated from the frontal, ethmoid, and superior maxilla, and was perforated from pressure. The patient had no headache, and only very slight discharge (muco-purulent).

Case of Bleeding Polypus of the Nose in a Girl æt. 15.

Shown by Dr. Kelson. The growth originated below the anterior extremity of left superior turbinate body, and was first noticed four months ago. It had twice been removed, with temporary cessation of the hæmorrhage. Microscopical examination showed a similar structure to the ordinary mucous polypus, but with more round-cell infiltration.

The President considered this a case of great interest, since, though he had seen several cases with some distension of the nasal bones, he had only seen one where this feature was much more marked than in the present instance. In the case he was referring to he extracted quite an enormous number of polypi from the nose, and eventually got the patient into a fairly good condition. With the polypi some sequestra came away. What struck him in the case under notice was the unusually large quantity of pus in the nostril. He would suggest that there might be an affection of one or more of the accessory cavities, and he thought in a case of this kind it would perhaps be a safer policy to have some tissue removed, and examined microscopically, since the naked-eye diagnosis between polypus and malignant growth was not always very simple.

Dr. Kelson said that trans-illumination had given no evidence of pus in the antra, for both sides were fairly translucent. He would make some sections of the polypi.

Case illustrating an Operative Procedure for the Relief of almost Complete Adhesion of the Soft Palate to the Posterior Pharyngeal Wall—the Result of Tertiary Syphilis.

Shown by Dr. Herbert Tilley. Patient was a female æt. 23, in whom the soft palate was so completely adherent to the posterior pharyngeal wall that only a small probe could be passed from the oro- into the naso-pharynx. It had already been twice operated upon before coming under the exhibitor's care;

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in each case the adhesions had been divided, but no means had been adopted to prevent re-adhesion. In the course of ten days to a fortnight the original condition had returned. The symptoms complained of were a collection of mucus in the nasal cavities which tended to constantly flow from the anterior nares, inability to breathe through the nose, snoring, and other local discomforts.

Operation.—In view of the possibility of free hæmorrhage occurring when the adhesions were divided, a preliminary laryngotomy was performed. The soft palate was then completely separated from the pharyngeal wall, and a strong silver wire was passed from before backwards through the soft palate close to its junction with the hard palate, and about half an inch from the middle line. The distal end of the wire was then made to re-pierce the soft palate close to its fore margin and from behind forwards. By this means a short segment of the wire rested on the posterior surface of the soft palate. The free ends of the wire were then passed from behind forwards, one upon each side of the root of the incisor tooth, firm traction exerted on the palate, and the wires twisted upon one another and cut off short in front of the tooth. A similar procedure was then adopted on the other side of the palate.

One wire cut out in about ten days, the second in a fortnight; but by this time considerable healing had taken place over the raw surfaces from which the adhesions had been separated.

Every day for three weeks the house surgeon had passed his finger into the naso-pharynx, and excited firm traction forwards upon the soft palatal structures.

The operation was performed six weeks ago.

The PRESIDENT said the result appeared to be most excellent; it seemed to him that it would be interesting if other members would give their experiences of ultimate results in such cases.

Mr. P. DE SANTI said he had seen two of these cases. The first was the original one operated upon by Mr. W. G. Spencer and shown to this Society, in which there was considerable hæmorrhage at the time of the operation. The second was a case of his own, which he had shown to the Society. Both cases were of a much more severe type than that of Dr. Tilley's; they were cases of absolutely complete adhesion; not even a fine probe could be passed into the naso-pharynx previous to operation. Severe pain in the mastoid region was the cause of operation in both cases. As regards the operation itself there

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was nothing of fresh importance in Dr. Tilley's case. With reference to the point raised by Dr. Tilley of suturing the soft palate forward to the teeth instead of to the muco-periosteum of the hard palate, he thought one method was as good as the other; but it was more comfortable for the patient to have the remainder of the soft palate sutured (as Mr. Spencer and he had done) to the muco-periosteum of the hard palate. As regards ultimate results in Mr. Spencer's case, which was in excellent condition when shown to the Society two months after operation, within about two years' time *re-contraction* had taken place, but no re-adhesion, and for some time Mr. Spencer had to pass his little finger in to keep the passage dilated, and when, finally, that could not be done, he had to pass an instrument up. Mr. de Santi had not seen the case now for two years, but when he last saw it, it had contracted so considerably that there was but little, if any, space leading into the naso-pharynx. In his own case, the condition was exactly the same as it was five years after the operation, and if it were wished, he would be pleased to bring it forward again; he had seen the case off and on during these five years, and undoubtedly the result of operation was excellent. With regard to the question of hæmorrhage, though Mr. Spencer had encountered in his one case a considerable amount of hæmorrhage, and though he had seen this particular case, Mr. de Santi himself did not think it necessary to do a preliminary laryngotomy in his own case, and he was surprised at the very little hæmorrhage. Of these cases one naturally did not have a very extensive experience, but he saw no reason to fear excessive hæmorrhage. He did not understand from Dr. Tilley's report whether there was severe hæmorrhage in his case to justify the laryngotomy. If he had another case to operate upon he would not think it necessary to do a preliminary laryngotomy. He thought the operation as described and carried out by Mr. Spencer was the best; every other method had resulted in failure, re-adhesion taking place. The result in Dr. Tilley's case at the present time was excellent, but he feared re-contraction would take place; he would be interested to see the case again in two years' time.

Mr. Cresswell Baber called to mind a case in which he had operated some years ago. In order to prevent re-contraction he taught the patient to use a White's self-retaining palate retractor, which was introduced every day, pulling the palate forcibly forward. By this means contraction was for a time prevented, but he did not know the ultimate result of the case. The chief danger was, he thought, subsequent contraction, and not adhesion soon after the operation.

In reply to Mr. de Santi, Dr. Herbert Tilley stated that there was no particular hæmorrhage during the operation, and that, as a matter of fact, the laryngotomy was unnecessary; but he had performed it because Mr. Spencer in one of his cases had found the hæmorrhage embarrassing; and had free bleeding occurred in the present patient the laryngotomy would have obviated all trouble with regard to blood entering the larynx. In his next case he should certainly not open the windpipe, unless during the operation it appeared advisable to do so. His reason for fixing the silver wires around the teeth was because they gave such an excellent fixed point from which to secure a firm hold upon the soft palate. The principle was, of course, that introduced by

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Mr. Spencer, and this case only differed in a modification of the details of the operation.

Case with Clonic Contractions of the Palate, Adductors of the Vocal Cords, and certain other Muscles.

Shown by Mr. F. J. Steward. The patient, a married woman æt. 52, with no children, and having had no previous illnesses, was in good health until eighteen months ago, when she was suddenly seized with difficulty in speech, and inability to walk without assistance.

Since the onset the symptoms had become slightly worse, but otherwise had not altered. At the present time the condition was as follows :—There were constant slight nodding movements of the head. Articulation was difficult and jerky, and speech quickly resulted in the patient getting out of breath. On looking into the mouth, the palate was seen to be constantly moving, the movements consisting of alternating quick elevations and slower depressions of the palate, the rate varying from 110 to 130 per minute. Laryngeal examination showed similar movements of the vocal cords, which were sharply adducted and more slowly abducted. On phonation, adduction of the cords took place in a sudden spasmodic fashion. At times similar, but slighter movements of the upper lip were present.

On placing the finger over the thyroid cartilage it was evident that similar movements of the elevators of the larynx were taking place, and again a like condition, although less marked in degree, affected the diaphragm.

The gait was markedly ataxic, but there was no inco-ordination of the upper limbs.

There was no loss of power, no spasticity, and no alteration in sensation. The knee-jerks and plantar reflexes were somewhat increased. The pupils reacted both to light and accommodation.

The clonic contractions mentioned, appeared to be constant and continued during sleep; they were not altered by the position of the patient, and were not increased by voluntary movement.

There was no headache, vomiting, optic neuritis, or other sign of increased intra-cranial tension.

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The **President** said this seemed a case of extreme interest, and one which certainly deserved discussion, especially by those who were interested in its neurological aspect. The fact that the movements probably proceeded during sleep, as Mr. Steward had said, was also of especial interest.

Sir **Felix Semon** said that one would only with very great timidity venture to give an opinion on this case, but it seemed to him most likely that it was a cerebellar tumour which caused the rhythmic movements. The condition might, of course, be due to a multitude of other causes, such as disseminated sclerosis (of which Mr. Steward thought in the first place), paralysis agitans, chorea, hysteria, and tabes. One might think of the last-named in view of the patient's unsteady gait, but against this view was the fact that the patellar reflexes were completely preserved. On the other hand, the patient could not stand with eyes closed without nearly falling, nor could she walk straight. The gait, however, was not exactly of the ataxic type, but like that of a person whose equilibrium was disturbed. Mr. Steward had told him that the symptoms, according to the patient's own statements, had come on suddenly, and a belief in this seemed to be the main reason why the possibility of there being a tumour had not been seriously entertained. Personally, in all such cases he believed that the statements of the patient as to the suddenness of origin must be received with great caution. One often heard, for instance, in cases of œsophageal carcinoma, that the difficulty in swallowing dated from one definite occasion; whilst they all knew that it could not have originated in this way, but that there probably had been some occasion on which the patient first perceived that he had a difficulty in swallowing, and that date was given as the definite starting-point of the onset of the disease. To return to the present case, it was, of course, possible that at first there had been hæmorrhage into the substance of the cerebellum, and then, of course, a sudden origin of the symptoms would be conceivable; but he thought now there was more likely to be a cerebellar tumour than anything else.

Mr. **Charsley** said he had seen a precisely similar condition in an old lady, a patient of his, who for twenty years suffered from paralysis agitans, and who lived to be seventy-four years of age. He was led to examine her larynx by noticing the rhythmic movements of her soft palate and tongue. Her phonation was natural in the cold weather, but during hot weather she generally spoke in a whisper. In this case there could be no question of the accuracy of the diagnosis, as there seemed to be in the case under discussion.

Tumour of Vestibule of Nose. Microscopic Section.

Shown by Mr. **Cresswell Baber**. Beatrice H—, æt. 26, applied at the Brighton Throat and Ear Hospital on November 6th, 1902, with a growth filling the anterior half of the right vestibule. It

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was the size of a small bean, soft, solid, and slightly lobulated on the surface, and attached by a very thin pedicle to the outer wall of the vestibule, close to its anterior end, and about $\frac{1}{8}$ inch from its external edge. It was easily detached by avulsion. There was rather free hæmorrhage, which was arrested with the galvanic cautery point. The history was that the growth had been coming for three or four months. There was no known cause. It was said to bleed easily. There had been no return of the growth (March 2nd). The nasal cavities were noted as normal, except a ridge on the left side of the septum. The report of the Clinical Research Association was that the "growth is composed of much young spindle-celled tissue covered with skin. It is chiefly inflammatory in origin, and traversed by numerous large lymphatic channels. There are no signs of tubercle or malignant disease."

Tongue-depressor for Exposing the Tonsil.

Mr. Cresswell Baber showed a modification of Jænicke's tongue-depressor, which he had found useful for examining the tonsil and the opening of the supra-tonsillar fossa, and for facilitating manipulation in that region.

The President said that an instrument which had not been used by any of them hardly lent itself to discussion, but it certainly seemed, from inspection, a most ingenious modification.

Dr. Dundas Grant referred to a paper by Professor Killian, in which he described a method of examining the tonsil which he had found very useful. It consisted for the left tonsil, in turning the patient's face somewhat to the left and letting him hold out his tongue with the left hand. One could then, by retracting the right cheek slightly, look at the left tonsil almost fully in the face and get a very good view of the supra-tonsillar fossa and the crypts of the tonsil, which one did not get if the head were kept in the middle line.

Dr. Watson Williams was interested in these depressors, yet, although he thought it was very important to get a good view of the supra-tonsillar fossa, he could not help thinking that the plan he had adopted of introducing a rhinoscopic mirror, combined with the use of an ordinary tongue-depressor, gave one a perfect image and answered every purpose, without in any way distorting the parts.

The President thought that the advantage of Killian's method (which he had made great use of) over the "mirror" advocated by the last speaker, was that one could easily introduce a probe—and also, when necessary, a sharp hook with cutting edge—into the fossa and

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open it out. This was more easily done directly than by the aid of a mirror.

Mr. Cresswell Baber wished to say this depressor was of especial advantage in examining the supra-tonsillar fossa. By its use the tongue could be depressed and the anterior faucial pillar, or the plica triangularis, be drawn forward with one hand, whilst with the other a probe or any other instrument could be introduced into the fossa.

Case of Lupus (?) of Nose and Face.

Shown by Mr. Vinrace. Mrs. X—, æt. 56, married at 22; nine children, of whom six were living. All the children were healthy; youngest was born seventeen years ago. Ten years ago Mrs. X— was treated for diphtheria at Fever Hospital. Three months previously a rash had appeared on her chest. The diphtheria was immediately followed by ulceration of the skin generally, and especially of the tongue, nose, and throat. The ulceration of the soft tissues progressed very rapidly, but the bone was unaffected, and at the end of three months, she was practically in the condition as now. She was treated for sixteen months at St. John's Hospital, one month as an in-patient, and the remainder of the time as an out-patient, and had since attended various other hospitals. At the time the ulceration commenced Mrs. X— was 46, her husband 57, and the youngest child 7 years old. The husband died four years after the onset of the attack from stricture of bowel (? syphilitic). At some of the hospitals she had attended lupus had been suggested, but Mr. Vinrace was inclined to suspect tertiary syphilis, masked by the diphtheria (?). He would be glad of any comments as to diagnosis, and also for suggestions as to treatment. The patient was unable to work owing to the eruption on the face, and was anxious that, if possible, the shape of her nose should be somewhat restored. She had lost the tip of her tongue and had difficulty in protruding that organ.

Dr. Wm. Hill remarked on the difficulty of pulling forward the tongue in order to make a laryngoscopic examination, and said he had elicited from the patient the fact that the tip of the tongue had ulcerated away some years ago; this was strongly suggestive of syphilis. On the other hand, the nodule or growth on the posterior part of the tongue looked like lupus, and supported the view that it was really a "mixed" case.

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Dr. FitzGerald Powell thought there was very little doubt that this was a case of tertiary syphilis; in addition to the manifestations in the forehead and nose, the patient was suffering from chronic indurated glossitis, and she had a scarred sulcus in the posterior half of the tongue. If put on antisyphilitic treatment the patient would probably improve.

Dr. Dundas Grant said that the appearance of the patient could be very materially improved by means of an artificial appliance such as he remembered seeing on a patient from the North, who was shown before the British Laryngological Association some years ago. He was a coach-painter, and in order to rectify his disfigurement he made a hollow model of the nose in tin or aluminium, and coloured it himself so perfectly that when it was stuck on to the stump of the nose without the aid of spectacle frame or anything else, from a very little distance it looked like a natural organ. This man now manufactured these noses for others. He thought this case one of lupus, for one reason that the disease seemed to have confined itself to the softer parts, and the septum could be seen quite intact. Three months was certainly a very short time for so great disfigurement to occur, but he did not think that excluded the possibility of its being lupus.

Mr. F. H. Westmacott said that the maker of the artificial noses referred to by Dr. Grant was Mr. H. Brook, of 23, Savile Parade, Halifax.

Mr. Vinrace, in reply, said that as regards the suggestion of tertiary syphilis made by Dr. FitzGerald Powell, he thought that this was supported by the circumstance that a rash (? secondary syphilitic) appeared three months before the supposed attack of diphtheria. Up to that date her health had been perfect. Four years afterwards her husband died of stricture of the bowel, said to be due to the "errors of his youth," but possibly due to disease contracted about the time that his wife had developed her malady. Against the syphilitic theory was the fact that immediately on leaving the Fever Hospital Mrs. X— went to St. John's Hospital, where she received a perfect course of antisyphilitic treatment without any material result. Dr. Hill had noted that the tongue was deficient. The fact was that during the six weeks of terrible ulceration, the tip of the tongue had fallen off, and the tip of the nose also came away. He was not in a position to express an opinion whether Dr. Grant's suggestion of lupus or Dr. Powell's diagnosis of tertiary syphilis was the true solution, but he was grateful to Dr. Grant for suggesting an artificial nose. Certainly an improved appearance would enable her to obtain work more easily.

Case of Anosmia. (For Diagnosis and Suggestions as to Treatment.)

Shown by the President. Mr. B—, æt. 39, was first seen on June 13th, 1901. He stated that he had lost the sense of smell for the last six months, but that at occasional periods he could

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"smell and taste a little." He could appreciate the difference between salt and sweet. On examining the nose anteriorly both middle turbinals were seen to be large, the inferior fairly so. On posterior rhinoscopy the right middle meatus appeared to be blocked. The left side seemed to be fairly clear. He was ordered to use a nasal spray of menthol and paroline. On July 11th he was seen again, when he stated that five days after his first visit, smell and taste had returned perfectly for one day. This had been repeated several times, but only between the hours of 1 and 7 p.m., excepting on the first occasion. After the application of cocaine to the middle turbinals, smell at once returned. On August 3rd, 1901, he could smell peppermint and nitrous ether. On this occasion the application of cocaine was followed by disappearance of the sense of smell. On this and on the previous visits, pieces of mucosa were removed from the middle turbinals. The treatment was continued as before, with the addition of strychnine internally. On October 2nd, 1901, he could smell occasionally. A considerable piece of each middle turbinal was removed with Grünwald's forceps. After this more of the middle turbinals was removed, and eventually the greater part of the right was removed. On January 2nd, 1902, he stated that he had had the sense of smell for four or five weeks and then had gradually lost it. On June 18th, 1902, he reported himself to be still improving. On July 14th, 1902, he stated that he "has had sense of smell most days." On January 7th, 1903, the sense of smell was stated to be better in the right nostril, and during the earlier hours of the day. Killian's speculum was introduced into the left olfactory cleft and dilated; immediately his smell improved, and continued for two or three days. On March 1st he could smell turpentine, carbolic acid, and nitrous ether, but expected it to go off in the evening. In the posterior nares some hypertrophy was observed in the left choana (? cold), and a small, polypoid-looking mass in the right. Anteriorly, the left middle turbinal appeared to be enlarged; the anterior part of the right was absent.

Mr. Baber thought the Society was much indebted to the President for showing this interesting case, and for the careful way in which the history was given. In his opinion it was a neurasthenic case, and he

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should be very chary of doing any further operation. He suggested the application of the continuous current externally to the nose, and the administration of valerian internally, but he thought it doubtful whether the patient would recover.

Dr. DE HAVILLAND HALL agreed with Mr. Baber. Most cases of anosmia were secondary to influenza, and he had been trying to discover from this patient if there was any history of influenza, but he denied it. The attack came on with rather a severe cold, which suggested to him hay fever; was this severe cold of an influenzal nature, he wondered? He particularly remembered one case of influenza in which the patient, a man rather fond of the good things of this life, for over a year suffered from almost complete anosmia and great loss of the sense of taste, which was a source of great trouble to him. By persisting with arsenic and strychnine—a thirtieth of a grain of each—in pill form, taking two or three a day, the patient eventually made a complete recovery; he thought this combination of drugs the best for anosmia. Some seven or eight years ago he had seen in the 'Lancet' a paper recommending the application of carbonic acid to the mucous membrane of the nose, but, as far as his experience went, he had never seen results commensurate with the trouble involved in getting a stream of acid on the parts. In almost all cases of anosmia associated with influenza he had used a spray of menthol, which had a stimulating effect on the nasal mucous membrane; he thought these cases, without exception, eventually recovered; he could not call to mind at the moment any case of anosmia and influenza which had not recovered under a stimulating kind of treatment, including the tonic he had suggested.

Dr. DUNDAS GRANT said that unless cocaine had been already applied to the pharynx in this particular case that day, the patient seemed to have a remarkable diminution of pharyngeal reflex, which was indicative of a neurasthenic condition. He thought there was considerable evidence of neurasthenia being an element of importance. One dictum expressed by the late Morel Mackenzie as the result of his observations and experience, was that when anosmia had lasted uninterruptedly for two years it was incurable; he had never seen it recovered from after that length of time. Personally, he thought he had seen it in an hysterical case. With regard to the removal of portions of the middle turbinate body, he thought the President had probably been inspired by the same feeling that he himself had—namely, that it was a very critical question how to remove enough, and yet not to remove too much, because in removing large portions of the middle turbinal one was also removing a good deal of the distribution of the olfactory nerve, and it was quite possible to do more harm than good to the sense of smell. The action of cocaine was very peculiar. He remembered finding in a case of his own that its application caused the sense of smell to return. This subject was discussed in a paper in 'Archiv für Laryngologie' many years ago, the observer finding the opposite result, *i.e.* that the application of cocaine took away the sense of smell. The fact was, that after the application for a certain time, while the swelling of the mucous membrane was reduced, the drug might allow of taste and the presence of smell

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becoming perceptible, but after a longer time it paralysed the sense of smell and thus caused the contradictory symptoms observed by the President.

Dr. Donelan said he was interested in Dr. Hall's remarks with regard to the influenzal origin of so many of these cases of anosmia. He had seen a good many of them at the Italian Hospital, which was situated in a densely populated district. There, they seemed to have a constant succession of cases of influenza even in the summer, and there were a number of cases which he had had under observation almost continuously for ten years. Some persons who had had consecutive attacks of anosmia were clearly recovering from definite influenzal symptoms. It would be in the experience of many members that there were many people who, having once had an attack of influenza, were liable afterwards on slight exposure to cold, or over-exertion, or from shock, to get an elevation of the temperature and suffer from another attack of influenza. He had had the presumption to form for himself the theory, that the spores of the bacillus were more difficult to destroy than the germ itself, and that a slight elevation of the temperature was sufficient to set them free and produce the distinct symptoms of the disease. With regard to the menthol spray and the treatment of influenza generally, about ten years ago Dr. Taylor (?) wrote an article in the 'British Medical Journal' advocating the internal use of carbolic acid, and another writer also wrote advocating the use of the essential oil of cinnamon. He had been trying these two remedies in combination in a great many cases—acute and chronic—where the symptoms were attributable to influenza, and he had found (using minim doses of each in combination with aromatic spirits of ammonia, in water) the remedy had a remarkable effect, so much so, that it might be regarded as a specific for the disease. He had tried it in thousands of cases, with good results. In regard to anosmia, by using the menthol spray recommended by Dr. Hall and supplementing its action with carbolic acid at the beginning of the treatment, this combination seemed to have a distinct beneficial effect.

Dr. Watson Williams agreed with the general consensus of opinion, *i. e.* that this was a case of neurasthenic anosmia; but in addition there were associated with it certain vaso-motor phenomena in the nose, which had resulted in swellings of the mucosa, which the exhibitor had to a large extent obviated by removal, he presumed, of the most prominent portions of the swollen middle turbinal. He thought that the variations in the function of smell in this case were to a large extent dependent upon the result of vaso-motor phenomena. Slight swellings in the mucosa would sometimes cause the sense of smell to be in abeyance, and this was observed in an ordinary nasal catarrh, even when the nose was subjectively fairly free. Physiological investigations demonstrated how easily the sense of olfaction was rendered inactive. The distribution of the olfactory nerve filaments was confined to quite the upper portion of the olfactory fissure, and did not extend so far down as the middle turbinal; and he thought that probably a comparatively slight swelling of the mucous membrane of the superior turbinal, and of the *upper* portion of the mucous mem-

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brane of the middle turbinal, would be sufficient to prevent olfaction for the time being. Whether one ought to apply the cautery constantly, or other local applications to slight swellings, depended, in some measure, upon the general condition of the patient, and one should take this point into consideration before removing the grosser results of the vaso-motor phenomena. Personally, he would feel disposed to rely upon his favourite remedy of arseniate of strychnine in this case, now that the hypertrophic tissues had been successfully removed. He had been himself a sufferer from hay fever, and so he could enter to a certain extent into the feeling of a patient in whom the sense of smell was apt to come and go with great rapidity.

Dr. Donelan said that the treatment by carbolic acid and cinnamon, to which he had referred, was used to commence with, and it was followed up by giving tonics such as those mentioned.

The President was glad to hear that the general consensus of opinion was not in favour of further operative measures. He might mention as an interesting fact that practically the whole of the right middle turbinal had been removed; now it was rather difficult to make out exactly what had been done. The point raised by Dr. Hall touched upon a matter of some importance. He had seen olfactory affections following influenza, and in two forms—one in which the anosmia existed permanently and remained; and the other in which it existed for a time without intermission and then improved. The anosmia was either constantly present for a time, or remained altogether. He had never seen the intermittent form follow influenza. In this case the anosmia was intermittent. He had employed menthol. The question of carbolic acid was not a new one; it was mentioned in many works which were published some years ago; he had referred to it in his own book, the first edition of which came out more than ten years ago. Alum, carbolic acid, and sulphate of zinc were long known to permanently injure the olfactory nerve. It reminded him of an instructive case in which a physician—not a member of this Society—ordered a carbolic douche for a lady, with the result that she immediately and completely lost her sense of smell.

Case of Functional Aphonia.

(Previously shown at the January Meeting.)

Shown by Dr. Lambert Lack. This patient was the man with spastic aphonia of functional origin, who, when shown at the previous meeting (see page 50, vol. x, January, 1903), could sing loudly, but could not speak above a whisper.

Under local applications of the faradic current and general tonic treatment, the voice had returned, at first for an hour or two daily, and gradually improved until it now lasted almost the entire day. Examination of the larynx showed pachydermia of

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the vocal cords, but the movements were now normal, both on breathing and phonation.

The sequel to the case added an additional reason for considering this case to be quite distinct from the ordinary spastic aphonia. In his (Dr. Lack's) experience it was quite unique.

The PRESIDENT thanked Dr. Lack for bringing this case forward again and thus giving the Society an opportunity of seeing it both in a good and in a bad condition.

Dr. DUNDAS GRANT said the interesting feature about the case seemed to be the fact that the patient originally found it much easier to sing than to speak. Singing required less effort on the part of the nervous centres, and he supposed that was the reason of this state of affairs. His brain had, perhaps, in the interval been gradually exercised and trained in some way; thus his recovery might be explained.

Dr. DE HAVILLAND HALL said that stammerers often sang perfectly well, in spite of their defective speech.

Mr. LAKE said he had seen the case some time ago and thought it one of syphilis. He heard that a long course of antisyphilitic treatment had been adopted, but without benefit.

CASE AND MICROSCOPIC SECTIONS OF ŒDEMATOUS THICKENING OF LARYNX AND PALATE IN A BOY.

(Previously shown at the Society.)

Shown by Dr. LAMBERT LACK. This patient, now æt. 11, was shown to the Society in February, 1902, by Mr. Hunter Tod (see 'Proceedings,' vol. ix, page 69). He was still under the care of Dr. Percy Kidd, who kindly allowed him to be shown. His further history was extremely interesting. He had had signs of laryngeal obstruction for three years, and he had certainly had stridor off and on, all the time he had been under observation—now fourteen months.

The present condition was almost exactly the same as a year ago. The boy was thin and pale, the temperature was normal, there were no tubercle bacilli in the sputum, and no signs of pulmonary phthisis. Enormous, smooth, pale, œdematous enlargement of epiglottis and arytenoids prevented a view of the interior of the larynx. The uvula and adjacent part of the palate was thickened. This description applied three weeks

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ago. As no improvement had taken place Dr. Kidd wished to have the epiglottis removed. This was done with Lake's forceps under general anæsthesia. A large piece of soft tissue in the arytenoid region was also cut away.

The boy recovered rapidly from the operation without any bad symptoms. The healed stump of the epiglottis could now be seen, the arytenoids were not much swollen, the interior of the larynx could be easily inspected, and the cords were seen to be normal both in colour and movement. The boy had lost all his stridor, etc.

Under the microscope the sections showed numerous roundish nodules, deep under the mucous membrane, which strongly resembled, but were not characteristic of, tubercle.

The case presented many points of similarity with, and some of difference from, those shown recently by Sir. F. Semon and Dr. Dundas Grant.

In spite of a year's observation, the well-marked symptoms, the microscopical sections, etc., the diagnosis still remained in doubt.

Microscopic Sections of Mucous Patches of Tonsils.

Shown by Dr. Lambert Lack. The tonsils were obtained from an adult with well-marked secondary syphilis. The sections showed great thickening of the epithelium in places, infiltrations with round-cells, etc.

On the suggestion of the President Dr. Lack said that he would hand the specimens to Dr. Pegler for the consideration of the Morbid Growths Committee.

Case of Perforation of the Nasal Septum. ? Trauma or Syphilis.

Shown by Dr. Donelan. The patient, an Italian æt. 42, denied ever having had syphilis, but admitted having had gonorrhœa about twenty years ago. He used to suffer from bad headaches for about a year, and conceived the extraordinary idea that by "punching" his nose and making it bleed,

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the headaches would be relieved. He said that this treatment had been successful, but it unfortunately had set up a chronic epistaxis, from which he had suffered almost every day for eight years. During this period he used to pick his nose a good deal with his fingers. The epistaxis continued until about a year ago, when he was treated in Milan with a grey ointment, which was rubbed on the outside of the nose. He was positive that it had not been applied anywhere else, and that the epistaxis had ceased completely in a few days. A purulent discharge with formation of crusts followed, and had continued until the present time. There was a very large perforation in the septum, as well as considerable depression of the lower third of the nose, and a marked fold in the right ala. In spite of his assertion, taking into account the nasal and pharyngeal appearances, as well as the general aspect of the man, Dr. Donelan was inclined to think the deformity due to syphilis.

The PRESIDENT was strongly inclined to think this a case of syphilis.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

EIGHTY-FIRST ORDINARY MEETING, *April 3rd*, 1903.

J. DUNDAS GRANT, M.D., F.R.C.S., Vice-President, in the Chair.

JAMES DONELAN, M.B.,
E. FURNISS POTTER, M.D., } Secretaries.

Present—34 Members, 2 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentleman was elected an Ordinary Member of the Society:

J. A. Knowles Renshaw, M.D., B.C.(Cantab.), Beech Hurst, Ashton-on-Mersey.

The Morbid Growths Committee reported on specimens examined, as follows:

Mr. Lake's specimen (No. 1) of new growth from inferior turbinal (*vide* 'Proceedings,' January, 1903, p. 52) was considered to be "a large round-celled sarcoma with a tendency to an alveolar arrangement." No. 2, of growth involving inferior turbinal and septum (*vide* 'Proceedings,' January, 1903, p. 52), was considered to be a "sarcoma with myxomatous degeneration on the surface."

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Mr. Hunter Tod's specimen (*vide* 'Proceedings,' February, 1903, p. 72) of bleeding polypus of the septum was considered to be an "angioma."

Dr. Lambert Lack's case (*vide* 'Proceedings,' March, 1903, p. 93), section removed from epiglottis; "no evidence of tubercle was found in the specimen, the structure of which corresponds with what is known as lymphadenoma."

The following cases and specimens were shown.

CASE OF LARYNGEAL DISEASE.

Shown by Dr. KELSON. The patient, a man æt. 55, a messenger by occupation, had suffered from loss of voice of six weeks' duration. There was no history of syphilis, no wasting, nor could tubercle bacilli be found in his sputa, which were scanty but yellow. Examination showed much swelling of the epiglottis, aryteno-epiglottic folds, arytenoids, and the right ventricular band; the vocal cords were very difficult to see, but appeared to be slightly swollen. The cervical glands were not enlarged, and the lungs appeared to be normal. The man had been attending hospital for two weeks, during which time his voice had certainly improved. Opinions were asked for as to diagnosis.

Sir FELIX SEMON said this was a very obscure case, and he spoke with great hesitation, but the most likely explanation seemed to be a very acute tubercular infiltration. The disease was so universal in its attack upon the parts which he was able to see, viz. epiglottis, right aryepiglottidean fold, arytenoid cartilages, but not the interior of the larynx, that one might practically, for diagnostic purposes, include anything of a similar character. It was too dense to be an ordinary œdema of any kind.

Dr. LACK was under the impression that one could actually see minute opaque caseating tubercles under the mucous membrane of the anterior surface of the epiglottis.

CASE OF SWELLING OF RIGHT SIDE OF LARYNX (FOR DIAGNOSIS).

Shown by Dr. H. J. DAVIS. The patient, a man æt. 29, first came to the Middlesex Hospital fourteen days ago. Six years

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ago the voice had become husky, and hoarseness had persisted ever since. He had no other symptom.

The larynx was partially occluded by a red, tense, unilateral globular swelling. The left cord only was visible, and appeared normal.

The swelling was firm to the probe, though softer in parts. It was unreduced by the application of a 20 per cent. solution of cocaine, and when incised with a rectangular palate needle hæmorrhage was profuse. The swelling diminished somewhat in size, but now, after ten days, it was as large as ever. The points of puncture were represented by the two yellow lines seen on the upper surface of the swelling. They had healed rapidly.

There was no external thickening of the larynx and no specific history.

At the apex of the right upper lobe posteriorly, there were indefinite signs of early consolidation of the lung, and, in consequence of this, the exhibitor was inclined to look upon the case as tubercular, though he did not think that the appearance of the larynx warranted such a conclusion.

The patient was a little pale, but his appetite was good; he had no cough or expectoration, and seemed quite unaware of his laryngeal occlusion.

The opinion of members was desired, first as to diagnosis, and secondly, in the event of the disease being considered to be malignant (sarcomatous), as to whether thyrotomy should be performed at once.

The patient was spraying the larynx with 20 per cent. lactic acid, was taking cod-liver oil, a teaspoonful night and morning, and ten grains of potassium iodide three times a day.

Mr. Butlin came to the conclusion that Dr. Davis was probably right in thinking this tuberculous. The swelling was very red on the surface, and had not the appearance of a new growth, even malignant, in that situation. He noticed *several* tiny yellow spots. If it were tuberculous, he confessed he had never seen any case of laryngeal tuberculosis quite like it. As to removing it, he thought if it caused trouble it ought to be exposed by a thyrotomy, and then one could ascertain its extent and nature, and be guided by this in the question of removal.

Sir Felix Semon would not venture to give any definite opinion as to the nature of this tumefaction. It might be anything. Sarcoma

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was not impossible; tuberculosis extremely unlikely. It might be a case of chronic perichondritis, or a case of exochondroma. Therapeutically he agreed with Mr. Butlin, that the proper thing would be, if it caused serious inconvenience, to do an exploratory thyrotomy, and be guided in one's further proceedings by what was found at this preliminary operation.

Mr. E. B. Waggett had seen a case rather similar to this at a meeting of the Society, which proved to be an adenoma, the glandular tissue being that of the thyroid gland. The peculiarly rounded contour on the inner aspect of the present swelling was rather unlike that of an infiltration, and suggestive of a tumour or of a cyst.

Sir Felix Semon, in criticising the remarks of Mr. Waggett, said the swelling followed too much the original outlines of the parts to be a thyroid tumour. He believed really it was an infiltration of the parts, since they were enormously enlarged and still showed their original outline.

Dr. Davis said the case was first regarded as one of tuberculosis owing to slight physical signs at the apex of the right upper lobe posteriorly, but they were very indefinite. The note on percussion was slightly impaired and expiration prolonged. Mr. Gould had removed some tuberculous glands from the neck of the patient's sister. The patient was in excellent health, and except for the hoarseness, he did not know there was anything the matter with his throat. He first saw him a fortnight ago, when the swelling was so tense as to have the appearance of a cyst. He felt it with a probe, and tried to puncture it with a laryngeal lancet, but the lancet would not go in. With some little difficulty he inserted a rectangular palate needle, and, to his intense surprise, the blood spurted out as if an aneurysm had been opened. The swelling diminished, and the patient said he could breathe better. The hæmorrhage soon ceased. Later he came back as bad as ever; there were two little yellow spots to be seen—the seat of the punctures.

He was inclined to think it a sarcoma, and that the larynx should be opened at once.

Dr. Grant thought Dr. Davis would now feel justified in the hesitation he felt in coming to a conclusion with regard to the diagnosis. It would be to the advantage of the Society if he would bring the man before them again at a later date. At present there did not seem any immediate call for active interference.

Case of Singer's Nodule (Left Vocal Cord).

Shown by Dr. Furniss Potter. The patient, a healthy-looking man æt. 41, who sang in a village choir and taught in a Sunday school, had suffered from slight huskiness for the last twelve months, which had come on after an attack of influenza. Impairment of voice was the only symptom complained of. On

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examination a small nodule was seen on the edge of the left cord in the anterior third. The cord in the immediate neighbourhood of the excrescence was very slightly reddened, but there was no swelling of the cord itself.

Case of Chronic Empyema of both Frontal Sinuses and Maxillary Antra; Radical Operations to illustrate the almost Complete Obliteration of the Maxillary Sinuses following the Radical Operation.

Shown by Dr. Herbert Tilley. Miss H—, æt. 41, had suffered from a purulent nasal discharge for about ten years. It followed immediately upon an attack of typhoid fever. During the past five years headache has often been sufficiently severe to preclude her from following her duties as a professional nurse. Inability to concentrate her mind upon her work has also been a more or less constant symptom. During the last-mentioned period polypi have on several occasions been removed from her nasal cavities.

When first seen last November patient would allow no external operation to be performed, but was very anxious to have any relief which might be obtained from internal treatment of the nasal cavities, *e. g.* curettage of ethmoidal region, removal of middle turbinals, etc. This was strongly advised against, but owing to the constant and urgent requests of the patient, it was eventually undertaken. The removal by curettage of the anterior group of ethmoidal cells upon the right side was immediately followed by hæmorrhage into the eye socket, causing protrusion of the eyeball. This followed the most careful handling of the parts, which were in a very advanced state of degeneration. During the following five days it was evident that suppuration had taken place within the orbit, and upon the sixth day (under "gas" anæsthesia) two drachms of pus were evacuated by an external incision in the large "cleavage line" of the lower eyelid. The patient rapidly recovered, and eventually desired to have the external operations performed as she had originally been advised.

Both frontal sinuses were operated upon by the radical

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method (a modified Kuhnt's operation) on January 12th. A free communication was made with the nose in each case, but it was allowed to close by granulation tissue as rapidly as possible, so that in the course of ten days or so the sinus cavities were shut off from the nose, and granulated up without further trouble.

January 28th.—The radical operation was performed on both maxillary antra. A large opening was made in the canine fossa, the thickened, degenerated lining membrane scraped away, the cavity disinfected with zinc chloride solution (grs. xl ad ℥j), and a light packing of cyanide gauze inserted for forty-eight hours. The gauze was removed at the end of this period and not reinserted, the antral cavities being only syringed out with warm boracic lotion twice daily, carefully dried, and then left alone. No opening was made into the nose.

Examination of the antra now would show that they were practically filled with granulation tissue, it being only just possible to pass a probe upwards through the fistulous track through the original opening in the canine fossa.

Dr. Herbert Tilley maintained that in these cases, where the radical operation was thoroughly carried out, cure was brought about by the growth of granulation tissue from the internal walls of the cavities uniting with the large mass of granulations which sprouted into the cavity from the soft parts of the cheek in the situation of the canine fossa. Eventually the original cavity of the antrum was so reduced in size as to form merely a slight extension of the outer wall of the nasal cavity.

Unfortunately the patient exhibited was suffering from an acute nasal catarrh, which rather detracted from the healthy appearance of the nasal mucosa, which now, under ordinary circumstances, was absolutely free from a suspicion of pus. Both sphenoidal sinuses could be seen opened in the upper and posterior region of the nasal cavities.

Dr. Hall asked what was the effect of transillumination in these cases.

Dr. Fitzgerald Powell thought Dr. Tilley was to be congratulated on the thoroughness of this operation so far as the frontal and sphenoidal cavities were concerned. As regards the maxillary sinus, he did not quite see the object of obliterating this cavity, even if it

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was possible—a fact which he very much doubted. As the cavity was deep and elongated, extending in an antero-posterior direction, he doubted much whether, even if a large portion of the anterior and lateral wall of the sinus were removed, one would get the soft tissues falling in sufficiently to unite with the granulation tissue to destroy the sinus altogether. On the other hand, he did not see the necessity of practising this obliteration method and destroying the antrum. There were much less formidable and simpler operations, such as thorough drainage and washing of the cavity through a large opening at its most dependent part, viz. through a tooth socket. He believed that in 99 out of 100 cases if this were thoroughly done, and a large enough opening made and large tubes were used, a perfect cure could be obtained without destroying the cavity.

Mr. WAGGETT would not now enter into a discussion upon the best method of attacking these cases, but he wished to state that the sinus in all the cases operated on radically did not become filled up. He had certainly met with several cases where, after removal of the whole outer wall of the inferior meatus of the nose, a very large cavity remained after complete healing had taken place. His own experience led him to think that obliteration in these and in frontal sinus cases depended on the amount of irritation which took place after operation; in other words, on the length of time during which post-operative packing was employed. If the outer wound were immediately sewn up and a large opening made into the nose, and no packing employed, he believed that the antral cavity did not by any means become obliterated, but, on the contrary, was very little decreased in size as a rule. That certainly was the case with the frontal sinus where, after the Ogston-Luc operation, and with immediate closure of the external wound, the cavity remained absolutely or very nearly the size that it was before operation, as far as could be tested by the use of a long probe. If, however, a frontal sinus were left open, and packing in diminishing quantity employed for a prolonged period, the cavity became filled up with a tough leathery growth of thickened periostium.

Dr. LACK agreed with Dr. Powell and Mr. Waggett in their remarks. It was absolutely impossible for a normal antrum to fill up with granulation tissue. To obliterate the antrum would require excision of the upper jaw. If the inner wall of the antrum between it and the inferior meatus were entirely removed, as in the usual radical operation, these cases would get quite well; there was therefore no need to obliterate the cavity.

Dr. SCANES SPICER agreed with Dr. Powell, Mr. Waggett, and Dr. Lack. He failed to see the necessity for obliteration, even if possible. The radical operation with which the names of Caldwell and himself were associated was so very successful in curing these cases that he could not see why one should wish to depart from a method which had become classic. Luc's modification (*i. e.* sewing up the bucco-antral wound at once) was preferable to leaving it open, as saving pain, irritation, and reinfection. In the present case he thought it was too soon to say yet that the cavity was obliterated, or even that the case was radically cured.

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Dr. Grant said that he was sure Dr. Tilley did not advocate this method of treatment, except for a comparatively small number of cases of empyema of antrum in which milder measures had failed. With regard to the obliteration of the antrum, there was no doubt it was a more radical method; nor did he see why it should be impossible, more especially if a very forcible invagination of the nasal wall of the antrum was carried out at the time of the operation. He thought Siebenmann had described how it should be done, viz. by putting a finger in the nostril right into the antrum, and forcing the inner wall of the antrum outwards, thus bringing it into very close contact with the soft tissues which grew inwards from the hole in the canine fossa.

Dr. Tilley, in reply to Dr. Hall, said that the result of transillumination after operation for radical cure was that the antrum was always dark. Whilst speaking on this point, he thought it somewhat curious that if one transilluminated the antrum a week after the radical operation, and after having curetted away the thickened mucous membrane, the darkness was just as great as it was before any operation had taken place at all. He had satisfied himself of this fact many times, and he thought the darkness of the antrum in an empyematous condition was due to the chronic inflammation in the bony wall, and had nothing to do with the pus and mucous membrane in the cavity.

With regard to Dr. Powell's question, and the doubt as to the possibility of obliteration, he did not wish to be understood as saying that directly one met with a case of chronic empyema of the antrum one advised a radical operation, for this was the last thing he would think of advocating. One should always give the patient a description of the two courses of treatment and let him take his choice. Naturally, to start with, every one chose the milder form of treatment. Then, if not cured, the patient began to get tired of the everlasting drainage and washing out; he found it a nuisance and a trouble, and wanted to know if something else could not be done. Then, he thought, one had a right to advise the radical operation, and hold out a very good prospect of complete cure by it.

With regard to the remarks of Mr. Waggett on incomplete obliteration, and of Drs. Lack and Scanes Spicer, he had evidently been misunderstood. He did not say the whole of the cavity could be obliterated. Having removed a large part of the anterior wall and the inner wall of the antrum at the radical operation, one found as the result that granulation had sprung up over the remaining portion of the antral wall; the epithelium spread in from the nose, and the soft parts fell in through the anterior opening. All these formed a certain amount of tissue in the original cavity of the antrum, which attained such a size that the antrum was practically obliterated. On looking into the nose six or seven weeks later and attempting to pass a probe, one found it impossible to insert it further than half an inch, therefore the cavity must be diminished to a very great extent, but not totally. The cases which were cured were those in which the greatest diminution of the size of the original cavity took place.

As regards the packing, to which Mr. Waggett had referred, in this

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case he took out the packing forty-eight hours after operation, and put in nothing else afterwards. He syringed out the antrum morning and evening, and dried it afterwards each time. The advantage of a large opening in the anterior wall, was that one could take a large speculum and look inside, and apply a suitable antiseptic if one saw any unhealthy point.

A Case of Clonic Spasm of the Muscles of the Palate and Pharynx causing Entotic Tinnitus in a Lady æt. 30.

Shown by Dr. Pegler. This and the following case were brought to display certain features in contrast to, and yet others in uniformity with, Mr. F. J. Steward's case shown at the last meeting. The latter case called forth an opinion that it depended upon a severe organic nervous lesion, probably cerebellar, whereas the present ones were almost certainly functional, and in fact fell into the second of the two classes into which Dr. Lack had arranged the cases of clonic palatal spasm described up to the time of his paper ('Laryngoscope,' vol. iv, No. 6).

E. H—, æt. 30, complained of a clicking sound mainly in the right ear, but occasionally in the left, rarely in both simultaneously. Duration three months. The clicking was audible with or without the aid of the diagnostic tube in the right ear, and was associated in the patient's mind with the right lateral pharyngeal band (salpingo-pharyngeus). On examining the throat it was observable that the sound was concurrent with clonic spasm of the posterior pillars of the fauces. The rhythm of the contractions was interrupted at intervals,—the rate per minute, now slower than formerly, 42. The movements in the throat were of two kinds: one, a high vertical upward contraction of the velum and uvula, presumably due to spasms of the levatores palati; and the other an approximation of the posterior pillars, due to contraction of the palato-pharyngei, the tubal slip of which apparently caused the sound complained of by suddenly separating the walls of the Eustachian tubes. Distinct movement at the mouth of the tube was visible through the nasal meatus, and the two kinds of movement were not always concurrent. There was a simultaneous adduction of the

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arytenoids and vocal cords, ceasing on phonation. No distinct causal relationship could as yet be affirmed, but there had been simple erectile tumefaction of both inferior turbinals, which had been treated by the galvano-cautery, and with much general benefit, whilst the clicking sounds were now considerably diminished in rate per minute. The patient had evidence of functional nerve deafness and other interesting auditory symptoms, which had been detailed elsewhere. She was slightly neurotic, but had no other marked hysterical symptoms.

Clonic Spasm of the Soft Palate causing Objective Noises in the Pharynx in a Woman æt. 20.

Shown by Dr. Pegler. As a matter of fact this patient also had entotic tinnitus, but in her left and deafer ear. Duration two months. The palatal movements were simple upward jerkings of the uvula as in the last case, due to symmetrical contraction of the levatores palati, but they had latterly increased enormously in rapidity; the first notes taken stated them to be 10 or 15 to the minute, but they had since risen to 240 per minute with scarcely any intermission.

Again, as in the last case, the adductors of the vocal cords contracted simultaneously, but every few seconds the cords remained widely abducted for a second or so. The clicking was very loud when the mouth was open, but when the sticky character of the secretion was changed, as by the use of the cocaine spray, the sound ceased entirely for a time. The naso-pharynx and pharynx were clogged with mucus excreted by the very considerable pad of pharyngeal tonsil, which might here be held to be the local exciting cause. After its removal, if there were any manifest improvement, the case would be reported upon to the Society again. The hysterical symptoms were not very marked. No hemianæsthesia, but pain, "pins and needles," and numbness were complained of on left side of face and head. Mother stated the noises were not heard during sleep. Palatal anæsthesia considerable, and when held forward firmly by the palate hook the laryngeal movements went on as usual. Dr. Pegler advised comparison with Sir F. Semon's (viii, 49) as well

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as with Dr. Lack's (v, 38) and Dr. Bond's cases (iii, 41), as equally interesting studies in the hysteriology of the pharynx.

Case of Pharyngeal and Laryngeal Lesions in a Woman Æt. 28.

Shown by Dr. Donelan. The patient, a married woman with three healthy children, had a severe attack of diphtheria seven years ago. She says her throat was severely ulcerated at that time, but that she recovered her voice. Her youngest child, a fine boy, was born four months ago. Dr. Donelan saw her only once, a week ago, when he found the uvula, velum, palate, and both anterior pillars eroded. There was a large ulcer on the epiglottis, and the laryngeal mucous membrane was much swollen and ulcerated in patches. There was complete aphonia and some dyspnœa. He put her on mercury and iodide with a view to clearing up the diagnosis.

Dr. Hall asked how long an interval intervened between the attack of diphtheria and the appearance of the lesions.

Dr. Donelan, in reply to Dr. Hall, said the patient had diphtheria seven years ago. He saw her for the first time a week ago, and immediately put her on antisyphilitic treatment. She was voiceless when first seen, but was already greatly improved.

Dr. Hall approved of the antisyphilitic treatment adopted. The case presented the characteristic appearance of tertiary ulceration of the pharynx and palate. There was considerable destruction of tissue. He thought a continuation of the antisyphilitic treatment would make a great improvement in the condition. He doubted whether diphtheria had anything to do with the present affection, considering that it was seven years ago since she had diphtheria.

Sir Felix Semon wished to make a general remark with reference to what Dr. Hall had said. He really thought that they, as throat specialists, ought to receive with the greatest scepticism all histories of ulceration and cicatrisation—to however trifling extent—in the throat, of such diseases as diphtheria and scarlet fever. He was by no means inclined to attack the possibility of sloughing occurring in exceptionally bad cases, but in the enormous majority of cases syphilis was the cause of the throat condition. They should be extremely careful in taking for granted, on the strength of the patient's statement, a history of such diseases.

Dr. Donelan said the history of diphtheria was given by the patient. He tried to get her husband to come and see him, but he would not. At first sight it presented the appearance of lupus.

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Case of a Woman, ÆT. 37, with Ulceration of the Soft Palate.

Shown by Mr. Lawrence. The palate was acutely inflamed and very painful two months ago. Iodide of potassium was given in, first, ten-grain, then fifteen-grain doses, three times a day. In less than a fortnight the case was well. The condition now remaining was one of extensive loss of substance between tonsil and uvula, leaving only one thick strand of tissue uniting palate and pharynx. No history could be obtained except the very doubtful one of exposure to "bad drains" six months ago.

Dr. Donelan thought it was syphilitic.

Mr. Lawrence said that although the ulcer was in a most unusual position he had little doubt that it was specific. The aspect of the disease in its acuter stage was suggestive, and the action of iodide of potassium in so quickly relieving the symptoms only added to the probable correctness of the diagnosis. Although the patient could not or would not give any history, he had been informed that her respectability was not above suspicion—another fact to be considered in making the diagnosis.

Specimen and Section of Acute Tuberculosis of Left Tonsil from a Man ÆT. 32.

Shown by Mr. Westmacott. The disease commenced in August, 1902. There was no family history or evidence of tubercle elsewhere. Ulceration had spread to the soft palate since removal. There had been great pain in the tonsil and neck on the left side from the onset.

Drs. Wingrave and Lack agreed that the specimen exhibited did not show evidence of tuberculosis in any form.

On the suggestion of Mr. Atwood Thorne it was decided that the specimen be submitted to the Morbid Growths Committee.

Dr. Westmacott, in reply, said the only point of clinical importance was the absence of enlarged glands in the neck. The other tonsil was perfectly healthy. There was a great deal of pain, and a sort of excavation on the front of the left tonsil. He did not take any steps to try and find bacilli in the sputum or discharge, as he had seen the patient only a day or two before he removed the tonsil. Since this operation the ulceration had spread to the soft palate, but with the application of lactic acid and formalin this had ceased and

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healed in about three weeks; the patient was now perfectly well. Before he saw him, the patient had been treated by iodide of potassium and mercury, but with no result.

Microscopic Section of Localised Psorospermosis of the Mucous Membrane of the Septum Nasi.

Shown by Capt. O'Kinealy. The patient, a married male Mahomedan, æt. 22, came under observation at the Medical College Hospital, Calcutta, on the 12th of May, 1894, on account of a growth in his left nostril. He was a native of Bihar, and had been working as a mason for the past two and a half years, previous to which he had been employed in a hide store for eighteen months. His appearance was healthy, and his past history, including that of his family, was good.

About three years previously, while working in the hide store, he first noticed the growth, which bled frequently, the hæmorrhage being worse in the hot than in the cold weather. He went to a hospital, where it was removed with forceps, and he suffered no further inconvenience for six months. After this, however, the growth began to reappear, so he had recourse to a native barber, who removed it a second time. He was again relieved for a few months, but the tumour once more recurred, accompanied by attacks of epistaxis, and he was compelled to seek further relief. He was not aware of any of those employed with him being similarly affected.

On examination a small vascular pedunculated tumour, about the size and shape of a large pea, was seen projecting into the vestibule of the left nasal fossa. It was a freely movable painless growth with all the appearances of a papilloma, and was attached by a short pedicle to the mucous membrane at the anterior and upper part of the cartilaginous septum, being entirely confined to that region. The remainder of the upper respiratory tract was healthy, and no evidence was found of any disease elsewhere.

The growth was easily and apparently completely removed by forceps and the cold snare, though it was composed of friable tissue which bled rather freely. The patient remained under observation for nearly three weeks after the operation,

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when he ceased attending the hospital, and all trace of him was unfortunately lost. By this time, however, there were definite signs of recurrence, and on the 6th of June, 1894, the date on which he was last seen, a small highly vascular pimple with a red apex was seen at the site of removal.

The tumour was examined by Major J. C. Vaughan, I.M.S., then officiating Professor of Pathology at the Medical College, to whom the exhibitor was much indebted for permission to put the case on record, as well as for the specimen and the following report.

Pathological Report by Major J. C. VAUGHAN, I.M.S.

"The growth was removed from the septum narium by Captain O'Kinealy, and to the naked eye had the appearance suggestive of a small papillomatous excrescence on the mucous membrane; but the tissue was friable, and there was rather free bleeding in removing it. The tissue removed was a piece about as large as a "marrowfat" pea. It was hardened for three or four days in absolute alcohol, and then embedded in paraffin and cut. The sections, placed first in turpentine, were washed afterwards, first in xylol, then in chloroform, and then in spirit. They were then transferred to water, and stained in picro-carmine, and mounted in Farrant's solution.

"*On microscopical examination* the tissue removed seems to consist of the following elements, disposed as described below:

"The free surface of the tissue under examination is somewhat irregular in its outline, and presents certain crypt-like involutions of its surface, which is covered with a layer of squamous epithelium of irregular thickness in different parts, and which extends down into and lines the free surfaces of the involutions above referred to; and is also in some sections seen as isolated nodules embedded in the general tissue. This surface epithelium is in parts clearly degenerated, the cells having mostly run together into a colloid-looking mass, in which no nuclei can be stained. In other, and more especially in the deeper layer, the cell outlines can be clearly distinguished, and nuclei stain fairly well.

"The mass of the groundwork of what is above referred to as the 'general tissue' appears to consist of a coarse, irregular granulation tissue, almost entirely of the nature of more or less organised granulation tissue, and, judging from its anatomical relationship to the epithelium, is apparently the submucous or subepithelial tissue, which has been the seat of a chronic slow inflammatory process, due probably to the irritation set up by the presence of, and by the continuous growth of, numerous cyst-like bodies which are seen scattered throughout both the epithelial and subepithelial tissue. These cyst-like bodies form at once the most remarkable and, indeed, the central feature to be described, and they occur in practically all stages of their development.

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"The fully developed cyst, examined under a Reichert's $\frac{1}{15}$ oil immersion lens with a Zeiss No. 1 ocular, shows the following structure:—It is seen to consist of a symmetrically rounded cavity, bounded by a clear hyaline wall or membrane, and filled with small cells or spore-like bodies. The tissue in which the cyst occurs is condensed around the wall of the cyst. Where it occurs in the epithelial parts of the tissues, the more or less polygonal epithelium is flattened out into cells, spindle-shaped on section. Where the cyst is found in the subepithelial tissue, the fibres and cells of this tissue form a dense zone immediately applied to the cyst wall. In these dense zones, both in the epithelial and subepithelial areas, nuclei are not readily made out. In the epithelial layer the cells in this zone seem undergoing a colloid-like degeneration; in the subepithelial area they seem to have become organised into a firm fibrous capsule, which varies somewhat in thickness in different cases, as well as in the density of its structure.

"*The hyaline cyst wall* is of pretty equal thickness throughout any given cyst. It is a clear membrane, highly refractile, and under oblique illumination shows a striation of its substance, the striæ running nearly parallel to each other and being concentrically arranged. There is no trace of cell structure observed in the membrane (or wall), and it does not appear to have any cell lining, either on the inside or on the outside, and both along its outer and inside edges it shows a clear single-contour line. In almost every case it resists stain with either carmine or picric acid or fuchsin, and is apparently quite unaffected by acetic or osmic acid $\frac{1}{2}$ per cent., or by Liq. Potassæ up to a strength of 30 per cent., even after some days in the case of this last. The average observed thickness of the cyst wall varies from ·02 mm. to ·01 mm. Where fully developed cysts in section are seen to have been ruptured, the cyst wall has either collapsed or is spread out in the neighbouring tissue as a distinct and clearly defined band-like structure, and seems, from the position occupied under such circumstances, to be possessed of some degree of elasticity. Cysts measure across from ·144 mm. to 2·24 mm.

"*The cyst contents*, seen in the case of cysts which have been ruptured.—These seem to be more or less symmetrically rounded or ovoid bodies, of an average diameter of ·005 mm. Each cell or sporule consists of a granular central material surrounded by a delicate bounding membrane, which under appropriate illumination gives a double fine contour line. These bodies are likewise refractile, their membranes darken slightly with $\frac{1}{2}$ per cent. osmic acid, and they seem to clear up slightly with acetic acid and with 30 per cent. Liq. Potassæ. The bounding membrane seems to be distinctly elastic, and where these bodies are observed inside an unruptured cyst, they seem crowded together, and apparently faceted to accommodate each other where they come in contact with each other or with the cyst wall. Whether there is any intervening substance or not it is difficult to say; but the cells in any case tend to stick to each other after they are shed from their cysts, and even to preserve their faceted appearance where they remain in contact with each other. As seen *in situ* in the cysts they stain slightly purple with picro-carmine, and also faintly but more

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marked with acid fuchsin. When shed from a cyst they infiltrate the tissue into which they are shed, retaining their characters as above detailed. This infiltration appears to be purely a mechanical one, and there is no evidence of the sporules undergoing, in the tissues into which they are shed, any change suggestive of multiplication, or of development towards the form of the complete cyst described above."

Remarks.—This was, the exhibitor considered, a case of true local psorospermosis, and he had been unable to find any record of the disease occurring in the nasal mucous membrane, though coccidia had of course been found in man in other situations. The condition, as was well known, existed in some of the lower animals, and he was therefore inclined to attribute its origin, in this instance, to direct infection from the raw hides among which the patient was working at the time he first noticed the growth.

Captain O'Kinealy, I.M.S., in reply to Mr. Spencer, said he had not the rest of the material. He had only one or two sections, which were stained and mounted at the same time. He was indebted to Major Evan for the specimen. He at first thought it was an ordinary papilloma, and was greatly surprised when he saw the condition they had seen in the specimen. He had reason to believe, though he did not think they had been published, that similar cases had been met with in Calcutta. He had not seen them. The late Major Evan, Professor of Pathology, who died from plague, had seen some of these cases, and they would have been published but for his untimely death. So far as he knew, this was the only case on record of the condition.

On the suggestion of Mr. Butlin it was decided that the specimen be submitted to the Morbid Growths Committee, and a drawing be made for publication in the 'Proceedings.'

Case of Ulcerating Growth of Left Tonsil, Side of Tongue, and Anterior Faucial Pillar in a Man æt. 52.

Shown by Dr. FitzGerald Powell. The patient came under observation on the 9th of March, 1903.

He complained of pain in his throat when swallowing, and of a pain extending up to his ears, which was worse at night. He could not open his mouth or protrude his tongue. The pain in the ears had existed for twelve months, and in the throat for three or four months. He had been losing weight.

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On examination his jaws were seen to be partially fixed, and he could only open his mouth slightly. The tongue could not be protruded. The left tonsil and the side of the tongue were seen to be the site of an ulcerating growth, which was covered with a greyish slough, and bled readily. This extended up on to the left anterior pillar of the fauces.

No specific history could be obtained, and there was no enlargement of glands in the neck.

The appearance of the disease was strongly suggestive of malignancy, but bearing in mind that not infrequently disease thought to be malignant in this situation cleared up under iodide of potassium and mercury, it was decided to give him twenty grains, with a drachm of the Liq. Hydrarg. Bichlor., three times daily.

Under this treatment he had improved very much; the ulceration was less extensive, and the pain was less. He could open his mouth wider and was gaining weight.

The ulceration had not, however, entirely disappeared, and Dr. Powell expressed a desire for the opinions of members as to the diagnosis and future treatment.

Mr. W. G. Spencer thought it was malignant. It was in an awkward situation and difficult to remove, as it had spread back to the inner side of the ramus of the jaw. It would need the L-shaped incision of Langenbeck, with division of the jaw, to remove the growth. He was doubtful whether it should be removed.

Large Papilloma of the Right Ventricular Band in a Woman Æt. 33, removed by Thyrotomy.

Shown by Mr. Waggett. The subject, drawings, macro- and microscopical specimens were shown.

The growth, about the size of a small filbert, was attached by a long base to the edge of the ventricular band. Although a simple papilloma, it had appeared in life studded with points of snowy whiteness. Intra-laryngeal manipulations under cocaine were out of the question, owing to the nervous character of the patient, and as neither the nature nor the extent of the growth was certain, laryngofissure was performed.

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The patient left the hospital on the eighth day, and the larynx was now (nine months after operation) normal in appearance and in function.

Aphonia had existed for eighteen months before the operation.

Sir FELIX SEMON said that, as he was originally responsible for the statement as to "white papilloma," he particularly wished to observe the second characteristic of these papillomata, which turned out to be malignant. Not only were they distinguished by their snow-white colour, but their excrescences were not rounded, but pointed as ordinary papillomata.

Dr. POWELL said it was an excellent result after thyrotomy. Was it not possible to remove the growth interlaryngeally?

Mr. WAGGETT said the woman was an exceedingly difficult subject, so much so that a distinguished laryngologist thought she had tubercular ulceration. It was impossible to remove even a piece for examination by the intra-laryngeal route.

CHRONIC EMPYEMA OF SPHENOIDAL SINUS; OPENED.

Shown by Mr. WAGGETT. He had employed in this case an instrument resembling a Krause's sliding attic chisel, inverted and enlarged, which Dr. Lack had devised.

CASE OF IMMOBILITY OF THE LEFT VOCAL CORD, ATTRIBUTABLE TO BRONCHOCELE, IN A YOUNG WOMAN; RESECTION; EXTIRPATION OF ISTHMUS AND LEFT LOBE.

Shown by Dr. DUNDAS GRANT. Florence A—, æt. 25, housekeeper, was first seen November 6th, 1902, complaining of soreness of throat with occasional loss of voice, which had developed during the previous three years. Although previously she had been fond of singing, she was now unable to do so, and occasionally she had complete aphonia; five years previously she had had hæmoptysis. The left vocal cord was absolutely fixed, and there was slight swelling in the region of the arytenoid cartilage. The left eyeball was slightly prominent, and there was firm general enlargement of the thyroid gland, especially on the left side. For a considerable time she was treated by means of internal administration of iodides, but

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no change took place. On the 24th March Dr. Grant excised the isthmus and the left lobe of the thyroid, leaving, however, a portion of this lobe behind, so as to avoid the risk of damaging the recurrent laryngeal nerve. A few days after the operation the patient's voice was clearer. Healing took place without any rise of temperature or other disturbance. The voice was now clearer than before, and there was movement of the left vocal cord for at least half its normal extent.

Dr. DE HAVILLAND HALL said there seemed to be more thickening and enlargement of the left arytenoid than was accounted for by pressure of the left recurrent. It was probably a joint case rather than a paralytic condition.

CASE OF PARESIS OF BOTH RECURRENT LARYNGEALS AND LEFT SYMPATHETIC IN A MIDDLE-AGED WOMAN.

Shown by Dr. DUNDAS GRANT. Mrs. A. H—, æt. about 40, was first seen on March 26th, 1903, on account of discomfort in her throat, which she stated had come on suddenly three years before. The voice was thick and seemed weak; she had a tickling cough, and on swallowing liquids there was frequent regurgitation through the nose. On examination there was found almost complete paralysis of the palate, and both vocal cords were nearly fixed halfway between adduction and abduction. The left pupil was contracted and fixed, not acting either to light or to accommodation. The left palpebral fissure was diminished and the eyeball somewhat prominent. The left eyebrow was drawn up in the endeavour to raise the left upper eyelid. The left half of the forehead was moister than the right. The movements of the tongue and lips were irregular. The knee-jerks were exaggerated, and the pulse abnormally rapid. There seemed to be a lesion in the medulla, and also one in the cilio-spinal region of the spinal cord, and in all probability specific in nature. It appeared that seven years ago she suffered from a severe sore throat, accompanied by falling out of the hair and a rash on the chest. Two children, however, born since then—one aged five, the other twelve—appeared to be in good health. She was ordered 10 grs. of

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iodide of potassium thrice daily, and when seen a week later expressed herself as feeling better and free from regurgitation through the nose when drinking, the other symptoms being, however, much the same as before.

Dr. GRANT said that the laryngeal paralysis was certainly less than when he first saw the patient, when paresis of both vocal cords was well marked. The evidence of affection of the sympathetic was still unmistakable. The improvement under iodide of potassium seemed to confirm the diagnosis of syphilis.

CASE OF DISEASE OF THE LARYNX OF TWELVE MONTHS' DURATION, PROBABLY EPITHELIOMA, IN A MAN ÆT. 50.

Shown by Dr. DUNDAS GRANT. Mr. J. M—, æt. 50, was first seen on March 31st, 1903, on account of hoarseness and loss of voice, which had developed rather suddenly and had been steadily getting worse during the last twelve months. His appetite was good; there was no pain in swallowing, and no difficulty in breathing; he was not getting thinner.

Laryngoscopic examination revealed an irregularly papillated outgrowth occupying the whole of the area of the left vocal cord, with some infiltration of the corresponding portion of the vestibule, and diminished mobility of that half of the larynx. There was irregularity and swelling of the anterior portion of the right vocal cord, with some infiltration of the corresponding ventricular band; no enlarged glands, and no apparent spreading of the thyroid cartilage. His medical attendant reported that he had been treated freely with iodide of potassium and mercury without any benefit. There was no sign of tuberculosis in the chest and no history of hæmoptysis. All possibilities of specific infection were denied.

The condition appeared to be one of extensive intrinsic epithelioma of the larynx. The patient was apparently a man of equable disposition, and otherwise in good health. The exhibitor asked for suggestions with regard to treatment. In view of the amount of infiltration and superficial extent of the disease he was inclined to think that thyrotomy with removal of the soft parts in the interior of the larynx would be insufficient, and that nothing short of complete excision of the

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larynx would be of avail. Failing this he would only advise tracheotomy, and would be inclined to place the issues before the patient and leave the choice to him. As regards removing a fragment for microscopical examination, he would be disinclined to do this unless the patient elected for radical operation, in case of the diagnosis being confirmed.

Sir FELIX SEMON agreed with the diagnosis of epithelioma, and saw no reason why a portion of the larynx should not be removed from either side. He would throw out a suggestion to members which he had found very useful in cases in which it was necessary to cut clean across the vocal cord. When the anterior part of the cord was affected it was advisable not to leave the posterior part alone, because it projected afterwards like a tumour into the interior of the larynx, but to stitch it with one or two stitches forward to the ventricular band. This procedure gave very good results, and astonishingly good results, with regard to the voice.

Dr. LACK agreed with the diagnosis of malignant disease and recommended thyrotomy. It might be possible to remove the whole of the disease by an operation which stopped short of total extirpation, but this point would best be decided after the larynx had been laid open.

Dr. GRANT asked what farther steps the members advised in the treatment.

Sir FELIX SEMON advised thyrotomy, and either removal of the soft parts or of half the larynx according to the depth of the infiltration.

Dr. GRANT said the disease had extended to the opposite side.

Sir FELIX SEMON said that made no difference. The larynx should be split, and he would then be guided by what he found.

CASE OF RAPID DESTRUCTION OF NASAL SEPTUM, PROBABLY LUPUS, IN A MALE ÆT. 34.

Shown by Dr. WYATT WINGRAVE. The patient, a well-nourished male, a plumber, complained of a sore nose of six months' duration. It commenced as a sore spot just inside the nostril, which soon became a hole, and, melting away like glue, ate its way on to the lip. He was in the habit of picking it freely and pulling out hairs. There was now complete loss of septum from before backwards, as far as the posterior limit of the vestibule, with nodular ulceration of the upper lip on the site of the philtrum, more or less covered with crusts. He gave no history of syphilis or tubercle. The gums were healthy, but

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he had some copper-coloured spots on the forehead. He had been married twelve years and had four healthy children. His wife had had no miscarriages. There was a submental enlarged gland.

Dr. GRANT said that the columella of the nose was eaten away entirely by a curious circumscribed ulcer. Had any member seen a similar case? It was very difficult to decide whether it was a case of primary syphilis, or of tuberculosis, or of epithelioma.

Mr. ATWOOD THORNE thought it was a remarkable case, of which an illustration should be given in the 'Proceedings.' He was not aware that such a case had ever been shown previously to the Society.

Mr. SPENCER said that such a condition was more often seen in inherited syphilis. One saw it coming on with great rapidity in children called scrofulous.

Dr. DE HAVILLAND HALL remarked that scrofulous tumours were mostly due to inherited syphilis; as a student he was taught to regard the two as the same thing.

Dr. WINGRAVE, in reply to Dr. Powell, said that at present he had adopted no treatment except the local application of boracic acid. The local conditions were strongly suggestive of lupus, and the process seemed almost quiet now. When he first saw the case the area affected was simply a mass of crusts.

CASE OF EXOPHTHALMIC GOITRE.

Shown by Dr. BURT. Female æt. 18. First seen about a year ago.

History.—Under treatment of family doctor for four years for anæmia and palpitation, swelling of thyroid not noticed, and had grown gradually worse.

On examination patient was very anæmic. Temperature normal, pulse 150, irregular. Hands very shaky. Very restless. No exophthalmos. Left internal strabismus. Pupils normal. Enlargement of thyroid, especially right lobe. Tongue large, pale, and tremulous. The case was diagnosed and treated as one of early exophthalmic goitre, giving first Ammon. Cit., Pot. Iod., and Digitalis, introducing strychnine and arsenic. The latter drugs did not apparently suit patient. In four weeks patient was quite free from anæmia, and the pulse was regular and normal. Hands still unsteady. Thyroid much smaller. In about three months patient was able to resume her studies, and could do her drawing, painting, and music with ease, which she

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had not been able to do for over a year. Mixture stopped three months ago. For past month, although free from anæmia, quick and irregular pulse returned with hands very shaky, again rendering it difficult for her to continue her painting, etc. Right lobe of thyroid much larger, and extended higher up beneath the sterno-mastoid. Placed under same treatment as before, but patient disliked having to take medicine. Would be glad to know if members could suggest further treatment, or whether they thought operative treatment advisable.

Dr. HALL said the patient seemed to him to be going on satisfactorily, but these cases lasted for years. As to the question of operation, there was no reason for it. The pulse was only 92, and that with the excitement of examination and strange surroundings. He advised arsenic, strychnine, and digitalis, and rest—mental and physical. He thought the iodide should be discontinued, for patients with exophthalmic goitre did not seem to tolerate the drug well.

Dr. BURT said he had kept the patient perfectly quiet, had forbidden tea, coffee, etc., all games, and everything tending to excite her.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

EIGHTY-SECOND ORDINARY MEETING, *May 1st*, 1903.

P. MCBRIDE, M.D., F.R.C.P.Ed., President, in the Chair.

JAMES DONELAN, M.B., } Secretaries.
E. FURNISS POTTER, M.D., }

Present—29 members, 1 visitor.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were nominated for election as Ordinary Members of the Society:

John Aldington Gibb, M.B., C.M.(Aberdeen).
John Malcolm Farquharson, M.B., M.R.C.P.(Ed.).

The following cases and specimens were shown:

CASE OF EPITHELIOMA OF THE LARYNX (SHOWN AT A PREVIOUS MEETING, JANUARY, 1903).

Shown by Mr. ATWOOD THORNE. When this patient was seen in January last he had had hoarseness for six months and dysphagia for a few days.

On examination the left cord was found to be absolutely fixed, and there was a growth of the left arytenoid extending on to the aryteno-epiglottidean fold.

He had been taking small doses of iodide of potassium and mercury for three weeks without improvement. The dose of

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iodide was increased, with the result that the cord gradually became more free, and the one continuous growth showed as two with an intervening space.

The patient improved up to a certain point, which was reached in the beginning of March, and the condition had remained stationary since.

When last seen, a fortnight ago, the left cord moved fairly well, the two growths remained distinct, there was no fœtor, no dysphagia, and the gland at the ramus of the jaw was distinctly smaller.

The improvement had certainly been very marked up to a point, but the diagnosis of epithelioma was adhered to. When now seen it was found that the left cord hardly moved, the growths had both ulcerated, and it was not possible to show the case (as had been hoped), as an "epithelioma showing marked improvement under treatment."

Case of Lupus of Fauces.

Shown by Dr. Kelson. The patient was a girl æt. 22, suffering from whitish patches and red infiltration of the soft palate and tonsils. She had been first seen five months ago, during the whole of which time she had been treated with antisyphilitic remedies without the slightest improvement. There were no other signs of primary or secondary syphilis. The exhibitor was now of opinion that the disease was lupus.

The President said that this case did not seem like previous cases of lupus of the pharynx which he had seen; he would like to know Dr. Kelson's reasons for arriving at this conclusion.

Mr. Cresswell Baber asked whether antisyphilitic treatment had been tried. He thought the case might be syphilitic in character.

Dr. Furniss Potter said that the appearance of this case suggested to him a condition typical of secondary syphilis. The patient had volunteered the information that she had had some "irritation" on the genitals for about three months, which had recently healed.

Dr. Kelson, in reply, said that the case was brought forward because of its resemblance to secondary syphilis. When first seen, five months ago, he had put it down to that disease, but he had altered his opinion now on the ground, first of all, that for the past five months she had been under antisyphilitic treatment, and till within the last fortnight without the slightest improvement. A fortnight ago he

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had changed the treatment and given arsenic, with the result that a small improvement was already taking place. Secondly, there were no other signs of syphilis. As regards the trouble complained of on the genitals, there was nothing there of a syphilitic character. There was no rash or falling-out of the hair.

Case of Ulceration of Tonsil.

Shown by Mr. Lake. The patient, a female æt. 33, married, complained of sore throat of five weeks' duration. The right tonsil was extensively ulcerated and covered with a thin slough; the ulceration extended on to the posterior pillar of the fauces. There was considerable dysphagia.

The President said that this case struck him as one the diagnosis of which might well give rise to conflicting opinions. He would like to know if Mr. Lake had removed a piece for microscopical examination.

Dr. Pegler suggested syphilis. The eaten-out appearance in the upper part extending to the soft palate, together with the coloration of the border of the ulcer, seemed to him to indicate specific disease.

Mr. Charters Symonds had examined this case carefully, and feared it was one of epithelioma. The edge was decidedly hard, and there was a well-marked gland in the carotid triangle, which seemed to him fairly characteristic. The short history might be misleading. He was struck by the fact, that in this situation a patient might have ulceration of an epitheliomatous nature for a considerable time with little pain. His last case was a man of sixty-five with ulceration involving the tonsil and soft palate, with a very short history indeed. It was removed and found to be epitheliomatous. Taking into consideration the hardness, the depth, and the character of the ulceration, and the presence of a gland, he greatly feared this case was malignant, and not syphilitic. Ulcerating sarcoma had also to be remembered, but the present case lacked the white appearance generally seen—an appearance more closely resembling syphilis. And again, glands occurred much later.

Mr. W. G. Spencer was in favour of Dr. Pegler's view, owing to the extension of the ulceration over the posterior pillar of the fauces, even so far as the posterior wall of the pharynx. This was rather a wide-spread area. The gland in the neck was somewhat soft. He would suggest in any case a course of antisyphilitic treatment for ten days or a fortnight. It would not hurt to punch off the edge of the tonsil where it was indurated for microscopical examination.

Mr. Cresswell Baber agreed with Dr. Pegler and Mr. Spencer as to the syphilitic nature of this case, and recommended in the first place antisyphilitic treatment.

Dr. H. Sharman said that one point which supported the syphilitic theory was, that this patient had had two children, both of whom died

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in infancy—one at the age of eight days, and the other when four months old.

Dr. LACK thought they were all rather astonished to hear Mr. Symonds' views. Most members considered this an ordinary straightforward case of tertiary syphilitic ulceration. The woman had, so far, had no antisyphilitic treatment, so there was nothing to contradict this view.

Dr. FITZGERALD POWELL proposed that Mr. Lake should show this case at the next meeting.

Mr. R. LAKE said he saw the patient for the first time only on Thursday (the previous day), and he suggested the idea of removing a piece for microscopical examination, but the patient did not wish to have this done. He would give her antisyphilitic treatment and, if anything worth reporting occurred in the further history of the case, he would bring it before the notice of the Society.

Microscopic specimens.—(1) Large papilloma from posterior aspect of cricoid cartilage, which was the apparent cause of obstruction in a case of carcinoma of the upper end of œsophagus.

(2) Papilloma from region of inferior turbinal, with absorption of internal antral wall.

Shown by Mr. LAKE.

Mr. SPENCER thought the appearance, under the microscope, of this specimen (1) represented an epitheliomatous condition. He understood it came from a case of carcinoma of the pharynx and upper end of the œsophagus. Surely Mr. Lake did not mean that the section was from a papillomatous growth, and not an epitheliomatous. It might be papillomatous in the clinical sense, but microscopically it was a portion of epithelioma.

Mr. R. LAKE, in reply to Mr. Spencer, did not consider this to be epitheliomatous.

CASE OF SUBGLOTTIC THICKENING OF RIGHT VOCAL CORD IN A MAN ÆT. 27.

Shown by Dr. DONELAN. The patient, an Italian open-air singer, had had several attacks of laryngitis, and was now just recovering from one which had lasted six weeks. On phonation the edge of the anterior third of the right cord swelled up and looked as if a subglottic thickening of the epithelium were protruding through the rima. There was some irregular thicken-

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ing of the epithelium over the posterior parts of the cord, ? pachydermia.

Mr. WAGGETT wished to confine the term pachydermia to those cases in which the mucous membrane overlying the vocal processes was affected.

Dr. FITZGERALD POWELL did not think that the term should be limited to those cases in which the vocal processes were alone the seat of the hyperplasia. He could not accept such an arbitrary localisation for a condition that was found on any part of the vocal cords, or more often in the interarytenoid folds. He understood that the term pachydermia should be kept for the description of cases in which there was a heaping-up of epithelium and a general thickening of the submucous structures—a hyperplasia of the submucous connective tissue—and not for cases of swelling of the mucous membrane, which were sometimes brought forward as cases of pachydermia. This case seemed to him, to be more of the nature of a swelling of the mucous membrane than a true pachydermia.

The PRESIDENT did not think they could possibly accept the restriction of the term "pachydermia" to those cases mentioned by Mr. Waggett, because if they did, they would do away with the fact that one met with pachydermia in the interarytenoid spaces, fold, and other parts.

Dr. DONELAN in reply, remarked that the interesting point about the case was that the right vocal process was distinctly enlarged and thickened. For that reason he thought that the swelling about the anterior third of the cord might be classed in the same category; whether it was merely an increase of mucous membrane beneath the cords, to which the term "ballooning" had been applied, he did not know, but he suggested that it took part in the same process as concerned the rest of the larynx.

CASE OF PRIMARY TUBERCULAR ULCERATION OF NASAL SEPTUM.

Shown by Mr. WAGGETT. A man æt. 35, in failing health, suffered a good deal of pain in the nose and frontal regions, and exhibited an extensive superficial ulceration of the mucous membrane of the left side of the nasal septum.

The area occupied was that opposite the anterior half of the middle turbinate, and the posterior extremity of that body was seen by posterior rhinoscopy to be enlarged, irregular in shape, and yellow in colour.

The septal ulcer was fully an inch in diameter, and its base was yellow and granular. The anterior edge alone was heaped

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up, and a specimen taken from this portion had shown tuberculous tissue with well-developed giant-cells. (Specimen shown.)

Examination of the lungs showed merely increased vocal resonance, over the right apex behind and in front. There was no history of cough or hæmoptysis.

For some two years the patient had been subject to pains in the head with nasal discharge. The symptoms had increased recently, and had been much exacerbated by taking potassium iodide.

Evidence of special exposure to tuberculous infection was wanting, but his trade entailed the inhalation of irritating fumes and dust.

The PRESIDENT considered this case extremely interesting; the only thing he regretted, and on which the patient congratulated himself, was that there was so little of the original condition left that one could scarcely see where the disease had been. He congratulated Mr. Waggett on the thorough eradication.

Dr. PEGLER had noticed a giant-cell in each specimen, but no true giant-cell systems. He did not consider that the sections confirmed the diagnosis of tubercle.

Mr. CRESSWELL BABER did not consider the appearance in this case that of typical tuberculosis of the septum. He asked whether much had been done to it.

Mr. CHARTERS SYMONDS thought the case was fairly characteristic of tuberculosis. A very marked nodular line could be seen pretty high up; it was yellowish and white in colour, and the fact remained that it was seen in a good many cases of tuberculosis of nasal septum. He had had recently a case in a clergyman who probably got it by infection with his own finger from attending tuberculous patients. He suggested that as a probable source of infection of the septum. His late assistant, Mr. Steward, now in charge of the throat department at Guy's Hospital, had published six cases of primary epithelioma of the septum, which they were able to confirm by microscopical examination, and which, after free removal, sometimes with perforation of the septum, got perfectly well. In the particular case now under his care, to which he had just referred, the septum was quite free from disease after free curetting, but the middle turbinal looked a little suspicious in character, and he found it necessary to remove it, because it was somewhat swollen. The disease was not quite so uncommon as one was inclined to think, and in the present instance there was a good deal more to be done for the patient. In one instance the affection had spread to the lips and pharynx.

Mr. WAGGETT, in reply, said that under examination with powerful illumination there was no sort of doubt as to the presence of a superficial ulceration fully as large as a penny. Its lower anterior edge was

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heaped up and fairly thick, and this he had removed for examination, but the main part of the ulceration had not been touched at all; it was exactly as he had first seen it two or three weeks ago. The man was very ill and suffered great pain in the forehead and nose, and he was losing flesh. As to this ulcer being tubercular, he ventured to think the specimens before them showed definite evidence of that disease. More specimens, however, were being stained for tubercle bacilli.

Case of Swelling in Post-nasal Space (for Diagnosis).

Shown by Dr. Furniss Potter. The patient, a man æt. 40, had come under observation two days previously complaining of a sore throat for the last three weeks, with pain on swallowing. During the last ten days the hearing had become considerably impaired in the right ear.

On examination the right half of the soft palate was seen to be paralysed, and in the post-nasal space there was an irregular swelling projecting from the right side of the pharynx, and also involving the posterior surface of the velum, which completely obstructed the view of the right choana. The swelling was covered with muco-pus and appeared to have an ulcerated surface. On palpation it felt firm and fixed. A gland could be made out below the lower jaw, but did not feel hard. The patient admitted having had a "sore" twenty years ago, but did not remember having any rash or other trouble which could be regarded as evidence of systemic infection. It was not possible to obtain any history of symptoms dating further back than three weeks.

The case was shown with the view of obtaining the opinion of members as to diagnosis.

The President said he could quite understand any hesitation in arriving at a definite conclusion as to the nature of this case. He had had the advantage of palpating it, and the diffusion of the growth made him strongly suspect malignancy. On the other hand, it seemed impossible to exclude a gumma. The only way of settling the matter appeared to him to lie in the removal of a piece for microscopical examination. This case was, he thought, worthy of detailed discussion.

Dr. Furniss Potter said he could not get the man to admit the existence of any symptoms previous to three weeks ago. His own opinion as to the diagnosis lay between malignant disease and gumma. He proposed giving the patient a course of potassium iodide and mercury.

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Case of Chronic Laryngitis with Papillated Thickening of the Vocal Cord and Chronic Rhinitis.

Shown by Dr. Dundas Grant. The patient was a middle-aged woman, who for about ten years had suffered from loss of voice, or, at all events, extreme dysphonia, almost amounting to aphonia. When seen a week ago there were some green crusts in the larynx. These were removed by brush after injecting menthol and olive oil, and a white fringe upon the edge of the left vocal cord was disclosed; it looked like one of those white papillomata which have been supposed by some to be malignant, and by others to be not necessarily so at all. During the week she had been using a vapour with some turpentine in it, and had been practising nasal irrigation (as he had always a suspicion in these cases, that the crusts came from the drying up of the secretion inhaled from the nose), with the result that the crusts had disappeared to a considerable extent.

On looking at the patient to-day, the fringe-like appearance on the left vocal cord was seen to be less than before, and a good deal of the whiteness then visible, was due to the presence of inspissated mucus on the surface. He did not think the case was malignant, but it was a question what to call it; whether to apply that much-discussed word pachydermia to a portion of it. In any case it was a chronic laryngitis which he attributed to nasal disease. He was anxious to have the opinion as to whether it was a neoplasm of the vocal cord or simply an inflammatory condition. He thought that, in any case, it was not malignant.

Dr. FitzGerald Powell said he thought this was a case of simple hypertrophic laryngitis consequent on an abnormal condition of the nose and pharynx (rhino-pharyngitis sicca). The left cord was swollen, and there was a small slough apparently on the edge of the cord. He would like to know if any caustic paint had been applied to the cord, as that would in all probability account for the white slough.

Mr. Cresswell Baber thought it looked more like thickening of the vocal cord than papilloma.

The President said that his opinion of the case after examination inclined him to take a more serious view of it than previous speakers. There was no doubt a very distinct thickening of the left cord as opposed to the right, and a certain amount of congestion. The

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left cord moved freely, but at the same time he would be sorry to say that the present condition was not the commencement of some malignant process. A maxim which experience had taught him to recognise and act upon was, that where one had a localised thickening of one vocal cord, one had usually the advent of some grave change, depending either upon general disease such as tubercle or syphilis, or upon local malignancy.

Dr. Dundas Grant, in reply, said it was difficult to understand why it should be confined to one vocal cord. They did occasionally find one vocal cord affected more than the other, particularly in cases of papilloma. It was sometimes seen on one vocal cord where the other was perfectly normal, but he did not know whether that was a very serious question, although worthy of consideration. His own opinion was, that it was simply a chronic laryngitis, and that the papillæ of the mucous membrane had become exaggerated. The appearance of papilloma was, he thought, very much exaggerated just now by the presence of inspissated secretion on the surface. He would like to show the case again.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

EIGHTY-THIRD ORDINARY MEETING, *June 5th,* 1903.

P. MCBRIDE, M.D., F.R.C.P.Ed., President, in the Chair.

JAMES DONELAN, M.B., }
E. FURNISS POTTER, M.D., } Secretaries.

Present—28 members, 1 visitor.

The minutes of the previous meeting were read and confirmed.

The ballot was taken for the following gentlemen, who were unanimously elected:

John Aldington Gibb, M.B., C.M.(Aberdeen), London Throat Hospital.

John Malcolm Farquharson, M.B.(Edin.), M.R.C.P.(Edin.), 2, Coates Place, Edinburgh.

The following cases and specimens were shown:

LARGE POST-PHARYNGEAL SWELLING IN A GIRL ÆT. 9.

Shown by Mr. WAGGETT. The right side and posterior wall of the œsophagus was pushed forward by a rounded mass the size of a pigeon's egg. A number of enlarged glands was present below the angle of the jaw on the right side. The

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child had been quite well until attacked by measles three years ago. Enlargement of the cervical glands was noticed soon afterwards, and nine months ago the large pharyngeal swelling had first been noticed, and this had latterly increased in size, causing some difficulty in breathing during sleep. The child appeared to be in good general health. No lesion was detected in the lungs, spleen, or lymphatics elsewhere. No family history of tubercle.

Dr. FOSTER MACGEAGH thought it was a chronic retro-pharyngeal abscess which had existed for some considerable time, probably tubercular in origin. Incision he thought would give relief.

Dr. SCANES SPICER thought that usually in a retro-pharyngeal abscess there was a more gradual shading off of the swelling into the surrounding tissues.

Dr. HERBERT TILLEY thought there could be no question as to the nature of the swelling; it seemed to possess all the characteristics of a retro-pharyngeal abscess, and was probably due to suppuration of a deep cervical gland, the pus from which had found its way behind the posterior pharyngeal wall. The gland in question might be tubercular or not. He had recently seen two such cases; the first supervened within a week of the removal of tonsils and adenoids by the medical attendant. High temperature and general symptoms of septic infection characterised the case. At the operation the retro-pharyngeal swelling was found to consist of an acutely inflamed gland, which would probably have suppurated in the course of a few days. The second case was under his care at present, and was noticed at the time the operation for removal of adenoids was undertaken.

Dr. DE HAVILLAND HALL said that in most cases of retro-pharyngeal abscess the swelling was in the centre, but this seemed to be rather on one side.

Sir FELIX SEMON was not so certain that this was an ordinary retro-pharyngeal abscess. It had not the usual smooth semi-globular appearance of such a one, but there were dimples on the surface. It might be a tubercular mass broken down in parts, or even a case of sarcoma. As to the operation for the removal of adenoids being *followed* by retro-pharyngeal abscess, in his own practice he had never seen such a chain of events, but he had seen two cases in which there was a *co-existence* of retro-pharyngeal abscess with enlarged tonsils and adenoids; the abscess in these cases had, of course, to be evacuated before performing the operation on the tonsils and adenoids.

Mr. CHARLES A. PARKER thought this was a case of retro-pharyngeal abscess. With regard to Dr. Tilley's question, he had seen one case of retro-pharyngeal abscess commencing one month after the operation for removal of tonsils and adenoids; but in this case the patient had developed measles a fortnight after the operation, so that it was quite likely that the abscess was secondary to measles, and not due to infection after the operation.

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Mr. E. B. WAGGETT, in reply, said one could not lightly dismiss the idea of a sarcoma, but he believed that the swelling was a large mass of tubercular glands. The enlarged cervical glands were observed three years ago after an attack of measles, while the pharyngeal mass made its appearance much later. He proposed to attack the case by an external operation.

CASE OF SWELLING IN POST-NASAL SPACE (SHOWN AT LAST MEETING).

Re-shown by Dr. FURNISS POTTER. When seen in May last there was a swelling occupying the right half of the naso-pharynx, and completely obscuring the right choana. Under the administration of potassium iodide and mercury the infiltration had completely disappeared. There was nothing abnormal to be seen now, except that the right Eustachian cartilage appeared to be somewhat larger and redder than the left, and there was still slight drooping of the right half of the soft palate.

CASE OF SUPRA-NASAL CYST IN AN INFANT 15 MONTHS OLD.

Shown by Dr. WYATT WINGRAVE. The cyst was present at birth, and had gradually increased in size with the infant's growth. It was about the size of a small haricot bean, situated in the middle line of the bridge of the nose. The base was apparently attached to the periosteum of the nasal bones, but not to the superjacent skin. No dimple or cleft in the osseous suture could be felt, nor any evidence of intra-cranial connection. It did not vary in size, shape, or tension during crying.

Dr. Wingrave considered it to be a simple dermal cyst, and asked for opinions as to the expediency of dissecting it out.

CASE OF GUMMA OF EPIGLOTTIS.

Shown by Mr. DE SANTI. The patient, a married woman æt. 32, attended the Throat Department of Westminster Hos-

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pital on April 23rd, complaining of great pain in swallowing and some dyspnœa. The symptoms had been coming on gradually for six weeks, and latterly the patient had been feeling very ill.

Examination of the larynx revealed a very large red, angry, œdematous swelling of the whole of the epiglottis. No view of the cords could be obtained. There was no history of cough, and examination of the chest showed nothing abnormal.

The patient had been treated eight years previously for syphilis.

A provisional diagnosis of gumma of the epiglottis was made, and the patient put on iodide of potassium.

After a week's treatment the swelling began to lessen, and now there was scarcely any swelling to be seen, just a little thickening remaining on the left side of the epiglottis.

Enormous Fibro-lipoma of Larynx.

Shown by Mr. P. de Santi. The specimen included the thyroid bone, larynx, and first ring of the trachea. At the posterior aspect of the larynx, to the left of the middle line, was a large pendulous tumour measuring seven and a half inches from above downwards. It was covered by the mucous membrane of the pharynx. It consisted of three distinct parts—two upper portions closely resembling each other, and separated by a deep sulcus. The right one of these was continuous with the left side of the epiglottis by a band of mucous membrane, and it sent a prolongation into the upper aspect of the larynx. It had been bisected. The cut surface looked like fat, but on close examination bundles of fibrous tissue were seen passing through it. The largest part of the tumour was rounded in shape, measured rather over five inches in length, and was connected with the two upper portions by mucous membrane. Anteriorly, where it was attached to the wall of the œsophagus, it was not covered by mucous membrane. Its cut surface was similar to that of the portion already described.

History.—J. A—, æt. 80, a robust man of active habit, had been admitted into Westminster Hospital in 1853. About twelve

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years before he had suffered from occasional fits of choking, especially marked when he became excited. This increased in severity, and a swelling was noticed in the throat. Four years before death, during vomiting, a large mass protruded from the mouth, and the patient had to return it as speedily as possible to prevent suffocation. Sometimes he could swallow solids better than fluids: he was fairly comfortable if he took food slowly. The voice was husky, and during excitement often became inarticulate. The patient died suddenly whilst smoking, and it was presumed that the fumes of the tobacco produced sudden cough with displacement of the growth and suffocation.

At the post-mortem examination the viscera generally were found to be healthy. In addition to the tumour preserved in the specimen several small ones were noted in its immediate neighbourhood.

Microscopic examination showed the growth to consist of fat, arranged in part in layers separated by fibrous tissue. The mucous membrane covering the growth was separated from it by a capsule of connective tissue.

The PRESIDENT said that some years ago he had several cases of fibro-lipoma of the larynx, and in one of them there was a recurrence—a tumour the size of a bantam's egg grew from the upper surface of the epiglottis. This he removed, and after some months recurrence took place, and he removed another tumour just as large. What especially struck him about this case (and another which he reported at the same time) was the very small amount of symptoms produced in proportion to the size of the tumour. At the time the literature on the subject was very scanty, and he was sorry to say it had not much increased even yet. He thought this subject of lipoma of the larynx exceedingly interesting, and one which he fancied was very little touched upon, owing to the fact that there were very few cases on record, and that the material was insufficient.

Sir FELIX SEMON said that he had been informed that in the 'Transactions of the Pathological Society' for 1853 an illustration of this specimen was published, but there it lay buried and little accessible to specialists, both in this and other countries. He thought it would be a good thing if permission could be obtained from the Council of the Pathological Society to reproduce this illustration in the 'Proceedings' of their own Society, where it would be welcome abroad generally as well as to themselves. He therefore proposed that they should approach the Pathological Society with this end in view.

Dr. DE HAVILLAND HALL seconded the proposal of Sir FELIX SEMON, which was carried *nem. con.*

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CASE OF INFILTRATION OF SOFT PALATE (? CAUSE).

Shown by Mr. F. J. STEWARD. George W—, æt. 39, stevedore, came to Guy's Hospital in August, 1902, suffering from a quinsy on the right side. This was opened, and at first the patient seemed to be doing well. A month later, however, the soft palate was still infiltrated, and the uvula was somewhat œdematous. This improved at times and again relapsed, so that on the whole little change took place.

In January, 1903, some change in the voice was noticed, and found to be due to paresis of the soft palate, which was still infiltrated. As on inquiry the patient admitted having had syphilis twenty years ago, he was given iodide of potassium in increasing doses, and later mercury also. No improvement took place, but rather the reverse.

In March, 1903, a small sinus was found opening in the right supra-tonsillar fossa; this was opened up and quickly healed.

The present condition showed some infiltration of the soft palate and uvula, and complete paralysis of the same parts. The nose, naso-pharynx, and larynx were normal; the knee-jerks were present; the pupils reacted normally, and there was no evidence of paralysis in any other part of the body. There was no complaint of headache or vomiting, the optic discs were normal, and, in fact, no evidence of disease of the central nervous system could be discovered.

Dr. DUNDAS GRANT asked if Mr. Steward had described the condition found on palpation of posterior nares, or the post-rhinoscopic appearance.

Sir FELIX SEMON said he thought it was a matter of regret that the description of this case was so very brief, and he would like to mention that the palate was absolutely motionless on phonation, and fluids regurgitated. The infiltration was not a very prominent feature, and additionally in his opinion there was a good deal of simulation in this case. The patient phonated differently on different occasions, uttering sometimes unearthly sounds, and at other times phonating quite properly.

Mr. F. J. STEWARD said there was nothing abnormal to be made out by post-rhinoscopic examination. In reply to Sir Felix Semon, he said that the only reason he described it as a case of infiltration of soft palate was that the infiltration appeared first. The palate moved well at first, but in March last it became paretic.

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Microscopical Section of Gumma of Nasal Septum.

Shown by Dr. Pegler. The patient was a gentleman æt. 30, who complained of right nasal obstruction following what he described as a "cold in the head," which had lasted long and had not cleared up. The obstruction was of about three months' duration, and at one time a fleshy substance, "half as big as a marble," had been blown into the handkerchief, attended by bleeding. Inspection disclosed a red flattish mass in the right nasal chamber, which, owing to a deflection of the septum to the same side, was completely blocked. The growth was attached to the septal cartilage, and considerably overhung its broad basal attachment. It extended backwards somewhat indefinitely, and reached upwards to the roof of the fossa. From its outer aspect numerous fibrous adhesions extended over to the opposite inferior turbinal. The surface was slightly rough, and easily penetrated by a probe.

The mass was removed under cocaine at one sitting with septum knife aided by scissors and snare, exposing the triangular cartilage; a strong solution of chloride of zinc was applied to all the remaining portions that could not be detached.

The patient was seen but once after this, having to rejoin his company, but he wrote a short time afterwards saying that the nasal passage had filled up again, and that a small and inconspicuous nodule that had been pointed out in his hard palate had broken down and formed a huge sore. This fact went far to justify a diagnosis of syphilis, which the very beautiful section under the microscope, kindly made for the exhibitor by Dr. Wingrave, seemed to confirm.

The section was that of "a granuloma of the mucous membrane, the connective-tissue framework of which is infiltrated with small round-cells, which abound especially towards the circumference; these granuloma cells exhibit a strong tendency to develop into fusiform cells and sclerotic tissue. A few groups of altered racemose glands remain, but there are no giant-cells, and the periphery is enclosed by a limiting mem-

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brane destitute of columnar or stratified epithelium. The most characteristic feature of the specimen, however, is the activity displayed by the endothelial layer of the connective-tissue cells of the vascular sinuses and small vessels. The lumen of these latter is in many instances completely blocked by these cell masses, exhibiting in a remarkable manner the peculiar features of endarteritis obliterans."

Dr. Wyatt Wingrave said, with reference to the histology, that the most characteristic feature of the section was the endoarterial changes taking place. There was complete occlusion of some of the blood-vessels, which was very suggestive of a process allied to syphilitic conditions.

A Case of Laryngeal Fistula.

Shown by Dr. W. H. Kelson. The patient was a man aged about 58, who had cut his throat with a razor in November last, dividing amongst other structures the thyro-hyoid membrane and stylo-pharyngeus, thyro-hyoid, omo-hyoid, and sterno-hyoid muscles, the result being that the larynx had fallen downwards and forwards, and that he could not swallow or speak in an audible voice, though the vocal cords moved perfectly. Suggestions as to treatment were requested.

Mr. Waggett said that Dr. Kelson had allowed him to see the case beforehand, and the man was very eager to have the fistula closed. It seemed to him this would be quite the proper thing to attempt, and it should not be very difficult. The dislocation of the larynx was one of forward rotation rather than of depression. There was no scar tissue holding the organ in its abnormal position, and he believed that after section of the sterno-thyroid muscles it would be possible to bring it up so as to obtain secure suturing to the base of the epiglottis and closure of the pharyngeal fistula.

Dr. Lack was inclined to think it would be difficult to close the fistula from the short examination he had been able to make that day. He suggested that if it were found impossible to close it, it would be well to allow the opening into the larynx to remain, but to sew up the opening into the œsophagus. In this way the man would be able to swallow perfectly, although he would continue to breathe through the external opening.

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Case of Thickening and Impaired Mobility of the Left Vocal Cord.

Shown by Dr. Lambert Lack. The patient, a man aged about 58, had suffered from hoarseness off and on for the past nine months. The hoarseness had increased lately, and he was now almost aphonic. The man's general health was good, and he complained of no other trouble.

Upon examination both vocal cords were slightly thickened and congested, but the left cord was more congested, slightly more thickened, and it moved less than its fellow. The rest of the larynx was normal.

The case was shown to elicit opinions as to diagnosis, the suggestion being that the case was probably one of malignant disease. The patient had been treated with iodides without improvement. Was it advisable to wait or to perform an exploratory thyrotomy at once?

The President considered the case one in which doubt as to the cause of defective movement was justifiable. The deficient mobility seemed most noticeable when the patient laughed. The left cord appeared to him thickened. Putting all the facts together, he was inclined to suspect that possibly, if not probably, this might be the commencement of a malignant process.

Sir Felix Semon agreed entirely with the President's remarks.

Case of Multiple Sinus Suppuration, showing the Results of Operation upon the Sphenoidal Sinus, with Demonstration of a New Instrument.

Shown by Dr. Lambert Lack. The patient, a woman æt. 25, had been under the exhibitor's care for over two years with suppuration in all the nasal accessory sinuses on the left side. The antrum had been drilled through the tooth socket, and a tube was still retained. The ethmoidal cells were then curetted, and subsequently the frontal sinus was obliterated. Pus still continuing to come into the nose, and to enter the post-nasal space, further exploration was carried out, and it was found

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that the sphenoidal sinus was full of pus. The opening of the sinus had been brought well into view, as the result of the removal of the ethmoidal cells. As washing out the cavity through a cannula inserted into the ostium of the sinus failed to cure the patient, the opening was enlarged with a Hajek's hook, and the instrument now shown was then introduced, and the entire anterior wall of the sinus was cut away. The operation was easy, and was performed under cocaine anæsthesia without much pain. The opening made was permanent, and allowed free drainage of the sinus.

Dr. Herbert Tilley asked what treatment the patient was carrying out at present, as there still seemed to be some suppurating foci in the left nasal cavity.

Dr. Dundas Grant said that the difficulty with regard to the sphenoidal sinuses was not so much that of making an opening as of keeping the opening, when made, from closing. He asked Dr. Lack what method he had employed in this case, and whether he had any difficulty in keeping the opening from contracting, and how long ago it was since the opening was made.

Dr. Lack, in reply, said that the opening had been made some three months ago, and showed little if any disposition to close. The only precaution he took was the removal of the entire anterior wall of the cavity. The sides and floor of the cavity still remained flush with the edges of the opening.

Pedunculated Tumour growing from the Region of the Right Tonsil.

Shown by Dr. Herbert Tilley. The patient was a boy æt. 6 years, in whom a freely movable pedunculated tumour the size of a Tangerine orange was growing from the right tonsillar region. It was first noticed two months ago, when the child complained of choking fits while eating. Since this period the growth had been twice removed by Dr. Williamson, of Earlsfield, but it had rapidly recurred. As seen at present the tumour was freely movable, and could be projected towards the anterior part of the mouth or partially swallowed. The surface of the tumour was red, granular, and dotted here and there with small superficial ulcers. It did not bleed when manipulated, neither had it done so when it had been accidentally bitten

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by the patient, although, as a result of this, small portions of the surface had sloughed off.

There was a small, hard, freely movable gland behind the angle of the right jaw. Dr. Herbert Tilley could not state the exact region from which the growth sprung, because the lad was too nervous to examine without an anæsthetic. It was proposed to remove the growth without delay.

The PRESIDENT would very much like to hear whether any member had seen a similar case. He had not exactly. He had seen pedunculated growths, but none which recurred in the way this one did after removal.

Sir FELIX SEMON said he spoke at the risk of being a false prophet, but he was practically certain, from both the description of the repeated rapid recurrences after operation and from the present aspect of the tumour, that this was a malignant growth, and the only point which seemed to be an obstacle to this diagnosis, viz. its *pedunculated* nature, was, in reality, no obstacle at all. He might perhaps remind the Society of a case published by him ten years ago in the 'Transactions' of the Royal Medical and Chirurgical Society; the specimen was in St. Thomas's Hospital. The case was one of malignant growth of the thyroid gland which perforated into the trachea, and from the moment it did so and met with no resistance it became pedunculated. The specimen in the museum of St. Thomas's showed a big mass, very similar to that in Dr. Tilley's case, in the trachea, and a smaller mass besides, which was also pedunculated. In his remarks on the case Mr. Shattock drew attention to the fact that there was a tendency for malignant growths, if they perforated into a cavity where they met with no resistance at all, to become pedunculated. Therefore, having regard to the rapidity of recurrence and ulcerated appearance of the growth in conjunction with this tendency, he had little doubt that Dr. Tilley's case was one of malignancy.

In answer to Sir Felix Semon, Dr. Herbert Tilley said that he thought the growth would not turn out to be one of the most malignant forms of sarcoma, in spite of the fact that it had already recurred twice after removal. Its non-vascular nature and free mobility would suggest a preponderance of fibroid tissue rather than the embryonic tissue associated with the more malignant forms of sarcoma.

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Archivii Italiani di Laringologia (Naples).
Annales des Maladies de l'Oreille, du Larynx, etc. (Paris).
Bollettino delle Malattie dell' Orecchio, etc. (Florence).
The Laryngoscope (St. Louis, U.S.A.).
Monatsschrift für Ohrenheilkunde, etc.
Archivio Italiano di Otologia (Turin).
Archives Internationales de Laryngologie, Otologie, et Rhinologie (Paris).
La Parole (formerly Revue de Rhin., Otol., et Laryn.).

Transactions of the following Societies:

British Laryngological, Rhinological, and Otological Association.
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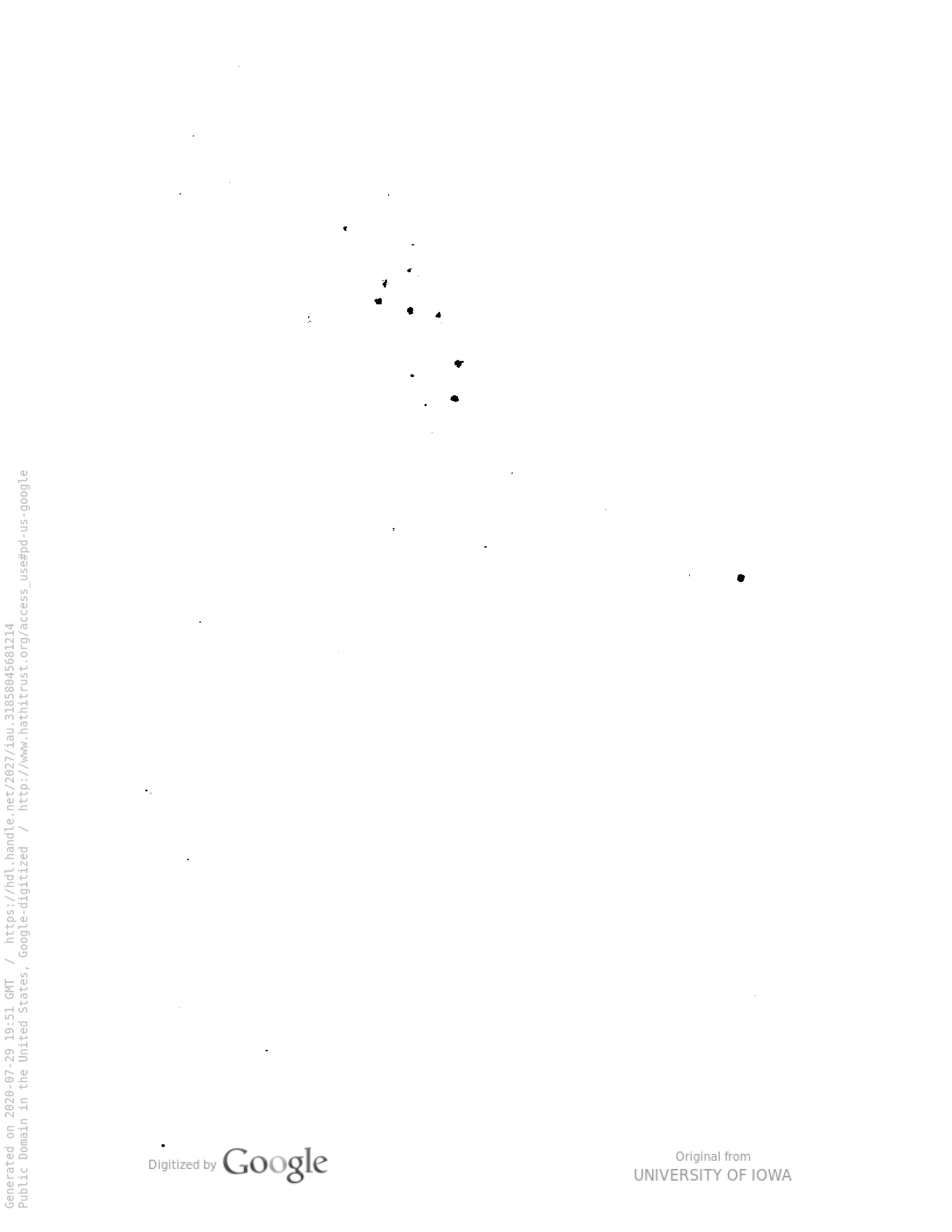

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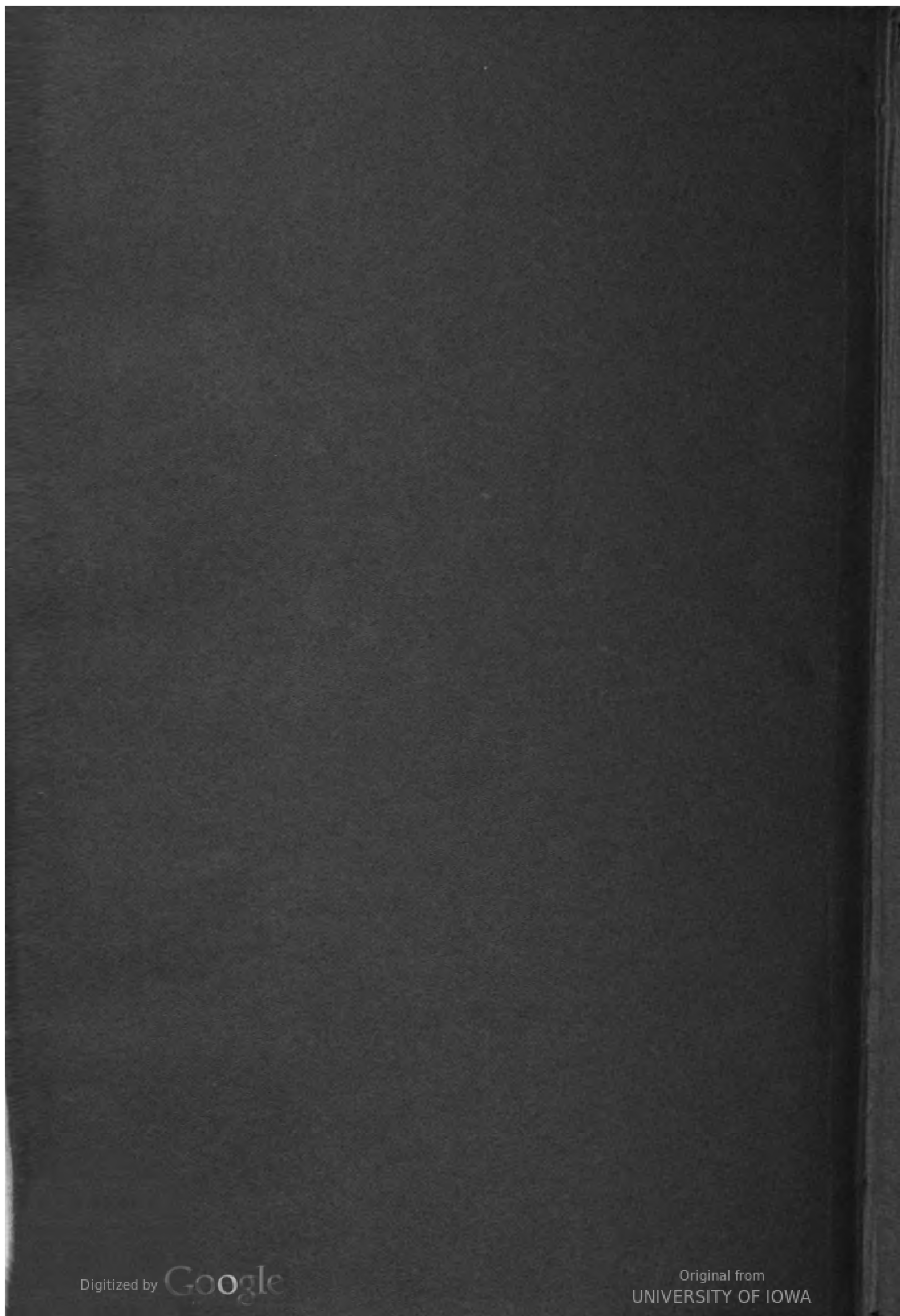
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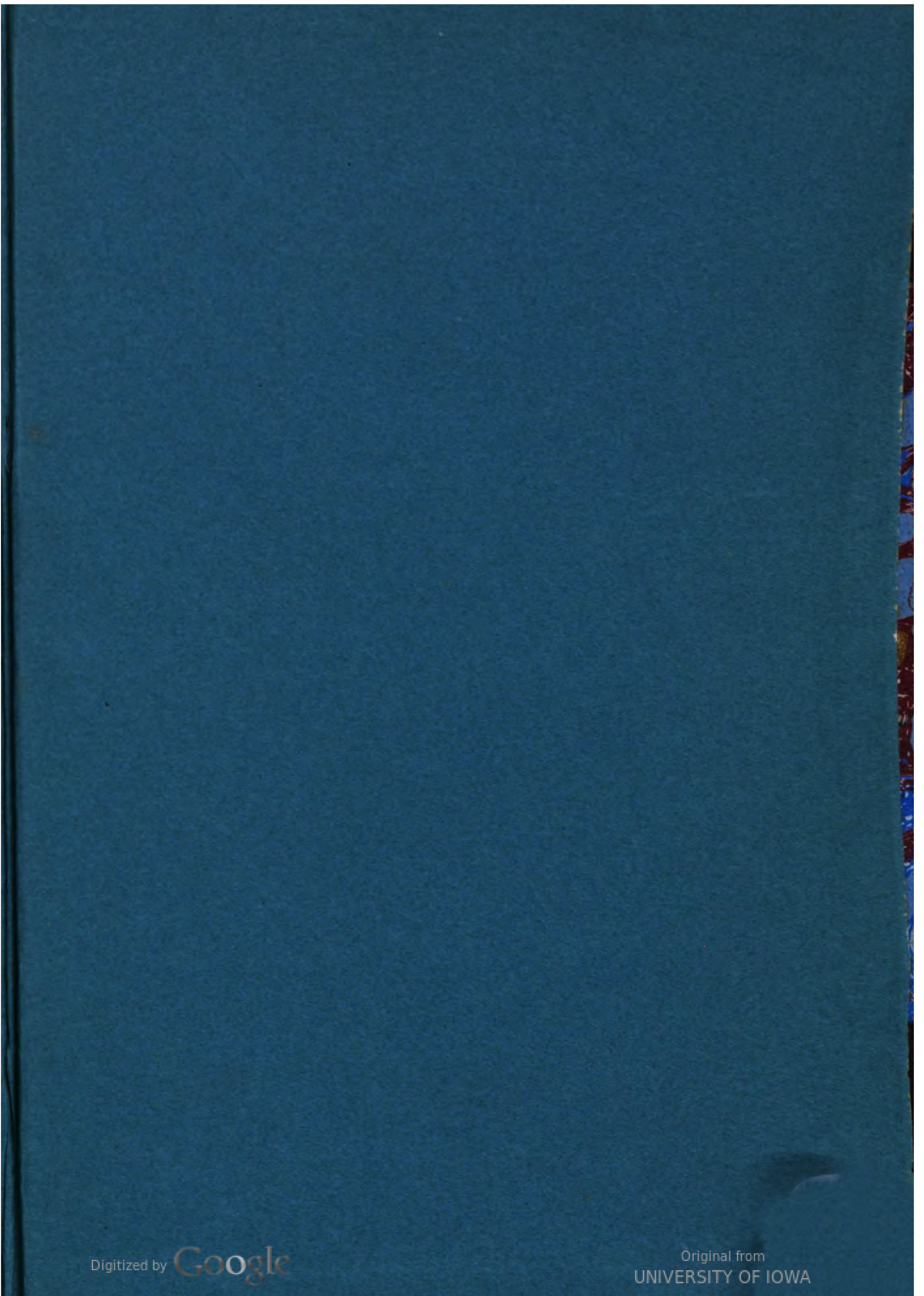

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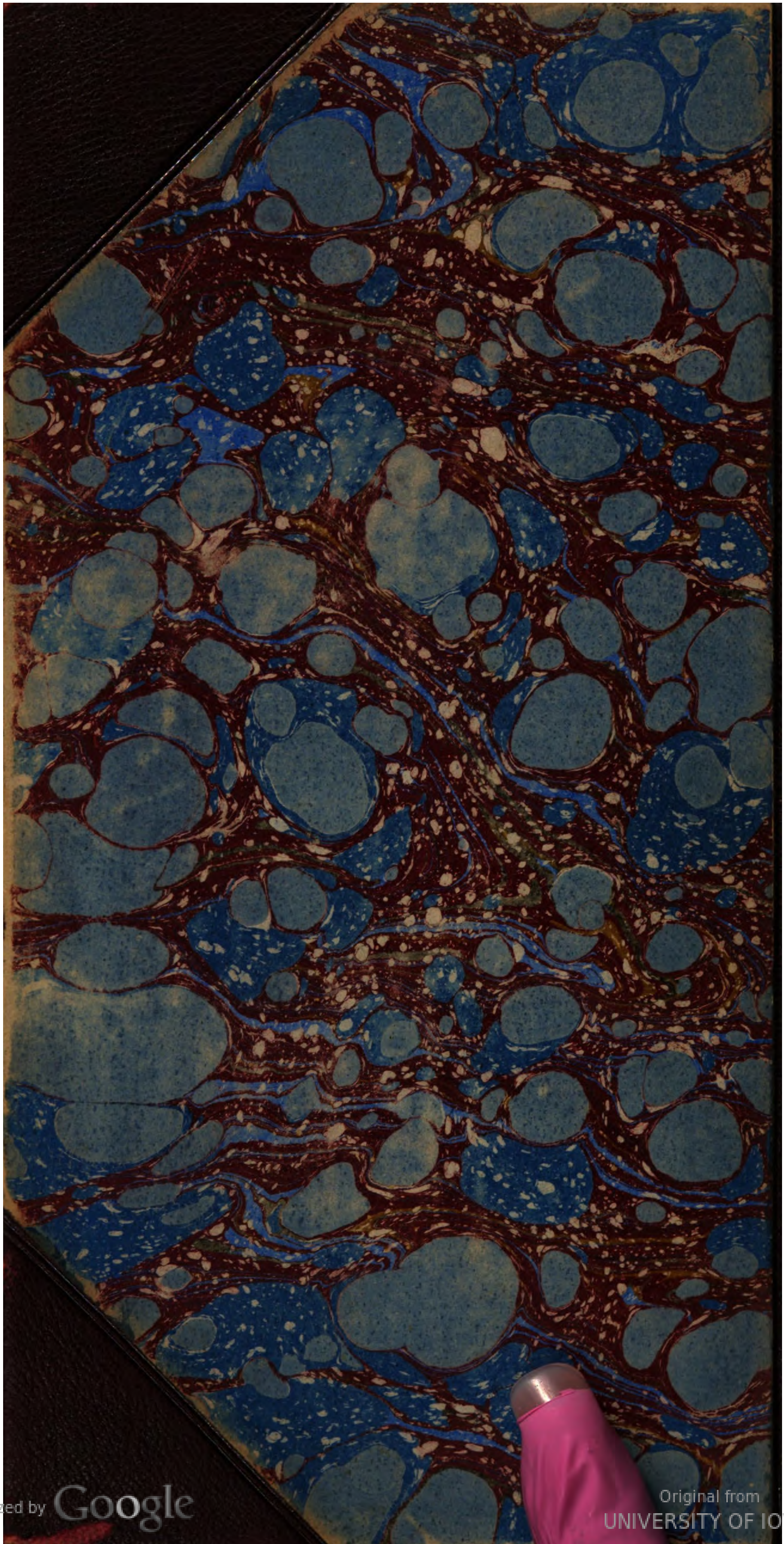

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