PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY

OF

LONDON.

VOL. I.

1893–94.

WITH

LISTS OF OFFICERS, MEMBERS, RULES, ETC.

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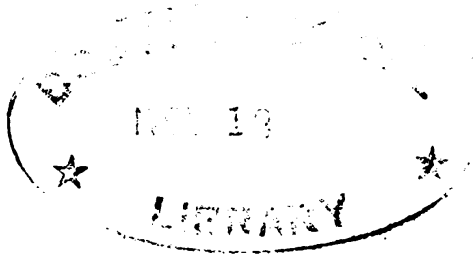
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OFFICERS AND COUNCIL

OF THE

Laryngological Society of London

ELECTED AT

THE ANNUAL GENERAL MEETING,

JANUARY 10TH, 1894.

President.

FELIX SEMON, M.D., F.R.C.P.

Vice-Presidents.

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E. CRESSWELL BABER, M.B. | DUNDAS GRANT, M.D.
A. BRONNER, M.D. | T. MARK HOVELL, Esq.
C. J. SYMONDS, Esq.

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Present—16 Members and 3 Visitors.

The following gentlemen were elected Members of the Society:
Herbert Tilley, M.D., F.R.C.S.
Richard Lake, F.R.C.S.
R. S. Charsley, M.R.C.S.

The following candidates were proposed for election:
Charles Rotherham Walker, M.D., Leytonstone.
Dennis Embleton, M.R.C.S., Bournemouth.
Henry Davis, M.R.C.S., London.
Vincent Dormer Harris, M.D., F.R.C.P., London.
William Arthur Aikin, M.D., London.

The minutes of the previous meeting were read and confirmed.

Dr. de Havilland Hall moved, and Dr. Dundas Grant seconded, a vote of thanks to Dr. Semon for his generous gift to the Society of twelve electric lamps. This was carried by acclamation, and Dr. Semon replied.

The following case was exhibited by Mr. Cresswell Baber.

CICATRIX OF PHARYNX.

M. B—, æt. 15. At three and a half years of age the patient had severe scarlet fever with a very bad throat, and subsequently an attack of measles. Scarlatina left her with purulent discharge from either ear; also a difficulty in swallowing, which latter has not given her much trouble till recently. Admitted into the Brighton Throat and Ear Hospital November 7th, 1892. She takes soft food readily, but

for meat requires an unusually long time. Liquids in small quantities are easily swallowed, but in large quantities produce a feeling of suffocation. Makes a slight noise during sleep. No dyspnœa. No reliable history of congenital syphilis. Oro-pharynx presents a broad white band extending across its posterior wall. Behind uvula it leaves a gap measuring some $\frac{1}{2} \times \frac{1}{4}$ inch. On depressing the tongue firmly the upper end of a second opening comes into view. Irregular granulations on sides of cicatrix. With laryngoscope the cicatrix is seen to extend to either side of the epiglottis, leaving a heart-shaped opening about $\frac{1}{2}$ inch across, through which the larynx is seen.

Nose.—Catarrh.

Ears.—A perforation of either membrane.

November 19th.—Under cocaine the lower opening in cicatrix was enlarged posteriorly by removal of a piece of the cicatrix of about the size of half a sixpence. The tendency to contraction was as far as possible prevented by systematic dilatation with the forefinger. The result is that the opening is slightly larger and the patient swallows quite well now, but still makes some noise during sleep. It was thought that a large ulcer on the posterior pharyngeal wall had, in healing, drawn the two sides of the pharynx together.

Dr. HALL thought that no further treatment was advisable in this case.

Mr. CHARTERS SYMONDS referred to two cases of pharyngeal stricture. One in a syphilitic child, where the opening was small and annular, admitting the tip of the forefinger. The child could swallow freely through the opening. In the other the pharynx was closed at the root of the tongue by a thin web, in which was a small orifice. The palate was not adherent, and nasal respiration was possible. He did not think that dilatation by bougies was of any use in such cases.

MYXŒDEMA TREATED BY FEEDING WITH FRESH THYROID GLAND.

Mr. CRESSWELL BABER showed photographs of a patient, a married lady, æt. 57, who had exhibited symptoms of myxœdema for about ten years. First seen January 24th, 1893, in consultation with Dr. Uhthoff. Thyroid gland could not be felt.

January 27th.—Half lobe of raw sheep's thyroid was given. This was followed in about thirty hours by the usual "aching" all over the body. Temperature, which had been subnormal, rose, and a teasing, hacking cough came on. Examined on February 3rd the

larynx and pharynx were found normal. No abnormal chest-sounds, except slight rhonchus. Tenderness on pressure over region of thyroid isthmus. Puffiness slightly diminished.

During next three weeks rather over half a lobe of gland was given.

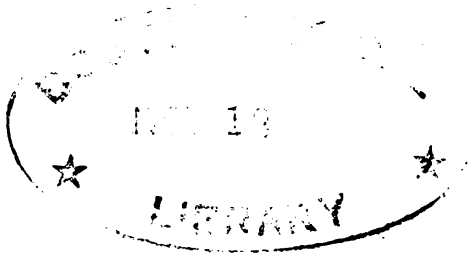
On 26th her head began to feel queer, as if she were going out of her mind. She became completely changed from her usual manner, being very excitable, trying to lock herself into her room, and exhibiting symptoms resembling subacute mania, with sleeplessness. Seen March 4th she had a wild look about her eyes, but no delusions. Her appearance had greatly improved. There had been general desquamation, which was still going on on hands and feet. Ordered Ammon. Bromid. gr. x, 4tis horis. Soon after this the head symptoms disappeared, sleep returned, and the patient gradually improved. One third of a lobe of thyroid given at longer intervals produced slight headache, but no further head symptoms. Previous to other treatment there had been no mental disturbance, and there is no insanity in the family.

Between January 25th and April 28th she lost 1 stone 1 lb. 6 oz. in weight. Very slight return of perspiration, which was absent before treatment. Some regrowth of hair on head. Marked improvement in brightness of intellect, quickness of movement, &c. The presence of tenderness over the region of the thyroid isthmus with cough and attacks of choking at night are said to have occurred on and off for several years, and were perhaps temporarily intensified by the treatment.

Dr. Clifford Beale showed a case of myxœdema successfully treated by small doses of simple glycerine extract of thyroid gland. Considerable laryngeal dyspnœa had at first been present, owing to œdema of the uvula, ary-epiglottic folds, and other parts of the larynx, which had subsided. The skin had been perfectly dry until small doses of pilocarpin had been given, after which sweating had been at first profuse but normal ever since.

Syphilitic Disease of Pharynx and Larynx in a Tubercular Subject.

Dr. Clifford Beale showed a patient with marked family history of phthisis, and a clear history of infection of syphilis four years previously. The pharynx was scarred and cicatrised, but the larynx when first seen presented all the familiar appearances of tubercular disease, except for detachment, and contraction of the detached end,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of the left ventricular band. Under treatment all the acute symptoms had disappeared, but the œdematous swelling of the epiglottis and the arytænoid cartilages had only begun to get less after the syphilitic signs had cleared up.

Rhinitis atrophica fœtida.

Dr. William Hill showed a pathological specimen of rhinitis atrophica fœtida in association with—

1. *Absence* (? congenital) of—
   (*a*) Septum (mostly absent).
   (*b*) Middle turbinals.
   (*c*) Inferior turbinals.
2. Cleft of hard palate (complete).

There appeared to have been at a former period a cleft of soft palate and hare-lip, since united by operation. The openings into the accessory cavities were normal, with the exception that there was a large accessory opening into the antrum of Highmore on each side. The sphenoidal sinuses were small.

Mr. Stewart suggested that the absence of the turbinals was due to the atrophic rhinitis, and not the rhinitis to the absence of the bones. A congenital malformation might have been present in addition to the rhinitis.

Mr. Baber thought that the condition was probably the result of syphilis.

Dr. Hill, in reply, urged that the symmetrical absence of the parts, the cleft in the palate, and the want of evidence of bone disease, pointed to a congenital rather than a pathological origin.

Right Hemiplegia; Paralysis of Right Half of Soft Palate and Abductor-paresis of Right Vocal Cord, the last-named certainly not of cortical origin.

Dr. Felix Semon showed this case. K. H—, æt 19, dressmaker. (The patient is shown by kind permission of Dr. Hughlings Jackson, F.R.S., under whose care she is at present as an in-patient in the National Hospital for Epilepsy and Paralysis.)

History.—Previously always well. Family history good. In December, 1890, a box of matches got alight in the patient's hand one night, frightening her very much, although she was not burnt. But the fumes, she says, went down her throat. Next morning on

waking she was unable to *speak* or to move her *right arm and leg*. Fluids also *regurgitated* through the nose. She remained like this three to four days: then first the speech returned, a little later she could swallow well, in about fourteen days the leg began to get better, and she could walk in four to five weeks; about a month after the attack the arm began to improve, and since then she has gradually recovered.

Present condition.—No facial or ocular paralysis. Tongue not wasted, put out in median line. The soft palate on phonation is decidedly drawn up towards the left. Its right half acts less to faradism than the left. Tactile sensibility and reflex irritability. Voice very slightly nasal, but all consonants correctly pronounced.

Larynx.—Right vocal cord does not stand quite in median line, but very near it, and on attempted phonation makes a slight but very distinct *in*ward movement, so that during the act of phonation, the left cord coming up perfectly normal, the glottis is entirely closed in the median line. On inspiration the right cord returns to its previous position very near the median line, whilst the left is well abducted. In deep inspiration the right cord does not go any further outwards, whilst the left goes completely to the side of the larynx. The right Santorinian cartilage stands considerably more inwards than the left, so that, even apart from position of the right vocal cord, the laryngeal image is somewhat asymmetrical. The laryngeal conditions appear to be stationary.

Arms.—The right arm feels colder to the touch than the left. Right deltoid appears smaller than the left, and the right arm moves less perfectly than the left. She cannot put the right hand to the back of her head, and, as she raises the arm, there is more rotatory movement of the right scapula than on the left. Flexion and extension of the right elbow are less powerful than on left. Flexion and extension on right wrist very imperfect. Right fingers in a state of flexion, allowing of passive extension, but can only be moved voluntarily to a small extent. No defect of sensation.

Legs.—Movements are perfectly carried out, but with less power on right than on left. Plantar reflexes present, more on left than on right.

Slight systolic murmur over base.

Lungs normal. Catamenia normal.

Remarks.—The interest in this case, of course, centres in the

question, whether the paralysis of the soft palate and larynx are of cortical origin or not. With regard to the palate I wish to leave this question somewhat open, although I do not know of any clinical case proving the occurrence of cortical paralysis of the palate, because Mr. Horsley tells me that he and Beevor have obtained unilateral movements of the opposite half of the soft palate on cortical excitation. The *laryngeal* paralysis, however, I feel convinced is *not* of cortical origin, and this for the following reasons:

The only experimenter who states that he has obtained *isolated* movements of the *opposite* vocal cord on gentle stimulation of the phonatory area in the cortex (*i. e.* just posterior to the lower end of the præcentral sulcus at the base of the third frontal gyrus in the monkey, and in the præcrucial and neighbouring gyrus in the carnivora) is Masini. Previously Krause had found that unilateral irritation always produced *bi*lateral effect, and Horsley and myself in very numerous experiments, performed both before and after Masini's publications, have also always obtained a *bi*lateral effect, and have never been able to corroborate Masini's statement (vide paper "On the Relations of the Larynx to the Motor Nervous System," 'Deutsche medicin. Wochenschrift,' No. 31, 1890).

On *one* point, however, *all* experimenters are agreed, viz. that the laryngeal movements obtained on stimulation of any part of the cortex, *always*—except in the cat—are of the nature of *ad*duction of the vocal cords, never of *ab*duction. This result is entirely in accord with our general physiological notions on the two widely different functions of the larynx, its *purposive* function, phonation, only being specially represented in the *cortex* by the movement of *ad*duction, whilst its more *automatic* function, respiration, has its centre in the *medulla*, and is manifested by the movement of inspiration, *i. e. ab*duction of the vocal cords.

Even supposing, therefore, that Masini's contention were correct, and that an isolated cross effect could be exercised from one cortical phonatory centre, this effect could only concern the movement of *ad*duction. Or, pathologically expressed, supposing that such an isolated cross-effect existed and that the area from which it proceeded was destroyed in man by disease or injury, this could only manifest itself by the *opposite* vocal cord *remaining behind* in *voluntary ad*duction, *i. e.* in phonation, just as we see it *bi*laterally in functional aphonia. The *respiratory* position of the vocal cords, however, would in such a

hypothetical case of course be the same as under normal circumstances, and the *in*spiratory movement, *i. e. ab*duction of the affected cord, would be effected without the least hindrance to its fullest extent, as this movement is entirely governed by *bulbar* influences.

In the present case, however, the actual conditions are quite the reverse from what one would expect them to be, if Masini's statements were correct: the right vocal cord is *fixed* near the median line during respiration, its *purposive cortical* movement, *i. e. ad*duction during phonation, is still effected, whilst the actual impairment concerns the *automatic* and eminently *bulbar* movement, *i. e. ab*duction during inspiration.

From these facts the conclusion appears justified, that the *laryngeal* paralysis *cannot* be of cortical origin, and that it *must* be due to a lesion further down. The diminished reaction of the right half of the palate to faradic excitation certainly points in the same direction.

Attention may finally be directed towards the very remarkable case of hemiplegia, in many respects closely resembling the one now presented, and in which there was also *ab*ductor-paralysis of one vocal cord with paralysis of the corresponding half of the soft palate, which was brought forward as an example of *cortical* laryngeal paralysis before the Laryngological Section of the Eighth International Medical Congress of Copenhagen in 1884 by Dr. Bryson Delevan, of New York, and in which the post-mortem examination made four years later in the most thorough and painstaking manner, conclusively proved that the assumedly *cortical* paralysis of the vocal cord in reality was due to a focus of softening in the *medulla*, completely destroying the motor vagus-nucleus ('New York Med. Journal,' 22nd June, 1889).

Isolated Tertiary Syphilis of Naso-pharyngeal Cavity, simulating Paralysis of Left Half of Soft Palate.

Exhibited by Dr. Felix Semon. J. W—, æt. 30, accountant. Two months ago the patient suffered from what was declared to be tonsillitis. On recovering from this the voice assumed a very nasal timbre, which still persisted when the patient was first seen on April 26th. There had, however, never been any regurgitation of fluids through the nose, no paralysis of any other part, and there was no evidence that the acute attack had been of diphtheritic character.

On examination it was seen that the soft palate, which otherwise, as well as the rest of the mouth, throat, and larynx, seemed quite normal, was on phonation distinctly drawn up towards the right. No ocular paralysis.

On posterior rhinoscopy almost the whole upper part of the naso-pharyngeal cavity was seen to be ulcerated, a deep ulcer with steep edges especially occupying the posterior surface of the right half of the soft palate.

On inquiry it was then elicited that the patient had had a chancre ten years ago, but, according to his statements, there had never been any secondary symptoms.

It is difficult to say why the palate should be drawn up on phonation towards the *right*, the ulceration prominently occupying that side of its posterior surface, and no explanation of this fact is ventured upon.

The ulceration is rapidly healing under the use of iodide of potassium and mercury, but is still distinctly visible on the posterior surface of the right half of the palate.

Pachydermia of the Larynx.

Two cases exhibited by Dr. Felix Semon. J. G—, æt. 42, solicitor, and G. G—, æt. 52, clergyman.

The two cases were typical, and only shown on account of the comparative rarity of the affection. In the case of Mr. J. C— the left, in the case of the Rev. G. G— the region of the right vocal process, was the part affected, and in both cases the characteristic indentations on the top of the tumefaction were very well marked. Special attention was directed towards the free mobility of the affected cords. In both cases the voice was but very slightly hoarse and there was but little local discomfort. The case of Mr. J. C— is of about three months' standing, that of the Rev. G. G— of nearly a year's; the unusual persistence of the latter case is probably to be attributed to chronic alcoholism of very pronounced type. (It may be also mentioned that this patient, who for fourteen years or more has had two symmetrical lymphomatous tumours in the nape of his neck, has recently developed several more of these at the sides and in front of the neck. They are, however, diminishing under the use of arsenic in large doses.)

The treatment in both cases has consisted in as complete rest of the voice as possible, iodide of potassium internally, frequent sucking of ice. In both cases so far the affection has remained almost limited to the vocal cord first attacked. Only in the case of the clergyman a very small indentation, corresponding to the summit of the swelling opposite, is now becoming visible on the posterior end of the left vocal cord.

Dr. HALL, who had seen one of these patients some six months previously, concurred in the diagnosis, and commented upon the slight change that had taken place in the interval.

In reply to various questions, Dr. Semon stated that the disease did not show any preference for one or the other side. It generally appeared on the processus vocalis, and usually in voice users. It was certainly maintained by any condition such as chronic alcoholism which tended to keep up irritation. As a rule, the disease got well under the steady use of iodide of potassium. Attempts at removal were usually unsuccessful, and perichondritis was apt to follow. The crateriform depression on the tumour and the perfectly free movement of the cords were very strong diagnostic points.

TABES DORSALIS; BILATERAL PARALYSIS OF GLOTTIS-OPENERS WITH PARALYSIS OF INTERNAL TENSORS OF MORE THAN TWELVE YEARS' STANDING.

Exhibited by Dr. FELIX SEMON. W. G—, æt. 62, fishmonger. The patient, whose initial tabic symptoms dated back, according to his own statements, to nearly twenty-five years ago, had suffered from fully developed bilateral paralysis of the posterior crico-arytænoid muscles to a certainty as far back as 1881, when he was in Guy's Hospital under Dr. Goodhart, by whose permission he was shown to the Laryngological Section of the International Congress in London ('Trans. Internat. Med. Congress,' 1881, vol. iii, p. 332). Since then the general tabic symptoms, which are of the ordinary kind, have made, though steady, yet exceedingly slow progress, and it need only be mentioned that in the right knee Charcot's joint-disease has developed, and that in the larynx bilateral paralysis of the internal thyro-arytænoid muscles, manifested by elliptic gaping during inspiration of the glottis, which otherwise remains closed in front, and posteriorly has been superadded to the bilateral paralysis of the posterior crico-arytænoid muscles.

Remarks.—The case is again shown:

1. On account of its uncommonly slow course and the persistence

for certainly more than twelve years of the paralysis of the glottis-openers.

2. Because the paralysis of the internal tensors developed since 1881 corroborates the statement made by me in 1883, and since illustrated by Burger, viz. that these muscles are the next in order of occurrence to succumb to progressive organic disease, after the abductors.

3. Because this very paralysis of the internal tensors whilst the cords remain in the mid-line, incontrovertibly shows that the whole process is one of primary paralysis, and not one of primary neuropathic contracture.

4. Because this patient (as well as the one shown at the last meeting) is able, although his posterior crico-arytænoid muscles undoubtedly must have undergone almost complete fatty degeneration and atrophy, to produce without the least effort both high and low notes, which strongly militates against the supposed existence of a synergy of the antagonistic laryngeal muscles in the performance of their functions.

Chronic Induration in Pharynx.

Dr. Scanes Spicer showed a patient, æt. 50, a married woman, who had complained of difficulty of swallowing, especially of solids, which always required washing down with liquids; no pain, but a bad taste in mouth.

Had an injury over right temple ten years ago, leading to an external swelling. This disappeared and a swelling appeared inside mouth in region of right ascending ramus, which were lanced with escape of blood only, and *now* shows scars and thickening. No specific history. Catamenia stopped seven years ago.

There was an old perforation of posterior wall of pharynx on right side, through which was seen a yellow slough with much induration of right posterior pillar and adjacent parts.

Papillomata of Nostril and Gum.

Dr. Scanes Spicer showed microscopic specimens of the growths from the patient shown at the last meeting. One had been removed in 1888 and the other in 1893, and both appeared to be typical papillomata.

Mr. Charters Symonds thought that the microscopic characters pointed to the lupoid nature of the case. There was abundant small-

celled granulation tissue, arranged in nodules. The papillæ were irregular, and some of them very large.

Lupus of Nose.

Mr. W. R. H. Stewart showed a patient, R. B—, æt. 58. Fell on nose fourteen years ago and broke it. Some little while after the nose began to get blocked on the left side and sore outside. When seen last year left nostril was completely blocked by a papillomatous growth from the septum, and there was some superficial ulceration of the left side of the nose and upper lip. The growth was destroyed by the galvano-cautery, and antisyphilitic treatment was tried. The patient did not much improve. Unna's plaster was then applied to the outside of the nose and gave the characteristic reaction. The patient refused further operative treatment.

Mr. W. R. H. Stewart also showed the following case:

E. F—, æt. 10, came to the Great Northern Hospital two years ago, complaining of a stoppage of the nose and swelling outside which she had had for three years. The skin over the right side of the nose was smooth and thickened, the inside of the nose was quite normal, but the naso-pharynx was packed with adenoids. There was some keratitis and one tooth was decidedly pegged. The parents are both healthy, have nine children; this one, who is a twin, comes about seventh or eighth. The adenoids were scraped and there was a great improvement, but the thickening of the nose never got much less. Some time after, the nose again becoming stopped, the right nostril was found blocked with what looked like lupoid tissue. It was well scraped and lactic acid applied, and the breathing greatly improved, but the thickened condition of the skin remained, and some brownish patches and slight superficial ulceration appeared. This, however, has not yielded any reaction to Unna's plaster. The left nostril has now begun to be blocked.

Mr. Cresswell Baber said that he had found resorcin of some value in the form of ointment in cases of external lupus of the nose.

Dr. Hall asked if the direct application of cold had been tried in such cases, as advised by some continental observers.

Dr. Beale related a case of lupus of the cheek, in which he had used small ice-bags for several hours at a time over a period of about three weeks, with much discomfort to the patient and no result whatever upon the disease.

Mr. Stewart proposed to try resorcin. He mentioned the case of sarcoma shown at the last meeting, in which he had been using large

doses of arsenic as recommended by some of the members present. Hitherto it had done no good.

Probable Malignant Disease of Epiglottis and Right Side of Larynx.

Mr. Butlin exhibited a patient, æt. 62, a pastrycook, who had been attacked with almost sudden dysphagia six months ago. Enlarged gland discovered shortly afterwards. A little blood in expectoration occasionally (blood-tinged sputa only). *Temperature* normal. *Urine*, no albumen. *Lungs* natural. No history of syphilis. One brother said to have died of consumption. Has been taking Potass. Iod. 5 to 10 gr. for nearly a month. Grows worse instead of better.

Traumatic Perichondritis? of Larynx.

The patient, a male, æt. 62, exhibited by Mr. Charters Symonds, stated that four months ago he felt sudden pain in the left side of the larynx while eating fish, since which time he had had a painful spot on the left side and an irritable cough. When seen some ten days after there was a good deal of swelling of the left arytenoid, which looked shiny and smooth. Later it extended along the fold and the cord became fixed. At the present time there is a rounded smooth swelling of the arytænoid and ary-epiglottic fold, with fixation of this side. There is no rough surface, no ulceration, no purulent secretion, no external swelling. Antisyphilitic remedies have not done good. There is a suspicion of phthisis at the left apex. The case appears either a traumatic perichondritis or a new growth.

Epithelioma of Epiglottis.

Mr. Charters Symonds showed a male patient, æt. 60, who gave a history of ten months. The epiglottis was very much enlarged and thickened, and deeply ulcerated in its posterior surface. There were numerous glands in the neck also. A case was referred to in which the entire epiglottis was removed through the neck, with complete relief to all the symptoms. In the present case the patient swallowed fairly well.

Dr. Semon thought that the case was probably one of traumatic perichondritis, but observed that very little reliance could be placed on histories of sudden affections of the larynx, as they were often shown to be misleading.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *October* 11*th*, 1893.

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

E. CLIFFORD BEALE, M.B., SCANES SPICER, M.D., } Secretaries.

Present—17 Members and 2 Visitors.

The following gentlemen were elected Members of the Society:

Charles Rotherham Walker, M.D., Leytonstone.
Dennis Embleton, M.R.C.S., Bournemouth.
Henry Davis, M.R.C.S., London.
Vincent Dormer Harris, M.D., F.R.C.P., London.
William Arthur Aikin, M.D., London.

The following candidates were proposed for election:

Patrick Watson Williams, M.D., Bristol.
Walter George Spencer, M.B., F.R.C.S., London.
William Hale White, M.D., F.R.C.P., London.

The minutes of the previous meeting were read and confirmed.

An exhibition of pathological specimens, macroscopic and microscopic, illustrating malignant disease of the larynx, was opened by Mr. BUTLIN, who showed the following specimens, brought by the kind permission of the authorities from the museum of St. Bartholomew's Hospital.

1. Recurrent epithelioma (intrinsic) which had grown through and around the tracheotomy wound. From a man æt. 43; thyrotomy three months before death; very rapid recurrence.

2. A larynx from which (intrinsic) epithelioma had been removed. A man æt. 60; large abscess cavity around the tracheotomy wound.

3. Epithelioma (intrinsic) from a man æt. 56, who had presented symptoms for some months, and had been brought in dead of dyspnœa.

4. The parts removed from case of epithelioma of larynx (intrinsic). Patient æt. 50; symptoms of two years' duration. Disease began as warty growth of left vocal cord.

5. Epithelioma (extrinsic) from a man æt. 40. Symptoms of some months' duration; dyspnœa and dysphagia; death from sudden attack of dyspnœa, although tracheotomy was performed.

6. Epithelioma (extrinsic). Man æt. 45, who died two days after admission.

7. Epithelioma (extrinsic), old specimen.

Dr. DE HAVILLAND HALL exhibited a specimen from the Westminster Hospital Museum (No. 784), the larynx of F. B—, a gentleman æt. 56. The right half of the larynx was the seat of a ragged epitheliomatous growth, which extended across the middle line and affected the anterior part of the left vocal cord.

F. B— was examined by Dr. Hall for life assurance in June, 1884, and as he was hoarse a laryngoscopic examination was made, and a condition of chronic laryngitis discovered; the applicant stated that he had had hoarseness for twenty years. He consulted Dr. Semon on account of hoarseness in January, 1885, who noted "congestion and relaxation of vocal cords." In August, 1886, F. B— placed himself under Dr. Hall's care. He was then suffering from almost absolute loss of voice, and had some difficulty in swallowing. The right ary-epiglottic fold was swollen and concealed the vocal cord. There was some external swelling. There was no history of syphilis. Under the influence of iodide of potassium marked improvement occurred, but as there had been an attack of laryngeal spasm, tracheotomy was advised but refused by the patient. Three months later he was found dead in his bedroom, evidently from an attack of spasm.

Dr. FELIX SEMON showed the following specimens:

1. The left half of a larynx removed for epithelioma of the left ventricle of Morgagni on May 3rd, 1887, by Dr. Hahn of Berlin. This was the well known case of the late Mr. Montagu Williams. The patient entirely recovered from the operation, regained his voice to such a degree that he was able to fulfil for nearly six years the duties of a police magistrate, and finally died in the commencement of 1892 from cardiac disease, altogether unconnected with the previous laryngeal trouble. The case has been described in the 'Transactions of the Clinical Society,' vol. xx, 1887.

2. The right half of a larynx, removed by Sir William MacCormac on November 1st, 1887, on account of infiltrating epithelioma, from a gentleman æt. 57. The patient had been strongly advised to

undergo the operation at a considerably earlier date, but could not at once make up his mind, and when he finally consented the operation had become considerably more extensive than had been originally contemplated, the growth by that time having perforated externally beneath the crico-thyroid muscle. The patient died on the second day after the operation, apparently from septic pneumonia. No post-mortem examination was permitted. A remarkable feature of the case was the circumstance that there was an epitheliomatous insula in the middle of the *left* vocal cord, probably due to contact. The specimen well illustrates the necessity of arriving at a definite diagnosis in certain cases of malignant disease of the larynx from clinical symptoms only, without the aid of the microscope, as the infiltrating nature of the growth in this case rendered the intra-laryngeal removal of a fragment for the purposes of microscopic examination impossible. The case has been described as Case 2 in a paper read by Dr. Semon and Mr. Shattock before the Pathological Society of London under the title, "Three cases of Malignant Disease of the Air-passages." 'Transactions of the Pathological Society,' 1888.

3. Two specimens, one showing what remained of the larynx, the other a great part of the necrosed cartilaginous framework expectorated during life of a case of laryngeal cancer in which hæmorrhages, perichondritis, and exfoliation of the greater part of the laryngeal cartilages occurred. Subsequently pleurisy, gangrenous pneumonia, and death ensued. The case has been described under the above title in vol. xxii, 1889, of the Clinical Society's 'Transactions.' It was shown again to illustrate the fact that cancerous perichondritis in no way, clinically or histologically, differs from any other form of perichondritis. During life the symptoms of perichondritis had for a considerable time completely masked the phenomena of malignant disease.

4. The case to which this specimen belonged had been described in considerable detail in the Collective Investigation of the 'Internationales Centralblatt für Laryngologie' concerning the question of the transition of benign laryngeal growths into malignant ones, especially after laryngeal operation, on p. 160, *et seq.* The patient was a lady who first began to suffer from hoarseness and later on aphonia at the age of twenty-five. When, five years later, she consulted Dr. Semon, another London laryngologist had already operated in her larynx for a considerable time without improving the voice. When first seen by

Dr. Semon the larynx was in such a condition of swelling and congestion that it was impossible to decide whether the vocal cords had grown together anteriorly or whether there was a growth between them. Only after nearly a year's interval could it be seen that there was actually a papillomatous growth below the anterior commissure. The growth was removed and the patient fully regained her voice. For fully two and a quarter years after this she remained well, periodical laryngoscopic examination showing the complete integrity of the vocal organ. In May, 1888, it was seen that fresh growth began to appear at some distance from the original attachment of the papillomata, viz. on the lower surface of the epiglottis. The vocal cords were somewhat swollen and congested, their movements more sluggish than under normal circumstances. Within the next one and a quarter years, during which time the patient was under the care of Dr. Barclay Baron of Bristol, rapid development of growth took place in the larynx, an abscess formed in front of the thyroid cartilage, which had to be opened and never healed; and the patient, in whose case a radical operation for various reasons was quite out of the question, died in September, 1889. For fuller details of this very interesting case the original must be consulted. At the post-mortem examination it was seen that the whole larynx was involved in new growth, which microscopically was found to be a squamous-celled carcinoma. The vocal cords and ventricular bands could no longer be distinguished. The greater part of the thyroid cartilage had been eaten away, and the tumour, having perforated the anterior wall of the larynx, externally formed an extensive swelling below the anterior muscles of the neck. Within the tumour itself a large cavity was found lined by a markedly papillary surface, which only in some small portions was ulcerated.

The case is most remarkable in many respects, first, in its excessively long duration (from the beginning of aphonia to the death of the patient not less than $10\frac{1}{4}$ years). Second, in the fact that here in reality, a malignant new growth appeared to have followed a benign one, inasmuch as the two and a quarter years' interval between the removal of the original papillomata, during which repeated examinations showed the complete anatomical integrity of the larynx, practically excluded the idea that the disease had been *à priori* malignant. This interval equally excludes the interpretation that a transformation might have been produced by the irritation caused by the intra-laryngeal

operations. Thirdly, the marked tendency in this case to retain the original papillary type is very interesting indeed. When a year and a half before death recurrence was first manifested, the intra-laryngeal appearances were still those of papillomata, and the walls of the abscess cavity resulting from the perichondritis and disappearance of the thyroid cartilage, although epitheliomatous in character, show even how this papillary type most markedly.

Finally, it deserves to be mentioned that both the original papilloma and the subsequent development more than five years later of malignant disease of the larynx followed childbirth.

5. Two specimens of a case of malignant disease of the larynx, which originally appeared in the form of a pedunculated growth, springing from the left arytæno-epiglottidean fold. The patient was a gentleman aged 44, who was sent to Dr. Semon in 1891 by Dr. Malbranc of Naples, with the diagnosis of angioma of the larynx, and the appearances fully justified that diagnosis. The tumour was easily removed with the galvano-caustic loop, and on microscopical examination turned out to be not an angioma but an apparently typical papilloma surrounded by a shell of partly fresh, partly organised blood-clot (microscopic preparations shown). So far the case has been fully described by Dr. Semon aud Mr. Shattock in the 'Transactions of the Pathological Society' of 1891, page 37 *et seq.* Four and a half months later the tumour had recurred, and on being again removed showed distinct evidence of epitheliomatous nature. Subhyoid pharyngotomy was performed, and the basis of the growth entirely removed. On the third day after the operation the patient suddenly became comatose, the temperature rose to 107°, and twenty-four hours later death ensued.

At the post-mortem examination œdema and congestion of the brain, and considerable fatty degeneration of the liver were found (the patient was a hard drinker), but no clue as to the cause of the coma and the fatal issue was obtained (see 'Internationales Centralblatt für Laryngologie,' vol. viii, p. 317).

The microscopic preparations (which were demonstrated) were most curious, in so far as they showed the simultaneous existence of epithelioma and papilloma in almost all the specimens without any evidence of transition of the one into the other. Apart from this, the case was of importance because it was the first instance known in which malignant disease of the larynx had been observed to appear origi-

nally in the form of a pedunculated angioma. Besides several clinical points which were present in this case, and which had already on previous occasions been urged by the reporter as characteristic for the malignancy of an apparently innocent tumour,—such as repeated hæmorrhages, quick recurrence, spontaneous pains, difficulties in swallowing,—the unusual situation of the growth and the patient's age were referred to as giving valuable aid in diagnosis.

6. The specimen shown was removed by partial laryngectomy from the larynx of a gentleman aged fifty, who was sent to Dr. Semon by Dr. Kendal Franks of Dublin, and who had been suffering for several years from a curiously irregular tumefaction of the left vocal cord, the nature of which for a long time was doubtful, it being in part almost transparent. The diagnosis was left open between fibro-cystic degeneration of the cord, fibroma, and malignant disease. At last, in 1891, rapid changes took place in the appearances, and when the reporter saw the patient in the spring of that year, a general infiltration of the left half of the larynx had occurred. Radical operation was advised. The patient agreed, and only stipulated that no chloroform should be given, as he was supposed to suffer from weakness of the heart. It was suggested that ether should be given by the rectum, and the suggestion was followed, but this method certainly did not show to advantage in the present case. It took more than half an hour before the patient was sufficiently under the influence of the anæsthetic to commence the operation, large quantities of ether had to be used, and when the operation was finished the patient looked very white, and the pulse was very irregular. He also towards the end of the operation coughed up considerable quantities of *fluid* watery blood, the appearance of which was totally different from the expectoration sometimes met with in cases in which no complete occlusion of the trachea has been obtained. This expectoration continued, and three hours afterwards copious bloody discharges took place from the rectum, which in appearance was absolutely the same as the bronchial expectoration, and only in addition were very offensive. Within a few hours from the operation the temperature began to rise, the patient sweated profusely, and gradually got more and more comatose. With increasing coma, a temperature of 107°, and continuance of the bronchial and rectal secretions, the patient died twenty-four hours after the operation.

At the post-mortem examination, intense congestion of almost the

whole of the intestinal tract and of the bronchial mucous membrane was found, and there could be no doubt that death was due to ether.

The reporter added that nothing but a strong sense of duty could have induced him to report this lamentable case which might serve as a warning to future operators. It will later on be published *in extenso*.

7 and 8. The two last specimens illustrate the tendency of infiltrating malignant disease of the thyroid gland to become pedunculated when perforating into the large air-passages. The first was removed at the post-mortem examination of a man aged thirty-nine. It was a case of cylinder-celled carcinoma, and has been fully described in Dr. Semon and Mr. Shattock's paper, "Three cases of Malignant Disease of the Air-passages," 'Transactions of the Pathological Society of London,' 1888.

The second one is a specimen of epitheliomatous disease of the thyroid gland, in which repeatedly pedunculated projections grew into the trachea. At one time a projection which had been seen in the trachea by two competent observers completely sloughed away, so that two other distinguished observers could not detect a trace of its former existence ten months afterwards. The case is described in full in the forthcoming volume of the 'Transactions of the Royal Medical and Chirurgical Society.'

Discussion with especial reference to the present position of the question of radical operation.

Mr. Butlin, after referring to some of the specimens which he had brought from St. Bartholomew's Hospital Museum, said that to condense his remarks he would divide them under three headings: first, the circumstances under which laryngeal cancer should be removed; second, the operation which should be practised; third, the after-treatment of patients who had been operated on. Under the first heading he had little to add to what he had before said, but would repeat that the most favorable cases are those in which the disease is of intrinsic origin, and still limited to the interior of the larynx, is of small extent, uncomplicated, and particularly in which it lies towards the front of the larynx. Under the second heading, also, he had little to add to what he had previously said. The more he had seen of the operative surgery of malignant disease of the larynx, the more convinced he was that removal of the whole or a large part of the larynx for malignant disease was seldom followed by sufficiently good results to justify the operation. The best results had followed and were likely to follow thyrotomy with very free removal of the soft parts in the interior of the larynx. He could look back on one case in which the patient was alive and free from disease more than

five years after operation (sections of this growth, epithelioma, were under the microscope on the table), and on another case in which the patient was still well four years after operation. Compared with operations for extensive or extrinsic disease, such thyrotomies were comparatively free from danger. Out of many of the latter he had lost only one case; out of few of the former he had lost two cases. On the question of after-treatment he had more to say, because he had given a good deal of attention to it, and had regularly during the last three years carried out the suggestions he had made at Berlin. He removed Hahn's tube directly the operation was over. He made no attempt to close the wound. No tracheotomy tube was used, and no dressing was inserted into the interior of the larynx. But the surface was dusted with iodoform, and the iodoform was frequently applied; this was easily effected. Watching these patients, he had found that when they swallowed, the two sides of the wound into the larynx separated to such an extent that the nozzle of the insufflator could be easily inserted between them, and the powder blown directly on to the raw surface. He regarded this as of the highest importance; he had a great opinion of iodoform in wounds of the mouth and larynx, but it was not likely to do good unless it reached the actual surface of the wound, and this was difficult to effect when the powder was insufflated through the mouth. He covered the external wound with a piece of iodoform gauze, which was changed as often as was necessary, even if this were fifteen or twenty times a day. Instead of propping the patient up in bed, he took away all the pillows except one, so that the head lay low, placed the patient on his side, and thus did what he could to diminish the tendency of discharges to pass down into the bronchi. And, last, he fed the patients chiefly by means of nutrient enemata during the first few days; but, usually, on the day following the operation, he encouraged an attempt to take fluids by the mouth. Water was first tried, and the patient was made to sit up and lean well forward, or to lean over the edge of the bed, so that the fluid which passed into the larynx ran out through the wound immediately. If the patient succeeded in taking water without getting any quantity of it into the larynx, he was allowed to take beef-tea, milk, &c., and to try soft solids. Mr. Butlin had not lost a case of thyrotomy since he had employed these measures, and he fully hoped that his later success was due to the better measures which had been adopted in the after-treatment of the patients.

Mr. Cresswell Baber made a few remarks on perichondritis of the larynx, not associated with malignant disease.

Dr. Semon, first in reply to the question addressed to him by Mr. Cresswell Baber, said that he did not deny the *possibility* of primary perichondritis of the larynx, but that such an event in his experience must be exceedingly rare. He had never seen a case in point. The poor vascularisation of the perichondrium *à priori* made the occurrence of a primary perichondritis a very unlikely event, and in all his cases, either at the time or later, a true explanation of a traumatic or diathetic character had been found. With regard to the indications for, and the technique of, radical operation as laid down by Mr. Butlin, he agreed practically, with the exception of a

few details, to everything that Mr. Butlin had said, and wished especially to emphasise the desirability of arriving *early* at a decision as to the nature of the laryngeal growth and of operating early. The chances then were infinitely better than if the operation were postponed to a later period. Altogether the number of cases suitable for operation was small in comparison to the total of cases seen. He had now seen about 100 cases of malignant disease of the larynx in private practice, and had only in about 10 per cent. of all these felt justified in advising a radical operation, such as partial extirpation of the larynx or thyrotomy. The latter was, of course, not a very serious operation; at the same time he could not go so far as some of the continental surgeons did, and altogether deny or underrate its risks. Against septic pneumonia great care could perhaps protect to a certain degree, but the coma with rise of temperature which occurred in two of his cases, without the post-mortem examination giving a clue as to the cause of these phenomena, certainly formed a very serious feature, and one to be always taken into account when the prognosis of the operation was discussed. Broadly speaking, radical operation had been successful in his cases in exactly 50 per cent., *i. e.* in five cases the patients having survived in good health and without any recurrence for periods now varying from one and a quarter to seven years. Of the remaining five cases, in three earlier and hence less extensive operation might possibly have averted the fatal result, but in two cases death could not be accounted for. The methods of operation selected in his cases had been (1) partial extirpation of the larynx; (2) subhyoid pharyngotomy; (3) thyrotomy with and without resection of parts of the cartilaginous framework. The chances were, of course, the better the more the operation could be limited to the soft parts, hence he once more urged the desirability of *early* diagnosis and operation.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON

ORDINARY MEETING, *November 8th*, 1893.

P. McBRIDE, M.D., Vice-President, in the Chair.

E. CLIFFORD BEALE, M.B., }
SCANES SPICER, M.D., } Secretaries.

Present—20 Members and 8 Visitors.

The following gentlemen were elected Members of the Society:

Patrick Watson Williams, M.D., Bristol.
Walter George Spencer, M.B., F.R.C.S., London.
William Hale White, M.D., F.R.C.P., London.

The following candidates were proposed for election:

W. Milligan, M.D., Manchester.
P. R. W. de Santi, F.R.C.S., London.
Edmund H. Colbeck, M.D., London.
Charles S. Ayres, M.D., London.
Ernest B. Waggett, M.D., London.
L. H. Pegler, M.D., London.
Michael Foster, M.B., San Remo.

The Chairman briefly referred to the loss the Society had sustained by the death of Mr. Arthur Hensman, one of its original members.

The minutes of the previous meeting were read and confirmed.

The following case was exhibited by Mr. E. Cresswell Baber.

CONGENITAL OCCLUSION OF POSTERIOR NARIS, RELIEVED BY OPERATION.

Master H—, æt. nearly 6 years. Was first seen on August 16th, 1892, in consultation with Mr. H. H. Taylor.

History.—He had always had more or less difficulty in breathing through the nose, slept with his mouth open, and snored. Slight deafness at times. When an infant had great difficulty in sucking, both the breast and bottle, and had had discharge from right nostril since birth.

Present state.—Partial nasal obstruction and difficulty in keeping

the mouth closed. Anterior rhinoscopy showed on the right side a good deal of mucous discharge, inferior turbinated body much enlarged, firm to the probe, and a slight bending of the anterior part of the septum to the left. Right middle turbinated body normal. Left side, normal. *Palpation* only a few small adenoids; right choana blocked by an obstruction which did not project into the naso-pharynx. Left choana clear. After one or two unsuccessful attempts a view of the posterior nares by posterior rhinoscopy was obtained. Right choana was found completely blocked by a smooth, slightly concave membrane, with a small, round, dark depression at its lower part, but no perforation visible. The membrane was pale, and had a small vessel running across it, and was also slightly depressed at its upper part. Left choana normal. Posterior margin of the septum *not* deflected. No air whatever passes through the right nostril on forcible expiration. Further examination from the front showed that *on the floor* of the *right* nasal cavity a probe passed in just over 2 inches, whilst a little above this it was arrested at a point rather over 1½ inches deep. On the *left* side the probe passed through the inferior meatus into the naso-pharynx to the depth of 3¼ inches. On October 19th, under chloroform given by Mr. Taylor, the probe encountered an obstruction at the right choana, but with pressure passed through it; a band of obstruction appeared, however, to extend outwards from the posterior septum across the choana. This was broken down with forceps, and with a blunt chisel introduced through the nose, all being guided by a finger in the naso-pharynx. Down's No. 3 bougie with oval diameter then passed through into the naso-pharynx, and a probe introduced from the front moved vertically for about ½ inch in the choana. No. 3 bougie was at first passed daily, afterwards less frequently. The discharge gradually ceased, the right nostril became fairly clear, and on posterior rhinoscopy a vertical slit, measuring about ¼ inch, was seen near the centre of the membrane. But as some difficulty occurred in passing bougies Nos. 3 and 4, owing to their hitching on to a prominence on the back part of the septum, he was again put under anæsthetic on December 31st, and the projection on the septum attacked with a hollow chisel and mallet. The inferior turbinated body was at the same time crushed outwards by dilating freely with forceps, and as the result No. 4 bougie passed easily, and there has been no difficulty in passing it since. Posterior rhinoscopy showed that

the edges of the opening had healed, the opening itself being considerably larger, pear-shaped, and broader below than above. The right nostril was freely pervious, and there was no discharge. The bougie, which was at first frequently used, was now only passed by the mother once a month as a precautionary measure.

In regard to the nature of the obstruction in this case, the treatment showed that it was partly membranous and partly bony, the latter consisting in a projection on the bony septum about half an inch thick, but whether it was adherent to the inferior turbinated body in front of the membrane was uncertain. There was some asymmetry of the face, the right cheek being rather more prominent than the left, which helped to confirm the congenital character of the obstruction. The operative treatment in this case had been of benefit by producing considerable improvement in nasal respiration, and by arresting the discharge from the nose.

Dr. DUNDAS GRANT remarked on the rarity of the affection, having only seen one case, and that in an adult. Forcible perforation of the obstruction was effected by means of a trocar; the opening was further enlarged by means of a probe-pointed knife, and a vulcanite tube was introduced. The patient was ultimately able to introduce the tube for herself, and to retain it for periods extending as long as a fortnight at a time. He referred to the hemiatrophy of the face, but on being reminded by Mr. Cresswell Baber that the atrophy was on the opposite side to the obstruction, expressed the opinion that the value of hemiatrophy as an evidence of the congenital nature of the condition was more than doubtful.

LEPROSY WITH THROAT LESIONS.

Dr. J. B. BALL showed this case. G. F—, æt. 30, stableman, had been under Dr. Abraham's observation for some years, and was admitted at his recommendation into West London Hospital on October 12th, 1893, on account of gradually increasing laryngeal dyspnœa. On October 13th Mr. Bidwell performed tracheotomy.

Patient was born in England, and went to India with his father (a soldier) at six weeks old. He returned to England at ten years old, and appeared to have been quite free from symptoms of leprosy for at least ten years after his return home. For the last nine years the disease had gradually developed and increased, and was now well marked on the face, forearms, hands, legs, and feet.

The voice had been hoarse for three years. Difficulty of breathing

first commenced about a year ago. There had been some blood-stained discharge from the nose for about two to three years. He had not complained of any particular soreness of the throat, and had no idea how long ago it became affected. The cicatrised appearance of the throat, however, showed evidence of former ulceration over a considerable area.

Along the centre of the dorsum of the tongue were some large, broad tubercles. There were numerous small nodules on the hard and soft palate, and a small ulcerated area on the anterior aspect of the soft palate. The soft palate and pharynx were pale, and there was a good deal of cicatricial tissue in these parts. The uvula had almost entirely disappeared. The posterior faucial pillars were cicatrised to the posterior pharyngeal wall, and approximate to each other, thus narrowing the passage from the naso- to the oro-pharynx.

The epiglottis was thick and infiltrated, and the glosso-epiglottic folds, especially the median, were thickened. The regions of the arytænoids and ary-epiglottic folds were occupied by two pale irregularly pear-shaped swellings, with a somewhat uneven nodular surface. These swellings approached other in the middle line, and prevented a view of the glottis and cords.

There was some superficial ulceration over the cartilaginous nasal septum on both sides, and a cicatricial band running from the septum to the middle turbinated bone on the right side. No perforation.

Mr. Bidwell referred to the method of performing tracheotomy in this case. He had found it advisable to stitch the skin to the edge of the tracheal wound, thus making a permanent opening and obviating the necessity for the constant use of a tube.

Dr. Clifford Beale exhibited a new form of portable oxy-hydrogen lantern, which had been designed at his suggestion by Mr. J. H. Steward, Optical Instrument Maker, 406, Strand, London. The lantern being very compact and portable was especially adapted for use in laryngoscopic work at the bedside.

Mr. R. S. Charsley exhibited an improved form of galvano-cautery snare for nasal use.

Dr. de Havilland Hall had used this snare and had found it very convenient, and a decided improvement on some of the older forms.

Stenosis of the Larynx.

Dr. de Havilland Hall showed this case. C. A—, æt. 25, contracted a sore in August, 1892. On October 19th he attended at the Westminster Hospital with acute laryngeal and pharyngeal catarrh and ulceration of soft palate. He continued under specific treatment until November 9th; he then left London, and did not attend again until January 25th, 1893, when he was admitted into the hospital, as he was suffering from grave dyspnœa. The epiglottis was much swollen, and there was general infiltration of the ary-epiglottic folds and arytænoids, but no ulceration. Tracheotomy was performed on January 28th. About a week later he expectorated some pieces of necrosed cartilage. Six weeks after the tracheotomy, dilatation with Schroetter's bougies was commenced, but had to be discontinued on account of the formation of an abscess in the larynx. In May thyrotomy was performed by Mr. Spencer, and necrosed cartilage scraped away. No attempt was made at the time to bring the parts together. Later on, strapping was employed to bring the two halves of the larynx together. Eventually union took place, and the patient was left breathing through the original tracheotomy wound.

Dilatation with bougies was then resumed, and in the course of two months Dr. Hall was able to pass No. 9 easily. At the present time the patient can expire through the larynx, but on attempting inspiration the ventricular bands are sucked together and hardly any air enters. Dr. Hall attributed this to the collapse of the walls of the larynx from necrosis of cartilage, and asked the opinion of the members as to what further could be done for the patient.

Stenosis of Larynx after Tracheotomy.

Dr. Clifford Beale brought forward a case of stenosis of the larynx in a man æt. 46, who had suffered from hoarseness for nearly eight months before his admission to the Chest Hospital, Victoria Park, in August, 1893. He gave a clear history of a syphilitic infection some twenty years before, but no manifestations of syphilis had shown themselves of late years except in the larynx. A few days after admission he suffered from acute laryngeal dyspnœa. The vocal cords were seen to be fixed midway between complete adduction and the cadaveric position. Sudden obstruction of the larynx occurred, but tracheotomy was promptly performed, and in a short time he made a

good recovery, but the stenosis of the larynx continued. His general health was now very good, and he could breathe with difficulty through the larynx and speak hoarsely and with an effort by covering the tracheal opening. The right cord appeared to move slightly, but the left hardly at all, and the glottic chink remained very narrow.

What further operative treatment was advisable in such a case?

Dr. Felix Semon discussed the question of radical operation in syphilitic stenosis of the larynx. Whilst admitting that in certain cases methodical dilatation by means of Schrötter's bougies or of O'Dwyer's intubation tubes might yield good results, he warned against their premature application in recent cases of ulceration, as acute perichondritis might be produced under such circumstances by forcible introduction. He then dwelt upon the question whether in cases in which tracheotomy had been performed, and the patient could breathe comfortably, wearing the tube, whilst his voice was either normal or at any rate good enough not to interfere with his business, any radical operation ought to be performed, which, though enabling the patient to dispense with the tube, yet at the same time rendered him more or less aphonic. Although he admitted that every case of that sort ought to be judged on its own merits, yet from a general point of view he opined that preservation of voice with wearing of a tracheotomy tube was preferable to dispensation with the tube with more or less complete loss of voice, and illustrated this opinion by briefly detailing several cases in point, which had been under his own notice. More especially he referred to one example which he promised to show soon to the Society, in which in a case of syphilitic stenosis in which the tracheotomy tube had been worn for fully ten years, quite recently such a spontaneous improvement in the size of the glottis had taken place, that there was now a reasonable chance of removing the tube without performing any further operation. At the same time, in this case, the voice had improved to a marvellous degree.

Dr. de Havilland Hall agreed that in such a case as his any further attempts at dilatation would be useless as the cartilaginous framework of the larynx was already so much destroyed. A permanent opening in the trachea would remain, and the tube need not be worn.

Dr. Kirk Duncanson exhibited a specimen of Epithelioma of the Larynx complicated with Bronchocele.

Tubercular Ulceration of Vocal Cord cured by Lactic Acid.

Dr. Percy Kidd showed this case.

The larynx presented the following appearances:—Vocal cords

somewhat reddened and thickened, movements normal. Plate-like prominence of interarytænoid fold.

Physical examination of the lungs reveals slight weakness of breath-sounds at the right apex, but no further change.

History.—The patient, J. M—, æt. 29, a married woman, was first seen in May, 1892, when she came as an out-patient to the Brompton Hospital, complaining of a chronic winter cough and frequently recurring loss of voice, extending over a period of six years. Physical examination of the chest gave a negative result. The larynx showed general congestion, but no further abnormality.

The patient was transferred to the Throat Department, where the larynx was painted a few times with a solution of chloride of zinc (gr. xx ad ℥j). A fortnight later swelling of the interarytænoid fold and slight irregularity of the surface of the cords were noted. Local treatment was discontinued. In September, 1892 (four months later), fusiform swelling of the middle third of the right cord and a small whitish patch on the left processus vocalis were observed. Iodide of potassium in 10-grain doses, three times a day, was then prescribed; but in a few weeks superficial ulceration developed on both vocal cords. A solution of iodine in glycerine was then brushed over the vocal cords, and several times without avail, the ulceration slowly extending. In January, 1893, the cords throughout their whole length presented a crumbling, ragged, greyish, ulcerated surface. The sputum, which was very scanty, had been twice examined for tubercle bacilli with a negative result, but nevertheless it was determined to apply lactic acid without further delay. After two applications of a 50 per cent. solution, followed by nine applications of the pure acid, the cords showed distinct evidence of healing, having acquired a reddish, irregular aspect. The patient's general condition also manifested marked improvement about this time, viz. March, 1893. Early in the month tubercle bacilli were found in the sputum, although no physical signs of disease could be detected in the lungs. Owing to the development of fresh ulceration in the larynx pure lactic acid was again applied on nine occasions in April and May. By the beginning of June the larynx had assumed very much the same appearance as it now presents. No further relapse has occurred.

Septal Growths.

Dr. Dundas Grant exhibited a patient, a dairyman, who for six or eight weeks had complained of a feeling as of a foreign body in the throat. No foreign body could be found either by Dr. Grant or by Dr. Hugh Smith, by whom the case was first seen. By posterior rhinoscopy, growths could be seen projecting from both sides of the septum touching the hypertrophied inferior turbinated body on the left side. They were soft, corrugated, and easily compressible, and were visible also on anterior rhinoscopy.

The posterior extremities of the inferior turbinated bodies were removed with the ring-knife, and a week later a portion of the growth on the left side was removed with uvula scissors passed through the nostril. On examination by Mr. Wyatt Wingrave the growth proved to be little more than local hypertrophy of normal structures, and as comfort had been restored to the patient no further operation was thought necessary.

Functional Spasm of the Muscles closing the Jaws.

Dr. Felix Semon exhibited this case. The patient, J. W. D—, æt. 42, a clergyman, began to experience difficulties in opening his mouth, *but only when talking*, after a second attack of influenza about one and a half years ago. For all other purposes he could and can use the parts perfectly well; thus he can eat, bite, open and shut the mouth at command, yawn, &c. The difficulty in moving the lower jaw when talking quickly increased. At present he can only talk with his teeth firmly set, and after talking for a long while he has some difficulty in opening his mouth. The difficulty is said to be less in the mornings, and also when the patient has to speak unexpectedly, whilst every mental *effort* to *overcome* the trouble only leads to its *aggravation*. The movements of the lips, tongue, palate, larynx, &c., are perfectly unimpeded.

The case is, so far as Dr. Hughlings Jackson's (who sent the case to Dr. Semon) and the latter's own experiences go, unique. The fact that the spasm only occurs during the volitional effort of speaking seems to ally it to the professional neuroses, and even more closely, perhaps, to spastic aphonia. The localisation of the source of this form of spasm is likely to be in the cortical or subcortical areas for the movement of chewing, which have been described by various

authors, and most recently been accurately localised by Réthi* as situated in front and laterally from the cortical centres for the limbs. *Uni*lateral irritation of one of these centres would, in accordance with Réthi's experiments, suffice to produce bilateral spasm, just as in Semon's and Horsley's experiments *uni*lateral irritation of a phonatory cortical centre sufficed to produce bilateral spasm of the vocal cords.

Should the affection in the present case, as the reporter suspects, be analogous to the functional spasm of the glottis in spastic aphonia, the functional prognosis would not be favorable. The internal administration of arsenic has failed; at present the patient is about to take iodide and bromide of potassium in ten-grain doses.

Dr. Vivian Poore referred to the case of a clergyman who, in order to overcome a similar spasm whilst speaking, habitually used a plug between the teeth. The condition of Dr. Semon's patient appeared to be allied to stammering, but he was not aware that stammering had been known to come on after influenza. He related the case of an old lady who suffered from spasms of the muscles of the jaw and of the tongue which always came on when she attempted to eat, and which at times jerked the food out of her mouth. The spasm of the jaw in this case was clonic, and some amount of jaw clonus could be elicited. He thought that some senile degeneration might be going on in the cortex to give rise to these symptoms. He believed that the best way to overcome such forms of stammering was to use the voice in an unaccustomed manner, to "spout," like a pompous actor, and not to attempt the natural way of speaking. He mentioned a notable instance where such a tone was successfully used in the pulpit to overcome a tendency to stammering, although the artificial tone produced was very foreign to the character of the preacher.

Traumatic Perichondritis of the Larynx; Cure.

Dr. Felix Semon showed the patient, M. V—, æt. 21, a sister of mercy, who in February, 1892, swallowed a piece of rabbit bone which stuck in her throat on the *right* side. A practitioner attempted to push it down, but from that moment the patient lost her voice and experienced considerable pain in the right side of the throat, whilst she was feverish in the evenings.

When seen on April 2nd, 1892, the right half of the thyroid cartilage was acutely tender on pressure, and internally the whole right half of the larynx was much swollen, thickened, and, in part, œdematous. The swelling extended over the right hyoid fossa,

* 'Sitzungsberichte der k. k., Academie der Wissenschaften,' vol. cii, part 3, July, 1893.

arytæno-epiglottidean fold, ventricular band, vocal cord, and arytænoid cartilage, all these parts being so much glued together that they could hardly be distinguished from one another. The whole right half of the larynx was immobile during phonation and respiration, the voice was quite aphonic, and there was considerable dysphagia, but at that time there was no dyspnœa. The diagnosis of perichondritis of the right ala of the thyroid cartilage was made, it being supposed that the foreign body had been pushed into the larynx, and was probably still embedded in the inflammatory mass.

Antiphlogistic treatment and iodide of potassium failed to improve matters. On the contrary, the internal swelling and thickening gradually extended along the front wall of the larynx to the *left* side, and in about four weeks the latter was even more swollen and tender than the right side had originally been. At that time large masses of granulation tissue filled the whole anterior part of the larynx. The pain, difficulty in swallowing, and the fever had further increased. The patient was taken into St. Thomas's Hospital, and on May 25th Sir William MacCormac performed thyrotomy, and this seemed to offer the only chance of recovery. The larynx having been opened, and the granulation tissue having been scraped away, extensive necrosis of the *left* ala of the thyroid cartilage was discovered. On a probe being introduced into a fistulous tract, leading into the interior of the cartilage itself, an abscess cavity was entered, in the midst of which a piece of bone was found. This was examined by Mr. Shattock, and declared to be a piece of rabbit bone. The walls of the abscess cavity having been thoroughly scraped, the wound was dusted with iodoform and drainage was provided for. The patient made an uninterrupted recovery, and has to a considerable extent recovered her voice. There is still a good deal of thickening in the front part of the larynx at the level of the vocal cords, but the normal constituent parts can now be clearly distinguished from one another.

The case is put on record as illustrating (1) the danger of forcibly pushing down angular foreign bodies which have entered the mouth; (2) the possible peregrinations of foreign bodies under such circumstances (in this case the bone had certainly wandered from the right into the left half of the larynx); (3) the fact that even an acute perichrondritis is no contra-indication against opening the larynx with a view of removing the source of irritation in the event of foreign bodies having entered it.

Symptoms of Incomplete Graves' Disease, and later on Complete Premature Baldness, following Removal of Nasal Polypi.

Dr. Felix Semon exhibited this case. A. M—, æt. 39, a clergyman. The patient had been shown to the Clinical Society of London on April 12th, 1889, when exophthalmos of the right eye with Gräfe's and Stellwag's symptoms had developed after repeated operations (by means of the snare and galvano-cautery) for removal of recurrent nasal polypi from both nostrils. His case, so far, has been fully described in vol. xxii of the 'Clinical Society's Transactions.' In the discussion which followed the paper doubt was expressed as to the *causal* connection of the symptoms last named with the operation, especially as neither enlargement of the thyroid gland nor cardiac symptoms had then occurred. Shortly after the demonstration, however, it was noticed that the pulse-rate, which so far had been normal, had increased to over 100, and ever since it had varied between 100 and 110. There had been no heart palpitations, and the thyroid gland had not increased in size. The patient in 1889 left for India. On his return in the spring of the present year the exophthalmos had somewhat decreased, but the pulse-rate on the average was still about 100, and complete baldness—extending over *both* sides of the head—had developed shortly after the patient left Europe. The hair had also come off from other parts of the body. In what relation, if any, this alopecia stood to the symptoms formerly observed seemed quite obscure. The patient, whilst abroad, had not suffered from any other disease which could produce alopecia. Treatment by feeding with thyroid glands, which was tried at the patient's own suggestion, had not yielded any results.

Mr. Cresswell Baber mentioned the case of a man, æt. 26, under his care, in whom, after removal of polypi with the cold snare diplopia occurred on looking to the right, with want of power of the right external rectus. The ocular symptoms disappeared in about six weeks under the administration of perchloride of mercury and iodide of potassium. Numerous small growths were subsequently removed, but there was no return of the ocular disturbance. He stated that he had had a similar attack when operated on with forceps two years previously. There was marked erection of the inferior turbinated bodies.

Mr. R. S. Charsley had observed marked enlargement of the glands in the neck and protrusion of eyeballs, lasting for a period of three months after operation for removal of turbinate body with the galvano-cautery. The pulse had ranged as high as 110, but complete recovery ensued.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *December 13th*, 1893.

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

E. CLIFFORD BEALE, M.B., }
SCANES SPICER, M.D., } Secretaries.

Present—21 Members and 2 Visitors.

The following gentlemen were elected Members of the Society:

W. Milligan, M.D., Manchester.
P. R. W. de Santi, F.R.C.S., London.
Edmund H. Colbeck, M.D., London.
Charles S. Ayres, M.D., London.
Ernest B. Waggett, M.D., London.
L. H. Pegler, M.D., London.
Michael Foster, M.B., San Remo.

The following candidates were proposed for election:

C. E. M. Hey, M.A.Cantab., M.R.C.S., L.R.C.P., Hornsey, N.
St. Clair Thomson, M.D.Lond., Queen Anne Street, W.

The minutes of the previous meeting were read and confirmed.

The following members were nominated by the President to serve on the Audit Committee:—Dr. W. Hill, Mr. W. R. H. Stewart.

PERICHONDRITIS.

The following case was exhibited by Mr. ANTHONY BOWLBY. R. Z—, æt. 50, a coachman. Disease began with sore throat eight months ago. Lost voice three months ago. Pain in swallowing for several months. Has had slight winter cough for some years, and he has got worse since the throat became affected. *Abscess* formed over cricoid cartilage three months ago, and burst. History of syphilis twenty-five years ago.

Present condition.—Enlargement and thickening of soft tissues over

larynx. Enlarged glands in submental and submaxillary regions. Much pus in and about larynx. Epiglottis swollen and ulcerated. Soft red granulating mass on left side of larynx in subglottic region. General swelling of laryngeal mucous membrane with ulceration in parts.

Dr. Scanes Spicer thought that the case was probably tubercular.

Dr. Dundas Grant also thought that it might be tubercular. The formation and discharge of an abscess was not a rare occurrence in cases of perichondritis. He related a case somewhat similar to that exhibited in which the disease was certainly tubercular, and in which similar perichondritis had occurred.

Syphilitic Stenosis of the Larynx.

Dr. Felix Semon exhibited the following cases.

Case 1.—Mrs. G—, æt. about 55. Date of primary affection not exactly known, certainly very many years ago. Throat troubles began more than twelve years ago. In 1883 tracheotomy on account of steadily increasing dyspnœa; has worn tube ever since. The arytænoid cartilages were for many years greatly thickened and almost immobile, the glottis reduced to a very small triangle, formed by the internal aspects of the arytænoids and the posterior wall of the larynx, whilst in its anterior three fourths the vocal cords were seen to lie close to one another. The voice was quite aphonic all these years. From time to time superficial ulceration used to occur in various parts of the larynx, which could always be promptly checked by the use of iodide of potassium. Quite recently, *i. e.* within the last three weeks, without any apparent cause a surprising improvement had taken place in every respect. The glottis had become much larger, the swelling of the arytænoid cartilages had much diminished and their mobility improved; the previously aphonic voice had regained tone, and there was now a fair prospect that the tube could be ultimately dispensed with without any further operation.

Case 2.—This had been fully described by Mr. E. C. Stabb, in vol. xxvi, p. 239 of the 'Clinical Society's Transactions.'—W. M—, æt. 37, contracted syphilis in 1884. In 1891 tracheotomy had to be performed. On February 10th, 1893, Mr. Stabb performed thyrotomy, excised large quantities of cicatricial tissue, including the right vocal cord and ventricular band, and removed a large piece of the

necrosed cricoid cartilage. Quick recovery and remarkable return of voice, but still considerable narrowness of glottis.

Acute Œdema followed by Hæmatoma of Left Half of Larynx and Transitory Immobility of Left Vocal Cord after Football Accident.

Exhibited by Dr. Felix Semon. T. R. C—, æt. 32, a medical man. On November 25th, 1893, at 3.30 p.m., patient received a kick with a foot against the left half of the larynx whilst playing football. Immediate aphonia, but no pain and no dyspnœa. Patient came immediately to town, sucking ice on the way. When seen at 7 p.m. there was enormous œdema of whole left half of larynx except the epiglottis. Voice quite aphonic, considerable pain on swallowing, no dyspnœa. Expectoration of slightly blood-stained mucus just beginning. No crepitation to be detected. Patient taken into St. Thomas's Hospital. Four leeches to left half of larynx. Leiter's coil with iced water round neck, sucking of ice. Everything in readiness for intubation or tracheotomy. Night pretty restless, good deal of blood-stained expectoration. Temperature never went beyond 99° on second day after accident.

On November 26th, at noon, left half of larynx changed into brilliantly red, tense tumour, circumference of which, however, was slightly smaller than the extent of the œdema seen on previous evening, but the left half of the epiglottis and left pyriform sinus were also enormously swollen and congested. Antiphlogistic treatment continued.

November 30th.—Circumference of swelling about the same as on 26th, but colour markedly purple. Still complete aphonia; no dyspnœa. Slight pricking sensations in left half of throat; Leiter's coil continued. Potass. Iod. gr. x, ter die.

December 4th.—Colour of swelling now very dark blue. Circumference slightly smaller. Sounds can be produced with effort. Left cord in part seen, intensely congested and motionless in middle line. Iodide continued, but coil left off.

9th.—Voice much better. Swelling almost entirely gone. Left vocal cord still intensely congested, motionless in mid-line. Several patches of ecchymoses on left ventricular band. Iodide gr. v, and Liq. Strychn. ℥ij ter die. Massage of neck.

12th.—Mobility of left cord slightly improved. Front part of left ventricular band somewhat more swollen, covering anterior half of corresponding vocal cord. In its midst one large extravasation of blood. Voice much better. No subjective inconvenience.

Dr. SEMON mentioned another case of direct injury somewhat similar to the foregoing, in which the bruising appeared on the opposite side of the larynx, and was apparently an instance of "contrecoup." Such an occurrence he believed to be extremely rare and most difficult to explain, but the blow had undoubtedly been inflicted on the left side of the larynx, and extreme ecchymosis had appeared on the right side, the left remaining to all appearances healthy.

STENOSIS OF FAUCES WITH OTHER PALATO-PHARYNGEAL LESIONS, THE RESULTS OF ULCERATION, AND SUBSEQUENT ADHESIONS IN A SYPHILITIC SUBJECT.

Dr. SCANES SPICER brought forward the case of E. M—, æt. 31, a servant. In 1884 patient had a rash and sore throat, followed by hair falling out. Had had throat troubles, and been under treatment privately and in hospitals ever since.

Mr. C. Batchelor, of Staines, saw patient in August, 1892, for ulceration of fauces and dysphagia. There was then marked constriction of fauces. Under iodide the ulceration rapidly improved, the stenosis and dysphagia increasing.

She was sent by him to the Throat Department at St. Mary's Hospital on January 10th, 1893. She could then swallow ordinary food only after prolonged chewing, and it occasionally returned through nose; fluids usually came back that way. The isthmus faucium was so narrowed by adhesions of the anterior faucial pillars to the tongue that the channel would only admit an ordinary lead pencil; it was made out also that the soft palate was perforated, the uvula almost gone,—the soft palate adherent to the posterior pharyngeal wall. There was no existing ulceration to be seen; no difficulty of breathing or marked voice alteration.

It was then proposed to divide the cicatricial tissue constricting the fauces with a galvano-caustic knife, and keep channel enlarged with bougies, but before this could be arranged the cicatricial tissue spontaneously and rapidly ulcerated and a good isthmus was reproduced, allowing comfortable swallowing. The patient had remained thus for nine months, and only reappeared for treatment on November 28th,

complaining that the dysphagia was increasing again; and on examination it was seen that there was much narrowing, the faucial walls being also ulcerated.

Suggestions were invited (1) as to the best way of dealing radically with the faucial stenosis in this interesting case; (2) as to whether the palatal perforation and palato-pharyngeal adhesion should be simultaneously or subsequently treated, and if so, what method of dealing with these had hitherto given the best results.

Dr. DUNDAS GRANT asked if the patient had much trouble in swallowing, as, unless she had, he thought it was best not to attempt any operations. He considered that to enlarge the small opening between the pharynx and naso-pharynx would only make her worse. If it were thought proper to divide the bands extending on to the tongue from the anterior pillars he thought the case would be a favorable one for inserting wires like earrings into the bands, and when the apertures became permanent for making horizontal cuts from these apertures to the free edges. This might afford a chance of attaining permanent division as in the old operation for webbed fingers. Simple incisions would soon close up.

Mr. CRESSWELL BABER referred to a case of cicatrix of the lower pharynx, exhibited by him at a previous meeting ('Proceedings of the Laryngological Society,' No. II, p. 9), which showed the tendency that existed to contraction after excision of a portion of the cicatrix, and argued against excision in cases of that description unless there was difficulty in deglutition or respiration.

Mr. CHARTERS SYMONDS thought that so long as an opening was maintained which was sufficient for its functions of deglutition it was best to leave the case untouched. He mentioned an instance of a boy in whose pharynx the opening had been reduced to the size of a lead pencil, and yet was sufficient for all purposes.

Dr. CLIFFORD BEALE, referring to the closure of the naso-pharynx, mentioned two cases recently seen, in one of which there was complete closure, and in the other a tiny opening. The opening being guarded by healthy muscular tissue retained its function and permitted nasal respiration, while it prevented the entrance of food into the nose. In the other case no muscular tissue appeared to be present, and any perforation made by operation would leave the patient worse than before. Syphilitic contraction was the cause of the stenosis in both.

Dr. BRONNER suggested the possibility of transplanting mucous membrane to restore the normal shape of the pharynx. He had seen one such case, but did not know what the final result had been.

Dr. BENNETT asked whether any member of the Society had experience of the results of dividing the soft palate longitudinally, between the hard palate and the pharyngeal wall, in cases of completely adherent palate?

Dr. WILLIAM HILL thought that it might be taken as a general law

that it was best not to operate in the presence of a liability to syphilitic ulceration if possible.

Dr. Scanes Spicer, in reply, thought that the snggestion made by Dr. Bennett was a good one. He did not think that it would be possible to exclude a liability to ulceration in a syphilitic case such as the one he had brought forward, and this would not deter him from a radical operation if he considered the swallowing would be permanently improved thereby.

Occlusion of Posterior Naris.

The following case was exhibited by Dr. Dundas Grant.—H. M—, æt. 27, had complained of deafness in the right ear three years ago. She had then complete obstruction of the right nostril, which was full of thick mucus. On rhinoscopic examination the right choana was seen to be completely closed by what looked like a uniform cicatrix. There was no history such as would account for its formation as the result of disease or injury, and it was in all probability congenital. She had been told that at the time of her birth she breathed with great difficulty, and that the doctor "probed" her nose.

Dr. Grant perforated it by means of a bistoury and inserted an india-rubber tube, which was left *in situ* for three days. Unfortunately, this woke up the dormant ear-mischief and she had perforative inflammation, which had, however, left no trace on the drum-membrane. The opening in the choana soon closed on the removal of the tube, and the operation had to be repeated. She soon got accustomed to the introduction, retention and removal of one of Dr. Grant's vulcanite nasal tubes, and the perforation still remained. She had at times worn the tube as long as a fortnight. She now wore it at night. It was interesting to see how it caused absorption of the irregularities on the right side of the septum, which at first rendered its introduction much more difficult than it was at present.

The case had been exhibited before the Hunterian Society, in November, 1891.

Mr. Cresswell Baber thought that the greater tendency to closure which existed in this case compared with the one shown by himself at the last meeting was perhaps due to the difference in age of the patient. He pointed out not only the asymmetry of the face, but also the deflection of the septum to the left (the normal) side, present in both cases.

Mr. Symonds thought in such cases it was better to make a free opening by removing a piece from the posterior margin of the vomer. In one case he had cut through the membranous centre with a knife,

then enlarged with a saw. Then by two horizontal cuts a piece of the septum was isolated and removed. No after-treatment was required, and the success was complete.

Intra-laryngeal Growth.

Dr. Dundas Grant exhibited the case of Miss D—, æt. 73. Occupation: house and needlework.

The patient had applied to him on the 27th of last month on account of extreme hoarseness which had been gradually developing between three and four years. There was also a bleating or croaking sound in her voice, and her breath was short but not markedly stridulous. Swallowing was normal, and there was no cough. She was free from pain except a slight burning after prolonged talking. Externally there was found a considerable enlargement of the right lobe of the thyroid gland pushing the trachea to the left side, but no enlargement of lymphatic glands. Laryngoscopic examination revealed a growth of irregular shape, broad-based, and sessile in the anterior part of the larynx. Its base extended from near the anterior extremity of the right ventricular band across the commissure and along the anterior two thirds of the left ventricular band, apparently filling the ventricle and having the ventricular band stretched over and attached to it. It was seen to cover the corresponding portions of the vocal cords, but they appeared to move quite independently of the growth. The portion over the commissure seemed to have a downward offshoot intruding between the vocal cords so as to prevent complete closure and apposition. The surface was somewhat irregular, but in no part denuded of mucous membrane. The colour of the growth was almost that of normal mucous membrane, but with a slightly bluish tinge suggestive of its being more or less angiomatous. It was probably a diffuse papilloma.

The hoarseness was no doubt produced by the intra-laryngeal growth.

The dyspnœa and the peculiar "bleat" or "croak" was attributed to the compression of the trachea by the thyroid tumour, a symptom peculiarly characteristic of tracheal stenosis. Dr. Dundas Grant proposed to attempt to remove the portion intervening between the vocal cords by means of his intra-laryngeal forceps, but he was not very sanguine and would steer clear of the *nimis diligentiæ*. A portion of the growth would be examined microscopically.

Dr. A. Bronner exhibited a new form of forceps for the removal of nasal polypi in cases which could not be attacked successfully with the snare. The action of the forceps was cutting and not tearing, and had been found useful in clearing the way for the subsequent use of the snare.

Calculus of Soft Palate.

Dr. Charles A. Parker showed a drawing of the soft palate before removal of the calculus, and the stone itself.

W. R—, æt. 29, was first seen on October 17th.

History.—Had always suffered more or less with his throat, and three years ago had post-nasal growths, removed on account of deafness which was greatly relieved thereby. For the last six or eight months had constantly suffered from painful and difficult deglutition, accompanied by a sharp pricking sensation, the slightest cold greatly aggravating these symptoms. No marked family history of gout or rheumatism.

Condition when first seen.—Complained of great soreness of the throat, especially on swallowing; sharp pain shooting to right ear, and some deafness on the same side.

On looking into the mouth, the right side of the soft palate was seen to be very swollen and inflamed, and was bulging forward into the cavity of the mouth, and felt to the touch excessively hard and solid. Just to the right of the base of the uvula was what looked exactly like a dirty sloughing ulcer, extending backwards a considerable way. The right side of the post-nasal space was entirely blocked, and the swelling was pressing against the Eustachian tube. There were some enlarged glands on the right side of the neck. These appearances were evidently misleading, for the patient informed me that several doctors had told him it was an indolent ulcer.

On further examination, what looked like this ulcer was found to be the free surface of a calculus, the rest being embedded in the substance of the soft palate, lying apparently in a cul-de-sac between the muscular layers.

On October 21st chloroform was administered, and the stone removed.

The case seemed interesting chiefly from the *position* of the calculus. Formations of equal size had been reported as occurring in the crypts of the tonsil, but Dr. Parker was not aware of one in this position being on record.

The stone when dry weighed 54 grains, and Mr. Lake, who had kindly examined it, reported as follows:—"It was hard, but easily crushed and pulverised. It dissolved for the most part in dilute hydrochloric acid, the insoluble remainder consisted of epithelial *débris*, spores, and gladothrix mycelium. The earthy salts consisted for the most part, if not entirely, of carbonates and phosphates of lime and potash. It should be added that when heated on platinum it kept its shape, and became porous by destruction of its animal and vegetable constituents."

In Lennox Browne's 'Diseases of the Throat' it is stated, on the authority of Gruening, that all tonsillar and pharyngeal concretions are of parasitic origin, and are composed of leptothrix elements. This, too, seemed to be undoubtedly parasitic, but Mr. Lake thought it was due to the gladothrix, and not to the leptothrix mycelium.

Dr. Felix Semon remarked upon the rarity of such a calculus, of which he had never before seen or heard of an example. He was inclined to support the theory that it had been originally started by some injury to the soft palate, possibly during operation.

Dr. Ball suggested that the calculus might originally have been formed in the tonsillar crypt, and might have worked its way along the submucous tissue of the soft palate.

Mr. Lake mentioned the occasional presence of adventitious masses of adenoid tissue in the soft palate, within which it was possible that the concretion might have begun.

Dr. Spicer asked whether there was any relation between the position of the calculus and the two small orifices sometimes seen, one on each side of the median line, at the junction of the hard and soft palate. The exact significance of these orifices was unknown to him, but they looked like the openings of small secreting glands.

Dr. William Hill asked whether the stone was removed anywhere near the epitonsillar fossa, which was sometimes very large and a potential crypt. It that were not so, he made the suggestion that the calculus had formed around the residuum of an extra-tonsillar abscess, and asked whether there had been any history of quinsy.

Dr. Parker, in reply, pointed out that the stone was nearer to the uvula than the tonsil, and could hardly have worked its way so far inwards. For the same reason it appeared to be unconnected with the epitonsillar fossa. There had been no history of quinsy.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ANNUAL GENERAL MEETING, *January 10th*, 1894.

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

E. CLIFFORD BEALE, M.B., SCANES SPICER, M.D., } Secretaries.

Present—28 Members and 5 visitors.

The Minutes of the first Annual General Meeting were read and confirmed.

Dr. E. Law and Mr. L. A. Lawrence were appointed Scrutineers of the ballot for Officers and Council.

The Report of the Council for the past year was then read as follows:

In presenting their first Annual Report, the Council have much pleasure in recording the successful launching of the Society in February, 1893, and its steady and increasing prosperity since that time. Starting with forty-five original members, the Society now numbers sixty-eight ordinary members and one honorary member. One member only has been lost to the Society by the lamented death of Mr. Arthur Hensman. Five ordinary meetings have been held, all of which have been well attended, and many cases and specimens of interest have been exhibited and discussed. The Society's 'Proceedings' have been edited by the Secretaries, and placed in the hands of members as soon as possible after each meeting. A list of members has also been prepared. It will be noted that the 'Proceedings,' the Rules of the Society, and the List of Members have been issued of uniform size, in order to fit them for binding together. The examination of the cases exhibited has been greatly aided by the generous gift of twelve electric lamps to the Society by Dr. Felix Semon. In order to facilitate the use of these lamps, it was found necessary to re-wire the large room at 20, Hanover Square, and this work has been satisfactorily carried out, with the sanction and co-operation of the House Committee of the Royal Medical and Chirurgical Society. The Society's Library has already been established by the presentation of works on laryn-

gology, and by exchange of special periodicals in return for copies of the 'Proceedings.'

The Librarian would, however, be pleased to receive and acknowledge as many original contributions from the members as possible, whether published in pamphlet or book form.

The Report was adopted.

The Treasurer's Annual Statement was then presented as follows:

THE LARYNGOLOGICAL SOCIETY OF LONDON.

BALANCE-SHEET, 1893.

Income.	£ s. d.	£ s. d.
By Donation from Dr. Semon towards electric lamps . . .		30 0 0
„ 61 Subscriptions—		
42 at 21/-	44 2 0	
19 at 42/-	39 18 0	
		84 0 0
Total . .		£114 0 0

Expenditure.	£ s. d.	£ s. d.
To Adlard & Son, Printers—		
Sept. 29 .	19 6 0	
Dec. 29 .	11 0 10	
		30 6 10
„ Miller & Woods, lamps and installation . .		47 0 0
„ Royal Med. & Chir. Soc., Rent for ¾ year		15 0 0
„ Petty Cash Account—		
Dr. Spicer .	2 5 9	
Dr. Beale . .	3 14 1	
		5 19 10
„ Balance in Treasurer's hands, Jan. 1, 1894 . . .		15 13 4
Total . .		£114 0 0
Expenditure of the year . .	114 0 0	
	15 13 4	
	£98 6 8	

Audited and found correct. January 1, 1894.

W. R. H. STEWART.
WILLIAM HILL.

The Treasurer's Report was adopted.

The Librarian reported the presentation of the following works to the Society's Library.

Presented by Dr. Lichtwitz (Bordeaux).

Ueber de Häufigkeit des doppelseitigen latenten Empyems der Highmorshöhle, und über die Nothwendigkeit der Methodischen Probeausspülung dieser Höhle in Fällen von Nasenblennorrhoe (Lichtwitz).

Du Diagnostic de l'Empyème " Latent " de l'Antre d'Highmore (Lichtwitz).

Entfernung der multiplem Papillome des Kehlkopfes beim Kinde auf natürlichem Wege mit Hülfe einer neuen Methode; Intubation mit gefensterter Tube (Lichtwitz).

Carcinome de la Corde Vocale Gauche (Lichtwitz).

Instruments pour l'ablation des Néoplasmes Laryngiens de l'enfant (Lichtwitz).

Contribution à l'étude de l'Hydrorrhée Nasale (Lichtwitz).

Les Anesthésies hystériques des muqueses et des organes des sens et les zones hystérogènes des muqueses (Lichtwitz).

Ueber die pathologische Anatomie der Sängerknoten (Sabrazès und Frèche).

The employment of accumulators in medicine, and the best means of charging them (Lichtwitz).

Instrumente für die Entfernung der Kehlkopfneubildungen des Kindes mittels der Methode der Intubation mit gefensterter Tube.

Sur les maladies des sinus ou cavités accessoires du Nez. " Le Bulletin médical," 25 et 29 Octobre, 1893.

Presented by the author, Dr. Felix Petesohn.

Ueber einen von der Nase ausgeheilten Fall von Gesichtskramf.

Ueber Apsithyria.

Ueber Larynxödem.

Presented by the author, Dr. Edward Aronsohn.

Dermatol zur Nachbehandlung nach galvanokaustischen Operationen in der Nase.

Presented by the author, Dr. Hopmann.

Nasenpolypen in Alter unter 16 Jahren.

Ueber Messungen des Tiefendurchmessers der Nasenscheidewand bzw. des Nasenrachenraums.

Presented by the author, Dr. Max Thorner.

Imaginary Foreign Bodies in the Throat.

Report of a Case of Partial Laryngectomy for Carcinoma of the Larynx.

Case of Persistent Tinnitus Aurium relieved by the Removal of a Nasal Obstruction.

Rheumatic Throat Affections.

Thrush of the Pharynx and Nose in an Adult occurring during an Attack of the " Grippe."

Benign Tumours of the Larynx.

The Treatment of Tuberculous Laryngitis with Modified Tuberculin.

Some Experiments with Modified Tuberculin (Joseph Eichberg).

The Management of Foreign Bodies in the Air-passages.

Intubation in an Adult followed by a Fatal Œdema of the Larynx after Extraction of the Tube.

Un cas d'Atrophie d'une Tumeur laryngée chez une enfant.

Presented by the author, Dr. O. H. Beschorner.

Operation der Hasenscharte.

Heufieber.

Doppelseitige Paralyse der Glottis-Erweiterer.
Subcutane Injectionen von Cocain-salicylic bei Asthma und nervösen Husten.
Ueber Bauchrednerkunst.
Ueber Husten.
Beitrag zur endolaryngealen Operation von Kehlkopfpolypen.
Ueber chronische essentielle fibrinöse Bronchitis.

Presented by Dr. de Havilland Hall.

Hay Fever (Morell Mackenzie).
On Epistaxis and the Hæmorrhoidal Flux (Dr. Alexander Haskin).

Presented by the author, Dr. Felix Semon.

Syphilis of the Larynx.
Mechanical Impairments of the Functions of the Crico-arytænoid Articulation.
A Case of Myxœdema.
Removal of a Pin from the Larynx.
Case of Partial Extirpation of the Larynx.
Case of Laryngeal Cancer.
Unilateral Incomplete Graves' Disease after Removal of Nasal Polypi.
Obscure Affection of the Soft Palate.
A Case of Congenital Malformation of the Larynx and Trachea, with Diverticulum of the Œsophagus.
The Throat Department of St. Thomas's Hospital, 1882, 1883, 1884.
The Study of Laryngeal Paralysis since the Introduction of the Laryngoscope.
On the Position of the Vocal Cords in Quiet Respiration in Man, and on the Reflex-tonus of their Abductor Muscles.
Double Stenosis of the Upper Air-passages.
A Case of Rhinoscleroma (Payne and Semon).
Three Cases of Malignant Disease of the Air-passages (Semon and Shattock).
Two Cases of Laryngeal Growths.
Syphilis in the Larynx and Trachea.
Electric Illumination.
Empyema of Antrum.
An Address on Laryngology and Rhinology.
Intra-laryngeal Surgery and Malignant Disease of the Larynx.
Ueber die Lähmung der einzelnen Fasergattungen des Nervus laryngeus-inferior.
Ditto.
Zur Lehre von der verschiedenen Vulnerabilität der Recurrensfasern.
Die Krankheit Kaiser Friedrich des Dritten und die Laryngologie.
Ditto.
Sir Morell Mackenzie.
Proceedings of the Subsection—Diseases of the Throat—of the Seventh International Medical Congress.
The Culture of the Singing Voice.
On an apparently Peripheral and Differential Action of Ether upon the Laryngeal Muscles (Semon and Horsley).
On the Relations of the Larynx to the Motor Nervous System (Semon and Horsley).
On the Central Motor Innervation of the Larynx (Semon and Horsley).
Ditto.
Ein Schlusswort in der Controverse über die centrale motorische Innervation des Kehlkopfs (Semon and Horsley).
Erwiderung auf Vorstehenden Aufsatz (Semon and Horsley).
Du centre cortical Moteur Laryngé et du Trajet intra-cérébral des Fibres qui en emanent (Semon and Horsley).

Presented by Dr. Felix Semon.

The Abductor and Adductor Fibres of the Recurrent Laryngeal Nerve (Risien Russell).

On Infantile Respiratory Spasm (John Thomson).

Micro-organism of Diphtheria with Experimental Results in Animals (Albert Wilson).

Some Questions with regard to Tuberculosis of the Upper Air-passages (P. McBride).

Two Cases of Bezold's Perforation of the Mastoid Antrum (Guye).

Invalids suited for Treatment at Colorado Springs (S. E. Solby).

Quelques Observations relatives à l'Erysipèle du Larynx (Sokolowski).

Le Nez et la Bouche comme organes de la respiration (W. Schutter).

Ueber das Ansaugen der Nasenflügel (Moritz Schmidt).

Empyema antri Highmori (Wilhelm Repp).

Sing- und Sprech-Gymnastik (G. Gottfried Weisz).

Krankheiten des Kehlkopfes, der Luftröhre, der Nase, und des Rachens (L. v. Schrötter).

Die Laryngealen Störungen der Tabes Dorsalis (H. Burger).

Das Sclerom der Schleimhaut der Nase, des Rachens, des Kehlkopfes, und der Luftröhre (G. Juffinger).

Die Entwicklung der Lehre von den motorischen Kehlkopflähmungen seit der Einführung des Laryngoskops (Felix Semon).

An Experimental Investigation of the Central Motor Innervation of the Larynx (Semon and Horsley).

Presented by author, Dr. J. Mount Bleyer.

The Primary Action of the Galvanic Current.

The Value of Aëro-tonic Treatment.

The Influence of Climate on Temperament.

Presented by author, Dr. L. Bayer.

Observations démontrant l'influence de la Menstruation sur les Affections laryngées.

Ueber den therapeutischen Werth der Kohlenwasserstoffe.

Des Kystes osseux de la Cavité nasale.

Empyems der Highmorshöhle.

Ein Fall von Bewusstlosigkeit nach Körpererschütterung; Rückkehr des Bewusstseins nach Lufteintreibung ins Mittelohr.

Accumulator und Galvanocaustik.

Ueber die Transformation von Schleimpolypen in bösartige (krebsige oder sarkomatöse) Tumoren.

Einfluss des weiblichen Geschlechtsapparats auf Stimmorgan und Stimmbildung.

Deux cas de Mycosis Tonsillaire, lingual et pharyngien.

Epithelioma primaire du Larynx—Intubation—Tracheotomie—Laryngotomie—Laryngectomie—Larynx artificiel—Affections de l'Appareil respiratoire—Prodromes de la Fièvre typhoide.

Ulcérations typiques pharyngées.

Presented by the author, E. Cresswell Baber.

A Guide to the Examination of the Nose.

Remarks on Adenoid Vegetations of the Naso-pharynx.

Feeding with Fresh Thyroid Glands in Myxœdema.

Further Remarks on the Self-retaining Palate Hook; including its use in Post-nasal Catheterism.

A Recent Improvement in Posterior Rhinoscopy.

Lymphoma of the Tonsils.

Reflex Nasal Cough.
Remarks on the Theory of Bronchial Asthma.
Case of Rhinolith; with Remarks.
Contributions to the Minute Anatomy of the Thyroid Gland of the Dog.
Researches on the Minute Structure of the Thyroid Gland.

The following Bye-law proposed by the Council was then presented and confirmed:

"If a member wish to propose for ballot any candidate for office other than those whose names stand on the list recommended by the Council, the name of such candidate, duly proposed by one member and seconded by two other members, shall be sent to the Senior Secretary at least a week before the Annual General Meeting. It shall be the duty of the Senior Secretary to see that the name of such candidate with the office for which he is nominated, together with the names of his proposer and his seconders, be sent to all members at least two days before the Annual General Meeting."

The Chairman then, in the names of the Council, nominated the following gentlemen, all of whom had rendered distinguished service to the Science of Laryngology, for election as Honorary Members:

Sir George Johnson, F.R.S.
Dr. Wilhelm Meyer, Copenhagen.
Prof. B. Fränkel, Berlin.
Prof. L. von Schrötter, Vienna.
Prof. Stoerk, Vienna.
Dr. J. Solis Cohen, Philadelphia.
Dr. G. M. Lefferts, New York.
Prof. Massei, Naples.
Dr. E. J. Moure, Bordeaux.

The Scrutineers reported the result of the ballot as follows:

President.—Felix Semon, M.D.
Vice-Presidents.—P. McBride, M.D.; W. McN. Whistler, M.D.
Treasurer.—H. T. Butlin, Esq.
Librarian.—F. de Havilland Hall, M.D.
Secretaries.—E. Clifford Beale, M.B.; Scanes Spicer, M.D.
Council.—E. Cresswell Baber, M.B.; A. Bronner, M.D.; Dundas Grant, M.D.; T. Mark Hovell, Esq.; C. J. Symonds, Esq.

An Ordinary Meeting of the Society was subsequently held, the President, Dr. Felix Semon, being in the Chair.

The President briefly returned thanks for his election. The minutes of the previous Ordinary Meeting were read and confirmed.

The following candidates were elected Members of the Society:

C. E. M. Hey, Hornsey.
St. Clair Thomson, M.D., M.R.C.P.Lond.

The following gentlemen were proposed as candidates for election:

Dr. J. H. Drysdale, Liverpool, by Dr. Kanthack, Mr. Butlin, and Mr. Spencer.

Mr. Edmund Roughton, London, by Dr. W. Hill, Dr. Scanes Spicer, and Mr. Butlin.

Dr. James Cagney, London, by Dr. W. Hill, Dr. Scanes Spicer, and Dr. Hall.

Dr. BRONNER exhibited some laryngeal syringes which had been so constructed as to admit of their being rendered aseptic by boiling. He also showed some portions of deviated septum removed by means of a cutting trephine, which he had found useful in dealing with such cases.

Mr. CRESSWELL BABER expressed a preference for the saw in these operations in place of the knife or the trephine.

Dr. SCANES SPICER agreed that the saw was preferable for the larger spurs, but would use the cylinder trephine in the cases where the projection extended completely into the inferior meatus.

Mr. W. R. H. STEWART thought the best treatment for any but the very large spurs was to leave them alone.

The PRESIDENT deprecated the too hasty removal of spurs as a cure for neuroses.

Dr. BRONNER would only remove spurs and deviations when they were productive of actual obstruction.

RHINITIS ATROPHICA FŒTIDA WITH APHONIA.

This case was exhibited by Drs. HILL and CAGNEY. A. H—, æt. 24, a domestic servant, had suffered from dry nose and throat for four and a half years; aphonia three years. One and a half years ago voice returned for a week only when in Guy's Hospital, when the throat was faradised.

In May, 1893, consulted Dr. Cagney at St. Mary's Hospital for "loss of voice." Found to have rhinitis sicca, pharyngitis sicca, and laryngitis; under appropriate *local* treatment these conditions had so far improved that there was now no dryness of the pharynx and larynx, but the aphonia was unrelieved, and recently neuralgia of the left side of pharynx and head had become developed.

Galvano-cautery to the nose and base of tongue had been tried, also electrolysis to the nasal fossæ. Faradism and galvanism to the larynx had been applied three or four times a week for about two months with no practical benefit. Suggestions were invited as to best line of treatment.

Dr. Dundas Grant considered the laryngeal condition secondary to the disease of the nose, of which there was evidence in the right middle meatus, and which was probably of the nature of sinus suppuration, as the patient's consciousness of the offensive smell indicated. He believed that irritating material was simply displaced into the larynx by the action of inspiration, and this had given rise to a sodden condition. The aphonia was a remnant of the laryngitis so caused, and he believed that after successful treatment of the nasal suppuration, the laryngeal condition would yield to the judicious use of local applications and electricity.

Dr. Bronner mentioned that such cases were very common in Bradford. Of about 250 cases, at least forty would be cases of dry catarrh, but he had seen many cases where the larynx was alone affected, and which were successfully treated by intra-laryngeal injection.

The President was not convinced of the connection between the nasal and the laryngeal trouble in this case. The aphonia was still complete although the crusts and dryness were no longer visible. Mr. Symonds had restored the voice by faradisation, but it had been again lost. He suggested that the case should be shown again at a later stage.

Dr. W. Hill, in reply, agreed with the President's view. He did not think that the laryngeal affection was simply secondary to a suppurating sinus. There appeared to be a general atrophy of the mucous membrane.

The Function and Anatomy of the Epiglottis.

Dr. A. A. Kanthack read the following notes and showed the drawings referred to. The exact function of the epiglottis was not even yet fully understood. It was a respiratory organ as much as a phonatory one, but in man was more or less abortive. With the base of the tongue it also belonged to the complex protective mechanism of the glottis during deglutition. This had been denied by Prof. Anderson Stuart, but his method in demonstrating that the epiglottis comes forward and does not fold down was faulty. Mr. Anderson and the speaker had shown that if animals such as Stuart used be allowed to swallow in the natural position, with flexed and not over-extended neck, the epiglottis acts as a laryngeal lid. Allusion was made to the work of Moritz Schmidt and others.

In adult guinea-pigs, rabbits, cats, dogs, goats, oxen, horses, and pigs an intra-nasal epiglottis could always be demonstrated by means of frozen vertical sections. These were illustrated by an extensive set of drawings. Mention was made of the exhaustive work of Howse and Gegenbauer, and also that of Bowles and others.

According to Bowles the epiglottis of sucking pigs was small and intra-oral, and at a later age became intra-nasal, *i. e.* ascended behind the velum. The same change occurred in kittens and puppies. In fœtal kittens the epiglottis was as often intra-nasal as intra-oral. With age, therefore, changes in position of the epiglottis took place which required fuller investigation. In cats, rabbits, and guinea-pigs the velum palati extended vertically down to the base of the tongue in front of the epiglottis, so that in these animals swallowing under natural conditions could only take place with an epiglottis folded over the larynx.

In rats the epiglottis was found either in the oral or naso-pharyngeal cavity, in mice as a rule in the former; but the parts in smaller animals were so delicate that they were easily deranged.

In man and anthropoid apes the epiglottis was rudimentary, and did not show the intra-nasal arrangement. Gegenbauer had shown, however, that developmentally it was not connected with the mouth. In some monkeys the velum descended in front of the epiglottis, but in most the relations resembled those of man, and the epiglottis did not reach the velum. The human epiglottis was at times greatly enlarged, so as to be plainly visible on opening the mouth, and to hide the posterior wall of the pharynx from view. Dr. Kanthack asked whether in such cases the velum and uvula descended in front or behind the elongated epiglottis.

Dr. Scanes Spicer thought that the epiglottis, as seen clinically, was always posterior to the soft palate and uvula. The discharge from the uvula certainly dripped on the oral side of the epiglottis.

The President asked Dr. Kanthack to follow out this question of the epiglottic function. To what extent was the epiglottis concerned in phonation? It had been shown that *timbre* depended on the position of the epiglottis. In the production of open tones the epiglottis was said to be always more upright.

Dr. Percy Kidd mentioned the case of an aphonic boy, in whom any attempt at phonation resulted in the pulling down of the epiglottis to a nearly horizontal position.

Dr. Kanthack called attention, in reply, to the extreme difficulty attending all experiments as to function.

Recurrent Papilloma of Larynx twice operated on by Thyrotomy.

Dr. Percy Kidd showed this case. Chas. W—, æt. 9, was admitted into the Brompton Hospital on September 7th, 1893, on

account of loss of voice and slight inspiratory stridor. His voice had been lost since April, 1893. Laryngoscopic examination showed the presence of growths on the anterior portions of both vocal cords, especially the right.

On September 19th Mr. Godlee performed thyrotomy, and removed the growths with a sharp spoon. Nitrate of silver was applied to the base of the growths. Rapid healing ensued.

A fortnight later, October 3rd, a flattish outgrowth was detected on the laryngeal aspect of the right half of the epiglottis, and the corresponding vocal cord at its anterior third presented a pale œdematous fusiform enlargement. The patient then went to his home.

On November 21st he was readmitted, as the growth had recurred in the old site and was larger than ever.

On November 27th Mr. Godlee again performed thyrotomy, and cleared out all the growths with a sharp knife. A great part of the left vocal cord had to be removed with the growth. Rapid healing again took place, but on December 17th, less than three weeks after the operation, another recurrence took place. Both cords were then red, thick, and irregular, but moved fairly well. A large growth was attached to the right cord at its anterior half, and the corresponding part of the left cord was somewhat swollen. The outgrowth on the right side of the epiglottis remained unchanged.

Microscopically the growth was a papilloma.

Mr. Butlin recalled two cases in which he had performed thyrotomy on the same day. In one the operation was simple and successful, with good recovery of voice. In the other case the growth was diffuse and difficult to distinguish from healthy tissue; it was removed by scraping, but recurred again and again, and the patient was now wearing a tracheotomy tube.

Dr. Dundas Grant referred (1st) to the reported spontaneous disappearance of papillomata which sometimes occurred after tracheotomy; (2) to the reported curative action of arsenic given internally; (3) to the frequent coincidence of post-nasal adenoids; (4) to the value of applications of strong solutions of perchloride of iron. In the case reported he would attack the growth by means of his safety endo-laryngeal forceps under anæsthesia, and at the same time administer arsenic.

Dr. Scanes Spicer thought that the growth might be removed endo-laryngeally, and recommended the use of chloroform supplemented by frequent mopping with cocainised mops to produce complete anæsthesia and paralyse secretion.

The President mentioned a case in which no less than seventeen thyrotomies had been performed on the same patient, the result after

each being simply recurrence of the growth. He agreed that Dr. Kidd's case might be treated endo-laryngeally with Dr. Dundas Grant's forceps. As a general rule he would prefer to leave such growths alone in young children, unless they were causing dyspnœa. Although brilliant results might occasionally occur, recurrence generally took place and perpetual operations had to be performed. Even where there was dyspnœa it was sometimes better to perform tracheotomy and wait until the child grew older before removing the growth.

Angioma of the Larynx.

Specimen exhibited by Dr. Percy Kidd. Microscopical section of a portion of the tumour showing the characters of an angioma.

The patient, a Russian woman æt. 30, came to the out-patient department of the London Hospital in March, 1893, complaining of hoarseness and a sore feeling in the throat which had existed for a period of twelve months.

Laryngoscopic examination revealed the presence of a rounded tumour of the size of a pea springing from the left vocal cord, about the junction of the anterior and middle thirds. The growth presented a pinkish-grey colour, and was attached by a broad flat pedicle which permitted a considerable degree of movement. After cocainisation of the larynx the tumour was removed in two pieces with Mackenzie's cutting forceps. No bleeding of any note resulted.

Three days later the left vocal cord presented a reddish irregular appearance, but no trace of the growth remained. The patient ceased attending after this, and had not been seen again.

Enlargement of Posterior Faucial Pillars.

Mr. L. A. Lawrence showed a patient, F. P—, a man-servant æt. 30, who had suffered with his throat as long as he could remember. A diagnosis of enlarged tonsils had been made when he was eight years old.

The present trouble dated more especially from Christmas, 1884, as the result of a bad cold caught by exposure in a severe snowstorm. The tonsils were large. Posterior faucial folds very large, smooth, red, and hard to the feel, and extending some considerable way down the back wall of the pharynx. Uvula also swelled. Vocal cords normal. The turbinate bones were slightly enlarged, but the nostrils

not blocked. Patient could blow out a candle through either nostril. The pharynx was greatly narrowed laterally by the projection of the large posterior pillars.

In October last these conditions had been rather more aggravated than they were at present, and the voice was then nasal in tone. He had been using a paint of chloride of zinc, 30 gr. ad ℥j, till November 17th, since which time it had been increased by ten grains.

What further treatment was advisable in such a case?

Mr. W. G. Spencer thought it would be possible to divide the thickened faucial pillars with the cutting cautery and shell out the tonsil.

Laryngeal Papillomata.

Pathological specimen exhibited by Dr. Scanes Spicer. A. L—, æt. 8, a schoolgirl, lost her voice about January, 1887, during an attack of measles, and had not recovered it up to the period of coming under treatment in October, 1887.

On laryngoscopic examination the whole length of the right vocal cord on its upper surface and inner margin was covered with sessile warty growths.

She was given chloroform, placed in a sitting position in a nurse's lap in a chair, the tongue held out by an assistant on the right, the head steadied and kept square by an assistant behind. Anæsthesia was completed by spraying the throat with a 10 per cent. solution of cocaine. The growth was then removed piecemeal at two sittings by means of the laryngoscope and Mackenzie's lateral cutting forceps. Much mopping was required on account of exudation of secretions and bleeding.

Her restoration to health of voice and larynx was perfect. At the end of 1893 she presented herself for examination. There had been no trouble since, and on examination, six years after the operations, she had a perfectly normal larynx and voice.

This patient had a papilloma on her lip as well, and nasal obstruction from post-nasal adenoid hyperplasia, which were treated at same time.

The points of interest in the case appear to be the early age of the patient, and the methods which it was found necessary to adopt in order to see and remove the growth, and its successful removal without tracheotomy.

Mr. Cresswell Baber remarked upon the difficulty attending operations under chloroform alone in such young children. The plan of combining it with the local use of cocaine was a decided improvement.

Mr. Kanthack observed that in experiments upon animals it was always found that an exceptional amount of chloroform was required to paralyse the act of deglutition.

The President referred to the increased flow of saliva induced by chloroform, and agreed that the laryngeal reflex was the last to disappear under anæsthetics.

Dr. Spicer thought that chloroform alone was not sufficient to paralyse the pharynx. He used the cocaine mops persistently till all secretion had ceased.

Papilloma of Uvula.

Pathological specimen exhibited by Dr. Scanes Spicer. The patient, A. H—, æt. 15, a servant, came complaining of tickling in the throat, which led to irritating cough and "spasm" of the throat. These symptoms had been noticed three months.

On examination a papillomatous pedunculated mass the size of a pea was seen to be attached to a somewhat elongated uvula.

It was considered that the symptoms would be relieved by shortening the uvula about the attachment of the growth, which proved to be the case.

Dr. Spicer had never before seen a papillomatous growth of this size attached to the uvula or in the pharynx, and he believed that such cases were uncommon.

Carcinoma of the Œsophagus.

Specimen exhibited by Mr. W. R. H. Stewart. L. G—, æt. 29, a cook, an anæmic and somewhat emaciated woman, attended at the London Throat Hospital at the end of May, 1893. She stated that up to the preceding February, when she caught cold, she was well. She then had a sore throat, with dryness and difficulty of swallowing, taking fluids better than solids. After two or three weeks she went to Hastings for a fortnight, where she seemed to be quite well. On returning to London, however, the symptoms all returned with greater intensity. She began to lose flesh, and the food occasionally regurgitated through the nose. There was no history of syphilis or injury

to the throat of any description. The father and one brother died of phthisis. The voice was hoarse. There was tenderness over the right side of the larynx, and she expectorated a white frothy fluid.

Laryngoscopic examination showed some irregular swellings situated about half an inch above the arytænoids and more to the right of the middle line, and from one point pus was oozing; through this a fine probe could be passed into the œsophagus, some roughness being felt as it went through. Larynx normal. Patient gradually got weaker, the difficulty in swallowing, tenderness and pain in the right side of the neck increased, and there was a good deal of swelling in this region. Gastrostomy appeared to be imminent, and the patient was therefore transferred to the Great Northern Central Hospital. There on July 21st, the swelling in the neck having increased, Mr. Stewart dissected down to it, and found a mass of tough, thickened tissue, which proved to be the thickened wall of the œsophagus. This was removed, and a large drainage-tube inserted; but the patient gradually got worse, and as it was found impossible to feed her either through a catheter or by the tube in the wound, gastrostomy was performed by Mr. Macready, and a good meal was given through the tube during the operation; she seemed greatly relieved, but gradually sank, and died two days after.

Post-mortem.—The upper portion of the œsophagus for about four inches was found to be affected, and the microscope proved the growth to be carcinoma.

There were several points of interest in this case. First, with regard to the unusually early age—twenty-nine. The disease was thought to be very rare before thirty-five years, and although it occurred earlier in women than men, forty-five to fifty-five was the usual time. Again, it was an instance of the reputed disposition of children of tuberculous parents to develop cancer of the œsophagus. There was no traceable exciting cause, and the disease did not spread from an adjacent organ. Death took place very rapidly, within five months of the patient feeling any symptom, and the upper portion of the tube was affected; but it was probable that the disease had no special preference to any part. Does ulceration occur at an earlier stage when the upper part of the œsophagus is first affected?

Suppuration in the Ethmoidal Cells.

(This case was reported in the 'Lancet,' April 29th, 1893.) Mr. W. R. H. Stewart showed the case of M. W—, a married woman, who was sent to him at the Great Northern Hospital by his colleague, Mr. Morton, with the following history:—Scarlet fever twenty years previously. During convalescence a large abscess formed in the corner of the right eye, and she was slightly deaf. The abscess burst and both ears discharged. She had no further trouble in the eye for ten years, but suffered occasionally from severe headaches. When out one day she suddenly felt a most violent pain which lasted for a week, during which time she could not sleep or lie down, and was at times unconscious. She consulted an oculist, who told her she had a tumour at the back of her eye. He incised a hard lump in the corner, and a lot of discharge came away. Eighteen months afterwards the eye was again very painful, and once more opened without relief. The pain in the head was very severe, and the swelling was incised a third time. Since then, nine years ago, the pain in the head has been almost unbearable, from time to time lasting from a few hours to two or three days. The swelling in the forehead and temple was always much inflamed whilst the pain lasted. Five years ago, after using a very hot lotion, large quantities of discharge came down into the throat, and have continued ever since. During the past few months the substance in the corner of the eye had become larger, the eye itself was more prominent, the attacks of pain more frequent, and affected the teeth so much at times that she could not bite. The parts seemed numb when not painful. When seen, now three years ago, the eye was pushed outwards and downwards, and there was a round swelling in the interior and superior corner of the orbit; the canaliculi had been slit up, and there was some discharge oozing from them. Rhinoscopy showed a large, hard, and tense swelling occupying the place of the right middle turbinate. Nasopharynx free. Under an anæsthetic he punctured the turbinate swelling with a trocar, and then on inserting his little finger into the nostril the tumour crackled up before it, and he was enabled to pass his finger on into the orbit. He therefore made a free incision into the internal and superior corner of the orbit, found a large quantity of dead bone and the orbit full of stringy pus, which was pushing out

the eyeball; the pus had also hollowed out a cavity in the direction of the frontal sinus, into which he could insert the tip of his little finger. The dead bone was removed, and the pus and *debris* well washed out with a warm boric acid lotion; a large drainage-tube was then inserted through the nostril and brought out through the wound. The patient did remarkably well, and now, three years after the operation, the nose remained free. There was, however, some slight hyperæsthesia round the orbit, and some bone had recently come away. The late Sir W. Bowman saw the case with Mr. Morton before she came to him, and pronounced it one of suppuration in the post-ethmoidal cells.

Recent Syphilitic Stenosis of Larynx.

Mr. Symonds showed this case, a man, æt. 45, with syphilitic stenosis of the larynx of recent origin. There was a general diffused thickening of the mucous membrane, with much narrowing of the glottis and impeded respiration. The affection had existed for one year, and though so recent had not yielded to a vigorous course of remedies. A prophylactic tracheotomy was recommended.

Swelling of Ventricular Band and Arytænoid Cartilage of Uncertain Nature.

Mr. Symonds showed, for the second time, a man of 75 who was exhibited in May, 1893. At that time he had a swelling of the left band and arytænoid, with fixation of the cord. The symptoms arose suddenly while eating, and at first it was thought that the part had been wounded by a bone. There was no history to support this view. He had, when shown in May, a painful short cough with much dysphagia. At the present time, after an interval of eight months, there was still swelling on the left side, with fixation of the cord. It appeared hard and had lost its glazed appearance. There was a depression in the centre that looked like a superficial ulceration. The arytænoid was not so swollen as before. The cough and the pain disappeared, and he could swallow easily. In May the diagnosis lay between a growth and some form of perichondritis. At the present time the diagnosis was still open. The appearances did not closely resemble any known growth. Iodide of potassium had been tried.

There was no external change in the larynx. The case would come before the Society again.

The PRESIDENT thought that the diagnosis must still remain uncertain, but he inclined to his former view that it was originally a perichondritis. He expressed thanks to Mr. Symonds for the further exhibition of the case, and suggested that all such doubtful cases might with advantage be shown again and again to the Society, in order that their progress might be watched and studied.

EPITHELIOMA OF THE SOFT PALATE AND FAUCES.

Dr. WATSON WILLIAMS brought forward this case. F. F—, æt. 65, was admitted to the Bristol Royal Infirmary in August, 1893, with a large epitheliomatous growth occupying the soft palate, well displayed in the coloured drawing exhibited. It probably commenced in the soft palate on the right side eleven months before admission, when the patient first began to notice pain and difficulty in swallowing.

The case had previously been diagnosed and treated for syphilis, but there was no history of syphilis, nor any family history of malignant disease.

The main portion of the growth showed light pink, granular, but deep ulceration, covered with greyish muco-pus and disintegrated tissue which gave a characteristic fœtor to the breath. The surface of the ulcerated portion was fissured, nodular, and of a cauliflower aspect, while the margin was seen to be elevated, distinct, and hard. There was no glandular enlargement or infiltration in the neck at first, nor was the pain intense. It had been relieved by iodide of potassium for a time, and when it became more severe by ten-grain doses of analgen. The growth gradually spread and disintegrated. The gland of neck became rapidly involved, and the patient sank and died two months later. An attempt was made to arrest the growth by inoculations with pure cultures of the *Streptococcus erysipelatosus*, but without success.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON

ORDINARY MEETING, *February 14th*, 1894.

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

E. CLIFFORD BEALE, M.B., }
SCANES SPICER, M.D., } Secretaries.

Present—22 Members and 2 Visitors.

The following gentlemen, nominated by the Council at the previous meeting, were elected Honorary Members of the Society:

Sir George Johnson, M.D., F.R.S.
Prof. B. Fraenkel, Berlin.
Prof. von Schroetter, Vienna.
Prof. Stoerk, Vienna.
Dr. Wilhelm Meyer, Copenhagen.
Dr. J. Solis-Cohen, Philadelphia.
Dr. G. M. Lefferts, New York.
Prof. Massei, Naples.
Dr. E. J. Moure, Bordeaux.

The following gentlemen were elected Ordinary Members of the Society:

Dr. J. H. Drysdale, Liverpool.
Dr. James Cagney, London.
Mr. Edmund Roughton, London.

The Minutes of the previous Meeting were read and confirmed.

TUBERCULAR TUMOUR OF LARYNX.

Dr. CLIFFORD BEALE showed a patient, æt. 22, who had been under observation for the last four years, suffering on and off from tubercular disease of both apices. The active pulmonary disease had always subsided whilst the patient remained in hospital. The throat had at first been affected with occasional attacks of simple laryngitis. During the last year a nodular swelling had formed at the posterior part of the right arytænoid cartilage, projecting into the larynx and covering the right processus vocalis. It was smooth, rounded, and not

ulcerated, and only gave rise to occasional hoarseness. The firm character of the swelling, its position, its relation to the inactive disease in the lung, and the fact that it showed no tendency to disintegration placed it in the class of conglomerate tubercular tumours of the larynx, described by Stoerk and others.

Dr. TILLEY thought that the tumour must be classed as tubercular, and mentioned an exactly similar case. The position of the swelling was, he thought, sufficient in itself to warrant the diagnosis of tubercle.

Dr. DE HAVILLAND HALL, agreeing as to the tubercular nature of the tumour, would deprecate any interference with it so long as it gave rise to so little trouble.

The PRESIDENT described the case of a man, aged fifty, in whom no tubercular disease of the lung was manifest, but who had a slowly growing tumour in the anterior commissure of the cords. This was proved to be tubercular by examination of a portion of it, and was checked by applications of lactic acid. Possibly some tubercular lesion of the lung was present, but no physical signs of it could ever be discovered.

COMPLETE PARALYSIS OF THE RIGHT VOCAL CORD.

Mr. BUTLIN showed a patient with complete paralysis of the right vocal cord. The cord stood almost in the middle line, and its free border was incurved. The other vocal cord moved well, and came in contact with the paralysed cord, but the voice was gruff and unsteady. There were no signs of disease in the interior of the larynx, and the two cords were quite white and clean.

The patient said he had become gradually hoarse in the course of June, 1893, and was not conscious at that time of having suffered from a cold.

He had been an inmate of St. Bartholomew's Hospital for some days, during which a careful examination had been made, in order to discover a cause for the paralysis, but without success. There were no evident signs of central or peripheral nerve lesion; no signs of aneurism or tumour in the neck and chest; no signs of malignant disease of the larynx or œsophagus.

There was a history of venereal disease many years (thirty) previously, but no clear history of syphilis. The man stated that he had lately lost a stone in weight, but that was apparently only due to a sharp attack of influenza.

No physical signs of affections of the apices of the lungs were discovered.

The patient was a miller 52 years old.

The PRESIDENT thought it possible that the paralysis might be the forerunner of tabes. He had been struck with the frequency of early abductor paralysis in cases of commencing tabes, but agreed that in the present case no symptoms were as yet evident which could justify such a diagnosis.

CARCINOMA OF RIGHT SIDE OF LARYNX.

Mr. BUTLIN also showed for Mr. Bowlby a man, between 40 and 50 years of age, with considerable swelling and ulceration of the right ary-epiglottic fold and right half of the larynx, which was immoveable. There were enlarged, hard, fixed glands on the right side of the neck, particularly below the angle of the jaw. The larynx was broader than natural.

The patient suffered much from pain, dysphagia, and occasional sharp attacks of dyspnœa. His symptoms dated from September, 1893, when he first began to experience pricking sensations about the right side of the larynx.

RHINITIS FŒTIDA, WITH ANTRAL DISEASE AND HYPERTROPHY OF UNCINATE PROCESS AND MUCOUS MEMBRANE COVERING IT, SIMULATING SO-CALLED "CLEAVAGE."

Clinical case exhibited by Dr. WILLIAM HILL. Miss G—, æt. 45.

History.—The fœtid rhinitis was of five or more years' duration, and had been treated by removal of crusts, antiseptic sprays and douches, galvano-cautery, trichloracetic acid, iodol ointment, &c.

In January, this year, an attempt was made to drain the antrum through a tooth socket. A considerable quantity of pus escaped through this opening. The antrum had been syringed until within the last week, when the operation became too painful.

Rhinoscopic appearance.—In the right nostril could be seen the condition corresponding to the descriptions of "cleavage" of the middle turbinated body (Woakes). The body on the outer side of the cleft *in this case* was clearly a pathological enlargement of the *uncinate process* of the ethmoid, together with the mucous membrane covering it; this process normally bounds the hiatus semilunaris in

front and below. The hypertrophy of the uncinate process and its mucous covering might be conveniently described as the "*uncinate body.*" The body on the inner (septal) side of the cleft was the middle turbinated itself. The cleft was choked with granulations, and it was inferred that the antrum contained granulations or polypi, or some other diseased condition of the mucous membrane.

Proposed further treatment:

1. Removal of the hypertrophied area ("*uncinate body*").
2. Opening of the *maxillary antrum* through the *canine* fossa.
3. Establishing an accessory opening between nose and antrum, either in middle or inferior meatus.

Note.—Although the "*uncinate body*" is usually composed of overgrowth of bone *and* mucous membrane, the bone occasionally is of normal size, but covered by such an overgrowth of the muco-periosteum as to appear as a fibrous or mucous *tumour* which can readily be severed.

Obscure Pharyngeal Ulceration in a Case of Arrested Laryngeal and Pulmonary Tuberculosis.

Dr. Felix Semon showed the case of N. W—, æt. 36, a gentleman who, coming of a healthy family, began to suffer with severe sore throat in August, 1892. Had never had syphilis. Nevertheless in November, 1892, a London laryngologist considered the affection to be specific, having found considerable ulceration of the epiglottis. In December, 1892, Dr. Davison of Bournemouth pronounced distinct disease of right apex. He treated the larynx with lactic acid, and ordered constitutional measures. The throat got gradually better, and in April, 1893, Dr. Davison stated that the laryngeal ulceration had been definitely arrested. In June, 1893, the soreness started again, and the patient consulted the reporter, who found consolidation of the right apex and tubercular tumefaction and ulceration of the epiglottis, a diagnosis which was subsequently corroborated by Sir William Broadbent. The epiglottis was treated by energetic curetting followed by applications of lactic acid (30 to 50 per cent.), and the ulceration again healed, leaving a large loss of substance about the middle of the part, covered by a peculiarly white scar. The right half of the epiglottis has ever since remained tumefied. Internally the patient was

given, and had ever since taken, large doses of creasote. The condition of the right lung had remained perfectly stationary, and the general health very good. On the epiglottis once more, at the beginning of November, slight ulceration took place in the scar tissue, which was again promptly stopped by lactic acid.

At the commencement of this year Dr. Davison observed on the posterior wall of the pharynx some small, well-defined, clean, steep ulcers, which he at first was inclined to look upon as tubercular, but which did not yield to lactic acid. The patient states that he has once before had a similar ulceration, which gradually disappeared. The theory of syphilis once more being revived, the patient took for a fortnight iodide of potassium. This only resulted in the production of considerable œdema of the left arytænoid cartilage, with transitory immobility of the left vocal cord. The pharyngeal ulcers were now again spontaneously subsiding, and suggestions were invited as to their probable nature.

Mr. Symonds suggested that the pharyngeal ulceration should be curetted and treated with lactic acid.

The President had used lactic acid without any result, but not after curetting. The fact that the larynx had healed under lactic acid made it appear that the pharyngeal condition must be due to some other cause besides tubercle.

Œdema and Infiltration of Arytænoid Mucous Membrane of Uncertain Origin.

Clinical case exhibited by Dr. Scanes Spicer. J. F—, æt. 51, labourer, was sent to the throat department at St. Mary's Hospital by Dr. Maguire January 23rd, 1894.

Symptoms.—Shortness of breath; feeling of choking and suffocation; paroxysmal cough; excessive secretion of frothy mucus; constant discomfort in throat day and night; voice weak, but not otherwise affected; difficulty of swallowing extreme; had lasted two years.

Laryngoscopic examination.—Pale, glistening, semi-transparent, bladder-like swelling seen filling upper orifice of larynx, and obscuring glottis completely. After cocainisation this swelling somewhat subsided, and the left pyramid was seen to be œdematous and lobulated in the situation of cartilages of Santorini and Wrisberg. The left ventricular band was considerably infiltrated and red, but no ulceration could be

made out, and it overlapped the left vocal cord. Both vocal cords moved normally on phonation, and glottis widened at inspiration.

The diagnosis appeared to lie between—

1. Perichondritis with secondary thickening and œdema.
2. Malignant disease with secondary œdema.
3. Tertiary syphilis with secondary œdema.
4. Tubercular disease with secondary œdema.

(1) appeared to be excluded by free mobility of cords, and by long duration of case without much alteration in symptoms.

(2) by the same signs, by absence of ulceration or by glandular enlargement, and by absence of sufficiently marked cachexia.

(3). There was a history of syphilis, but had this laryngeal affection been gummatous, it must have led to ulceration and destruction of soft parts at all events, especially as there had been no antiseptic treatment.

(4). The case was probably of tubercular origin, on which had supervened an unusual amount of œdema. It is the observer's experience that such marked laryngeal disease in tuberculosis is seldom confined so entirely to one side. The emaciation, history of repeated attacks of bronchitis, slight hæmoptysis, together with depression about clavicular fossæ and upper intercostal spaces (in the absence of any marked pulmonary lesions), taken all together, confirm the tubercular view. Examination of sputa for tubercle bacilli had given negative result.

Dr. DE HAVILLAND HALL thought that the condition was one of perichondritis, and not of tubercle.

The PRESIDENT, Mr. BUTLIN, and Dr. TILLEY supported Dr. Spicer's view that the disease was tubercular.

MULTIPLE SARCOMA.

Mr. W. R. H. STEWART mentioned the case of F. P—, a fireman, who had been exhibited by him at the first Clinical Meeting of the Society in April, 1893. A full account of the case appeared in the first number of the 'Proceedings.' At the suggestion of two or three members Mr. Stewart had pushed the arsenic treatment, and within a month the patient was taking Liq. Arsenicalis ℥xv, t. d. s., and sometimes even larger doses. The result as far as the tumours were concerned was marvellous. The glands in the neck gradually got softer and disappeared; the edges of the ulcers, to use Dr. Freeborn's

description, who kindly looked after the case at Oxford, seemed to melt away, and the naso-pharynx became fairly free. The swelling in the tongue, however, did not get less, but it ulcerated, and a lump came away from it, which under the microscope proved to be simply a blood-clot. About six weeks after commencing the arsenic his fingers and toes began to feel numb, the feet swelled, his knees began to give way, and he fell on them occasionally when walking. The arsenic was then left off until July 4th, when it was recommenced, but it could not be continued in such full doses again. The trouble in the throat had gradually become worse, until it had reached its present condition, viz. much the same as it had appeared last April.

Retraction of Alæ Nasi—Ozæna.

Mr. W. R. H. Stewart showed the case of M. H—, who for the last eight years had noticed a bad smell from the nose, gradually getting worse. The nose became blocked and very sore. As the soreness passed away the sides of the nose fell in. On examination there was a contraction on both sides about half an inch from the opening. The patient had been under treatment for ozæna for about a fortnight with applications of lactic acid, 80 per cent. solution, and the passage of nasal bougies. Mr. Stewart had not much hope of greatly benefiting the contracted condition of the openings.

Dr. Tilley suggested that the patient should wear the small celluloid alæ nasi dilators introduced by Dr. Spicer, which, by a little trimming down to suit the case, would be found to give the patient relief from the obstruction to breathing.

Dr. J. B. Ball did not think that any special treatment was called for, as the patient seemed to have room for respiration.

Absorbed Gumma over Right Arytænoid Cartilage—Impaired Movement of Vocal Cord.

Dr. Hale White showed this case. Ed. S—, æt. 33, admitted December 19th, 1893. In Guy's Hospital three years ago for rupia, and nine months ago for sloughing gummatous testicle. Six weeks before admission he lost his voice, and this had not returned. Difficulty of breathing had slowly come on, and any slight excitement brought on choking attacks.

On admission cyanosis, enlarged glands in neck, specific scars on

legs, perforated nasal septum; voice very husky; cough difficult. Inspiratory stridor so bad that tracheotomy appeared imminent. Larynx did not move much. Some sucking in over lower part of chest. Any excitement increased the dyspnœa. Over the right arytænoid was a rounded, greyish, œdematous-looking swelling as large as a Barcelona nut. The right arytænoid could be seen, but the posterior part of the laryngeal aperture was blocked by the swelling; the right cord moved, but not the left. Under treatment with gr. x of Pot. Iod., gradually increased to gr. xxx ter die, and $\frac{1}{8}$ gr. of perchloride of mercury injected into the gluteal muscles, the swelling slowly subsided, and now there was scarcely any swelling, but the left cord moved but little.

Dr DE HAVILLAND HALL mentioned a similar case where tracheotomy was often threatened, but where the use of iodide again and again averted its necessity. Tracheotomy was finally unavoidable, and subsequently thyrotomy had to be performed. The patient died of pneumonia somewhat later, and the laryngeal disease was found to be malignant, although it had apparently healed on several occasions.

The PRESIDENT thought that while it was not well to wait too long for tracheotomy, it was always advisable to use iodide and mercury in the first instance if possible. Cases had occurred of rapid improvement by such means. In some cases the disease had been seated in the trachea, and a too hasty tracheotomy would only have complicated matters without giving relief. Replying to Dr. Hale White, he had found that the movement of the affected cord in a case similar to the one exhibited had been completely restored in course of time.

GUMMATA OF EPIGLOTTIS (?).

Dr. Willcocks showed a patient, R. C—, æt. 27, a Covent Garden porter, who had contracted a primary sore three years ago, followed by slight sore throat and erosions on edges of tongue. Rash on skin. Voice husky for last two and three quarter years; affected shortly after primary sore.

Present condition.—Epiglottis much thickened and irregularly nodulated; somewhat fixed; no visible ulceration; feels hard; view of interior of larynx imperfect; no enlarged glands to be felt under jaw.

Mr. STEWART referred to a similar case which cleared up under the use of iodide, but with occasional severe laryngeal spasm, necessitating the use of an anæsthetic. In another case the disease simply went from bad to worse, the iodide showing no result.

Dr. BRONNER advised the use of mercurial inunction.

Dr. WILLCOCKS proposed to treat the case with iodide and mercury.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *March 14th*, 1894.

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

E. CLIFFORD BEALE, M.B., } Secretaries.
SCANES SPICER, M.D., }

The minutes of the previous meeting were read and confirmed.

The President referred in feeling terms to the great loss that the Society had experienced in the death of Dr. Ernest Jacob, of Leeds. His wide range of interest in scientific work of all kinds, not limited to professional subjects only; his cordial sympathy and co-operation in the work of the Society, of which he was an original member, and above all his kindly and genial personal qualities, would always be held in remembrance by those who had the privilege of knowing him.

FIXATION OF LEFT VOCAL CORD.

Dr. J. B. BALL showed the case of Mrs. A. O—, æt. 31. The left vocal cord was immoveable in position of complete paralysis. Right vocal cord moved freely. No other sign of disease in larynx. In January, 1891, she had influenza and congestion of the lungs. She lost her voice during the illness, and though it had improved it had never returned to its natural condition. Was thin and anæmic. Catamenia scanty and infrequent. Breath short on exertion. Suffered from palpitation of heart. The feet and legs swelled at times. Never had rheumatic fever. Heart's apex beats in fifth space, an inch outside nipple. Systolic and pre-systolic apex murmurs present. Lungs normal.

TUMOUR OF THE LARYNX IN A CASE OF GOITRE.

Dr. J. B. BALL showed this case. Mrs. C. B—, æt. 48, was admitted into the West London Hospital on September 27th, 1892

with a very large goitre, which had been growing for ten years and was beginning to cause some dyspnœa. A considerable portion of the tumour was removed by Mr. Keetley. Larynx examined at this time was normal.

Readmitted on August 5th, 1893, suffering from severe dyspnœa. Tracheotomy was performed immediately, and she had worn tube since. On August 25th, 1893, a swelling was found involving right ary-epiglottic fold and almost hiding glottis. Not examined again till March 9th, 1894, when a rounded, smooth red swelling was seen involving the right ary-epiglottic fold, and covering nearly the whole of the upper aperture of the larynx.

Since the original operation by Mr. Keetley in September, 1892, there had been a considerable increase in the size of the portion of the goitrous tumour which was left. Microscopical sections of the tumour were exhibited.

Mr. SPENCER thought that the case was certainly one of thyroid carcinoma, both from its clinical appearance and from the characters of the specimen shown.

Mr. SYMONDS agreed as to the carcinomatous nature of the growth, and thought that the internal swelling was due to projection of the growth inwards, as it seemed to be continuous when manipulated externally, the larynx being examined internally at the same time.

The PRESIDENT suggested that the internal swelling might be a part of the thyroid, but not of necessity a part of the growth.

Dr. DUNDAS GRANT suggested that the appearance of invasion of the larynx by the growth might be due to the displacement caused by the external swelling pushing parts of the larynx itself inwards.

LARYNGEAL SYMPTOMS IN A CASE OF INSULAR SCLEROSIS.

Dr. F. W. BENNETT showed this case. R. P—, æt. 38, complained in April, 1892, of difficulty in swallowing, hoarseness, and attacks at night-time as if "some one were clutching the throat, preventing breathing." He attributed the symptoms to a bad cold, and had noticed also tingling and cramps in the hands, arms, and legs, especially of the left side, pain in the hips and spine, and severe occipital pain. He suffered occasionally from vertigo.

On examination the pharynx and larynx were found chronically inflamed, the uvula elongated. During inspiration the cords separated widely, the right moving most freely. In phonation the right cord

moved slightly over the middle line, but the left moved fairly freely. The vocal processes met, leaving an oval opening between the cords anteriorly and a triangular opening posteriorly. Occasional tremor of the cord was noticeable.

The pupils were very unequal in size; there was frequent spasm of the left orbicularis; fundus of the eye normal; the tendon reflexes were lively. Nothing abnormal could be detected in the chest or urine. The patient was thought to be suffering from insular sclerosis.

March, 1894.—The patient stated that he would feel well if it were not for his throat. His life was "made a misery to him" by attacks of "spasm of the throat," which prevent him from lying down at night. The voice was now better, but the spasms were much worse. The appearance on phonation did not show any important change. Occasionally, however, the left cord failed to meet the right, and retained a general concavity inwards.

The sensitiveness of the larynx was not impaired. The crico-thyroid muscle contracted moderately during attempts at singing.

Dr. Scanes Spicer called attention to the marked degree of nasal obstruction which existed in this case. He thought the laryngeal spasms occurring on lying down at night were due to the accidental passage of secretion from the naso-pharynx and pharynx into the larynx. It was observed that the naso-pharynx and pharynx were in a state of subacute inflammation, the palate and uvula inflamed, "dropped," and hypertrophied. He believed that these conditions could only be cured by first rendering the nose patent, and that if the catarrh were subdued, the nocturnal laryngeal spasms would cease. He did not regard the spasms as of central origin, nor as reflexly started in the nose, but as a direct mechanical irritation from excessive catarrhal secretions.

The President did not think that there was any connection between the nasal condition and the spasmodic movements of the cords. These he regarded as evidences of some central defect of co-ordination, and pointed out that the position of the cords was constantly changing even during examination, and especially on attempted phonation.

Dr. McBride suggested that the nocturnal spasms and the peculiar movements of the cords might be due to hysteria. He could not accept the explanation offered by Dr. Spicer, but believed that if the catarrh and its consequences were relieved by operative measures the laryngeal affection might or might not be cured, but still ought to be regarded as of an hysterical nature. Any severe shock, such as a surgical operation either in the nose or elsewhere, might bring about a cessation of such symptoms.

Dr. Bennett agreed with Dr. Spicer that the nose should receive attention. He had noted the changes of position to which th President had referred, and recalled the fact that at an earlier stage in

the case some temporary relief had been afforded by removal of a portion of the elongated uvula, but that no permanent benefit had resulted. He had no doubt that the general symptoms indicated the slow progression of insular sclerosis.

Tracheal Fistula.

Clinical case exhibited by Dr. de Havilland Hall.—M. S—, æt. 40. Tracheotomy was performed at the age of twelve on account of gradually increasing difficulty of breathing. A cannula was worn up to the age of nineteen, but a tracheal fistula remained after its removal. Closure of the opening with the finger caused dyspnœa. On laryngoscopic examination the glottis was found to be very much contracted by papillomatous growths springing from the vocal cords and the anterior commissure. After these were removed with the cutting forceps, Mr. Pearce Gould did a plastic operation, and closed the tracheal fistula, which had existed for twenty-one years.

Syphilitic Stenosis of Larynx.

Specimen exhibited by Dr. de Havilland Hall.—Larynx of a patient who was shown at a previous meeting of the Society suffering from syphilitic stenosis. During a wrangle in the street the canula came out, and being unable to replace it, the patient was brought into the hospital dead.

Mr. Spencer, who had originally performed tracheotomy in this case, observed that there had probably been some affection of the superior laryngeal nerve, as evidenced by certain disturbances of circulation from which the patient had suffered, which had decided him against undertaking any further operative measures. There was probably some amount of neuritis of the superior laryngeal nerve, and it was most likely that the sudden death was not due merely to the loss of the tube, but to some sudden disturbance of the heart's action.

Dr. Hall agreed with this view, and mentioned that the patient had on several occasions suffered from syncopal attacks and vomiting.

Laryngeal Stenosis (? Tubercular).

Dr. Percy Kidd showed this case.—C. H—, æt. 42, an ex-police-man. The patient had some venereal disease, whether syphilis or not is uncertain, fourteen years ago.

Two years ago he had "influenza and bronchitis," since which time his voice became weak, and a few months later was lost altogether. There had not been much cough or expectoration, but the patient had lost flesh considerably, and had suffered from dyspnœa on slight exertion.

Larynx.—The glottis was bounded by two dull red irregular bands, occupying more or less the position of the vocal cords, but apparently attached posteriorly at a lower level than usual with the normal cords. On each of these bands at their upper and inner aspects there was a fleshy, flattish, polypoid outgrowth. These bands were situated close together, causing considerable stenosis of the glottis, and were quite motionless. There was some partially healed ulceration over the left arytænoid cartilage close to the processus vocalis, extending to the interarytænoid fold.

Chest.—Weak breath-sounds on both sides. Muffled râles on cough at the right apex in front and behind. Slight dulness at the right infra-spinous fossa.

The patient had been under observation since last summer. The larynx had not altered much. A course of iodide of potassium and mercury had no effect. The pulmonary physical signs had varied considerably, at times no râles being audible, at other times râles had been heard at the left apex only. The sputum had been frequently examined for tubercle bacilli with negative result. The patient had wasted much, and his general condition had deteriorated sensibly.

Small Subglottic Tumour of Uncertain Nature in a Case of Laryngeal Tuberculosis.

Dr. Percy Kidd showed the case of P. B—, æt. 38, a caretaker.

Larynx.—Puckered and partly healed ulceration of tip of epiglottis. Ventricular bands much swollen, partly hiding vocal cords.

Ary-epiglottic folds both much swollen. In subglottic region just below anterior commissure, and slightly to the left of the middle line, a sessile, oval, smooth, reddish tumour, of the size of a coffee bean.

The tumour was at first regarded as tubercular, but although the patient had been under observation for three months, no change had occurred in its appearance.

Tubercular ulceration of the epiglottis was arrested by the application of pure lactic acid.

The patient was the subject of chronic pulmonary tuberculosis.

His general condition had improved greatly, and he had gained much weight during the last three months.

No history of any venereal disease could be obtained.

Two Cases of Malignant Disease of the Larynx cured by Thyrotomy and Excision of the New Growth.

Exhibited by Dr. Felix Semon.

Case 1 (already described in Clinical Society's 'Transactions,' vol. xxv, 1892, p. 300).—F. C—, gentleman æt. 40, sent by Dr. Bower of Gloucester, consulted the reporter in May, 1891. He was then suffering from an infiltrating tumour in the larynx, occupying the left ventricle and the left ventricular band, which almost completely covered the left vocal cord. He had been suffering for more than twelve months from hoarseness. Latterly, slight pain had occasionally been felt on the left side of the throat, extending into the ear. A small piece of the growth was removed with Mackenzie's forceps, and turned out, on microscopic examination by Mr. Shattock, to be a squamous-celled carcinoma. On June 2nd, 1891, thyrotomy was performed; the patient recovered without any incident, and had never shown a trace of recurrence. The phonatory result obtained was remarkably good, although all the soft parts on the left side of the larynx, including the left vocal cord, which was found to be somewhat infiltrated in the course of the operation, had been removed; his voice was practically normal. The situation of the former growth was occupied by a smooth cicatrix with a prominent ridge corresponding to where the left vocal cord had been, and the right cord crossed the middle line to some extent and almost touched this ridge.

Case 2.—The Rev. Canon B—, æt. 59. Sent by Mr. Lawford Knaggs, of Leeds, and Mr. Arthur Lucas, of Woburn, on account of a bipartite growth occupying the posterior part of the left vocal cord, which extended almost to the arytænoid cartilage; the cord showed a very slight defect of mobility. The voice was marvellously clear in spite of the situation and size of the growth, and of the congestion, not only of the base of the latter, but also of the rest of the vocal cord. The patient complained of pain in the left side of the throat, and of tenderness on pressure of the left side of the larynx. There was also some blood-stained expectoration in the mornings. The diagnosis of malignancy was further confirmed by Mr. Butlin. On June 25th, 1892, thyrotomy was performed, and the left vocal cord, together with a part of the left arytænoid cartilage, removed. The growth, on microscopic examination by Mr. Shattock, turned out to be a cavernous fibro-sarcoma. The patient recovered without the slightest incident, and in his case too the voice was nearly normal, a cicatricial ridge having formed in the situation of the former vocal cord very much as in the first case described.

Dr. Semon observed that this tendency to the formation of cicatricial ridges doing duty for a removed vocal cord did not appear to be an isolated phenomenon, exactly the same formation having also been observed in the case of the late Mr. Montagu Williams.

A Laryngeal Neoplasm of apparently Sudden Origin (Pachydermia).

Dr. Scanes Spicer showed the case of J. C—, æt. 42, salesman, who attended St. Mary's Hospital Throat Department on March 2nd, 1894, complaining of hoarseness of about fourteen days' duration, which came on with a severe cold. Voice was clear and strong before this attack. History of catarrhs, syphilis, rheumatism, and alcoholic excess, the latter ten years ago. Took snuff, but not a smoker. Not a voice user specially. Pupils markedly contracted, very slight reaction to light. Gait and patellar reflex normal.

Tongue showed smooth depressed cicatrices and rhagades. In region of right processus vocalis was a small oval swelling with long diameter parallel to vocal cord, papillated on surface, reddish in colour,

and on phonation dipping into reddened depression on opposite cord, but there was no hyperplasia. Cord mobility perfect. Slight thickening on posterior wall. Mucosa generally red and rough.

The crateriform depression of the top of the tumefaction described as characteristic of pachydermia was not to be made out, but the situation of the swelling, the nipple-like surface, and the persistence of the cord mobility pointed to the diagnosis of pachydermia in an early stage, to the exclusion of malignant, tubercular, or syphilitic disease. According to Sommerbrodt pachydermia favoured the right side, and according to Chiari often originated in catarrh, points with which this case was consonant.

The question must remain open whether the neoplasm had arisen suddenly, or whether, during the present catarrh, a sudden increase had taken place in a mass previously too small to cause hoarseness.

Pachydermia Laryngis.

Mr. C. J. Symonds exhibited a patient, Wm. F—, æt. 52, a tailor, who stated that his voice had been affected since a boy. He came to Guy's Hospital in February, 1893, with some hoarseness. The appearance of the cord was then identical with that seen now. He returned February, 1894. When he first came he was given iodide of potassium, and he believed that he was better for it. He had served in the navy and army. He then drank spirits, beginning as a boy with rum, which he took daily. Ten years ago he became a teetotaler and remained so till three months ago. He said he had never drunk to excess.

The principal elevation was on the left side. The summit was yellow and depressed. On the right the projection was much smaller, and was more definitely arising from the inner aspect of the cord.

Since February he had taken iodide of potassium, with the effect apparently of reducing the prominence and rendering it more glazed. He had had syphilis, and recently had nodes in his tibiæ. His face showed much acne.

The points of interest were the definite evidence of syphilis; and the early consumption of alcohol, followed by a period of abstinence.

Dr. McBride though that Dr. Spicer's case was analogous to the condition of pachydermia. The indentation on the upper surface of the swelling, and its adaptation to the similar swelling on the opposite cord, in Mr. Symonds's case, was characteristic. He considered that other forms of contact ulceration with induration, such as the "singer's nodules," might be classed as pachydermia.

Dr. Clifford Beale mentioned a case seen in a tubercular subject in which for a short time the physical signs were precisely those of pachydermia, but in which the signs were rapidly and markedly altered under treatment. Could pachydermia laryngis safely be diagnosed by its appearance only, without reference to symptoms, or might not certain cases of chronic local ulceration be easily confused with it?

The President stated that the characteristic signs were not present during the whole duration of such cases, and that they must be taken in association with the other symptoms present.

A Fold of Mucous Membrane protecting the Middle Meatus.

The specimen, exhibited by Mr. C. J. Symonds, showed the presence of a lunated fold on the outer wall of the nasal fossa, opposite the anterior extremity and the middle turbinated bone. It was convex forward, and ran from above downwards and backwards. Behind and above it was the opening into the antrum.

The object of showing the specimen was to suggest that it offered an explanation for the projecting (mass of hypertrophied mucous membrane or) granulations seen in cases of suppuration of the antrum, of the ethmoidal cells, and in some cases of polypi. The projecting granulations in these cases were often in contact with the middle turbinated bone, the pus escaping through the slit between. This was, no doubt, the appearance described by Dr. Woakes as a "cleft turbinated."

Though Dr. Greville Macdonald had correctly described this appearance, and was the first to publish a correct description, he had not described the existence of this fold. The fold was often absent, though there was always a ridge of greater or less prominence.

It might perhaps represent the fold usually found below the orifice of the antrum, somewhat anteriorly situated. In order to expose the meatus, Mr. Symonds was in the habit of cutting off this fold with a knife, or removing by an antero-posterior acting curette.

Dr. HILL considered the specimen originally a perfectly normal one which had been decalcified through long pickling in spirit, and thus the relative position of the uncinate process and the middle turbinal had been disturbed by shrinkage. The so-called lunated fold of mucous membrane represented the decalcified uncinate process; this, when hypertrophied, had even been mistaken for "cleavage" of the middle turbinal.

Mr. SYMONDS thought that Dr. Hill's view might be correct, but the position of the fold seemed to be too far forward for it to be regarded as normal.

TRACHEAL STENOSIS (? CICATRICIAL STRICTURE).

Dr. PERCY KIDD exhibited the case of Chas. N—, æt. 38, who had syphilis thirteen years ago with secondary skin eruption and sore throat. For the last two years he had suffered from an irritable cough with profuse expectoration. About the middle of January, 1894, he first noticed dyspnœa and stridor.

There was now dyspnœa on slight exertion, and stridor both inspiratory and expiratory. No recession of soft parts. No respiratory excursions of larynx.

Pharynx.—Scarring of posterior wall and soft palate.

Larynx.—Vocal cords pinkish, but movements normal. The trachea could be seen for a considerable distance. There appeared to be a narrowing of the lower end, but the bifurcation was not visible.

Chest.—Breath-sounds weak over both lungs, expiration prolonged. Snoring sounds heard with inspiration and expiration. No other abnormal sign.

The PRESIDENT observed that he had not been able to detect any stricture.

CASE OF ADDUCTOR PARALYSIS OF LEFT VOCAL CORD.

Dr. HERBERT TILLEY related the following case. R. H—, æt. 23, a cab trimmer, came to hospital complaining of hoarseness.

History.—Five months ago patient complained of "sore throat," which produced a slight choking sensation, and was usually worse in the morning. This discomfort increasing, he applied for hospital relief February 20th, 1894. Fifteen months ago he had had abscesses on the front of the neck, which were lanced, but his throat did not

trouble him at that time. On two or three occasions during the past winter he had spat up blood. He gave a good family history.

Examination of larynx showed complete paralysis of the left vocal cord. There was no swelling of the arytænoids or ary-epiglottic folds, nor was there any laryngeal or palatal anæmia. Tubercular mischief was present in both apices. The scars of the abscesses on the front of the neck were not deeply pitted, and were above the level of the larynx.

Dr. TILLEY suggested that pressure of enlarged bronchial glands might produce paralysis, but did not know of any cases.

The PRESIDENT had seen a few cases which could only be attributed to the pressure of such glands.

CASE OF ADVANCED TUBERCULAR DISEASE OF LARYNX.

Dr. HERBERT TILLEY exhibited the case of Mrs. G—, æt. 31½ years, a housewife.

Patient first complained of her throat in March, 1893, when it was sore on swallowing, and painful on speaking. She had spat blood previous to this, and noticed that she was losing flesh. She was confined October 14th, and before and after that occasion her throat got worse, so that she could scarcely swallow anything on account of the pain. Latterly the pain had much diminished, and she could swallow without difficulty any semi-solid food.

Examination showed marked anæmia of palatal muscles and larynx. The epiglottis had almost completely disappeared, only a small stump being left. The cords were much ulcerated, and there was a small prominent tubercular granulation in the interarytænoid space. The case was exhibited to bear out Dr. Kanthack's recent communication to the Society on the function of the epiglottis, which did not seem to be so necessary for successful deglutition as was generally supposed.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *April 11th*, 1894.

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

E. CLIFFORD BEALE, M.B., }
SCANES SPICER, M.D., } Secretaries.

Present—14 Members and 13 Visitors, of whom 12 were members of the Society of Anæsthetists (specially invited by the Council to take part in the discussion).

The minutes of the previous meeting were read and confirmed.

The following candidates were then balloted for and unanimously elected:

Dr. Hector Mackenzie, London.
Dr. Alfred Brown, Manchester.
Mr. E. Jessop, Hampstead.

The PRESIDENT briefly reported that the delegates of the Society had been most hospitably received at the meeting of the International Congress recently concluded in Rome, and that the work done in the department of Laryngology had been such as to bind together still more closely the interests of laryngologists of all nations.

DISCUSSION ON THE CHOICE OF THE ANÆSTHETIC IN OPERATIONS FOR REMOVAL OF POST-NASAL ADENOID GROWTHS.

The PRESIDENT, in the name of the Society, offered a cordial welcome to the members of the Society of Anæsthetists present, and explained that the principal object of the discussion to which they had been invited was to ascertain clearly what views were held by those who had most experience of the subject as to the best form of anæsthetic to be employed in cases of operation for the removal of adenoid growths. Statements had been made which had to some extent alarmed the public mind, that the administration of chloroform for this purpose was not only likely to be dangerous, but was even to be regarded as a criminal procedure. As to the actual danger or safety of any anæsthetic, the anæsthetist's opinion must be taken in preference to that

of the surgeon, and that opinion had already been expressed at the Anæsthetists' Society. But there were other questions with regard to this special operation upon which the surgeon's opinion must have considerable weight, and it was upon the whole question that the combined discussion was invited.

Dr. DUDLEY BUXTON opened the discussion, and deprecated any hard and fast rule being made as to the choice or method of giving the anæsthetic in these cases. The operator and the anæsthetist should discuss and decide the matter in each case. No class of operations varied so much in duration or degree of severity, and this fact had to be carefully remembered in selecting the anæsthetic for each individual patient. The ideal anæsthetic was one which could be rapidly administered, and yet could be capable of prolongation if necessary. This result was, in his opinion, best assured by the employment of nitrous oxide at first, then by allowing gas to pass over ether, and finally by giving ether itself, but no break in the administration should be allowed. Subsequently, by means of a metal mouth-tube, the vapour of chloroform or of A. C. E. mixture could be blown through a Junker's inhaler if it was necessary to prolong the anæsthesia. The reflexes should not be altogether abolished. Nitrous-oxide gas might be sufficient in a percentage of cases, but, as a rule, it produced too brief an anæsthesia; a second administration when hæmorrhage was proceeding introduced an unnecessary element of danger. Re-administration in the course of an operation was undesirable, and any anæsthetic which restricted the administrator to a limited period must be open to adverse criticism. The current objections to the use of ether for these operations were, he thought, traceable to incorrect methods of using it. Chloroform was in many ways the most pleasant anæsthetic, but in young children it materially added to the extent of "shock," which might be considerable in any case from the operation and from hæmorrhage.

A communication from Mr. BUTLIN was read, expressing regret at his inability to be present, concluding as follows:—"With regard to the performance of the operation under gas, I would say that, while there are occasional cases in which this is possible, there are very many cases, on the other hand, in which the operation could not be satisfactorily and thoroughly completed, at least by me."

Mr. TYRRELL advocated chloroform from the commencement, especially for children, given very slowly from a Junker's inhaler through a flannel face-piece, and carried just to that degree of anæsthesia which abolished the conjunctival reflex without abolishing the cough and swallowing reflexes. He believed that with no other agent could that degree of anæsthesia be kept so completely under control. He was strongly of opinion that the danger of chloroform, thus given, was in attempting to place the patient under its influence too rapidly. He had not infrequently placed young children under chloroform without awaking them from sleep, which proved the very gradual method employed. Mr. Tyrrell always had the Junker's apparatus with two bottles, one containing chloroform and the other ether, so that with weakly children a small addition of ether could be made.

Dr. WILLIAM HILL remarked that it had been assumed by previous

speakers that some general anæsthetic was in most instances desirable. Some surgeons rather ridiculed this idea, but he thought the very best argument against such a position was the case of a boy who had been operated on without anæsthesia by a skilled laryngologist, and who fell down dead from fright on the operator visiting the patient some four hours after the operation. Dr. Hill did not doubt that in a certain minority of instances the naso-pharynx could be more or less cleared of hypertrophies under nitrous oxide anæsthesia, but for those who were not content unless they had very deliberately and very thoroughly removed all overgrowths in Rosenmüller's fossa, and from around the posterior nares, the question lay between some form of *prolonged* anæsthesia. He was very satisfied with the use of gas and ether, but he thought that of even greater importance than the question of the anæsthetic was the skill and familiarity of the anæsthetist with the requirements of the throat surgeon in naso-pharyngeal operations. Only skilled anæsthetists should be employed if possible. Dr. Hill summed up strongly in favour of prolonged anæsthesia and deliberate thorough removal. He considered gas alone insufficient in the majority of cases.

Dr. Hewitt said that whilst he agreed that nitrous oxide followed by ether and subsequently by chloroform gave the best results in most cases, very brief operations upon the naso-pharynx were to be very satisfactorily performed under nitrous oxide mixed with oxygen. The anæsthesia obtained by the last-named method was of somewhat longer duration, and more satisfactory than that from nitrous oxide alone. The absence of cyanosis, venous congestion, and muscular twitching was an advantage. It was particularly necessary, in operating for post-nasal growths, that the patient should take no food for some hours before the administrations, owing to the inconvenience and possible danger from vomiting. Ether had the great advantage of allowing the patient to be placed in any position. He thought it best to place the patient fairly well under ether before the operation was begun, as temporarily suspended breathing from spasm or struggling was avoided. But the patient should be allowed to regain his reflexes before the chloroform was commenced. In conclusion he strongly advocated the lateral posture immediately after the operation, so that all blood might drain away, stertor subside, and free elimination of the anæsthetic take place.

Mr. W. R. H. Stewart quite agreed with Dr. Dudley Buxton's remarks with regard to the nature of the anæsthetic and the mode of administration. He thought that perhaps he was the first to use the Gottstein's curette in this country, as one was sent to him from Berlin some time before they were made in England. Since then he had used no other instrument, but always supplemented its use by a thorough and free scraping with the finger to destroy the very small soft growths (which the forceps cannot attack) which produce the so-called recurrence. For this operation he considered nitrous oxide gas with sometimes a whiff or two of ether amply sufficient. If tonsils had to be removed as well, the addition of the ether was always necessary. The patient should lie flat on the back, and as soon as the curette had been used he should be turned well on his

side. The practice of hanging the head down over the end of the table was quite unnecessary, and made a great mess. At the Great Northern Central Hospital the anæsthetist usually gave chloroform for these cases, and at the London Throat Hospital the A. C. E. mixture. If chloroform was used, he preferred that the patient should not be thoroughly under its influence, as it was only in those cases where the chloroform had been pushed to absolute anæsthesia that there had been cause for anxiety. With regard to the reported death of patients after the operation was over, he unfortunately had had such a one in his practice, but in that case no food had been given to the patient for upwards of seven or eight hours, and he put the death down to the faintness produced by under-feeding. He considered that if a skilled anæsthetist was employed he ought to be entirely responsible for the safety of the patient as far as the anæsthetic was concerned. If the surgeon had confidence in his anæsthetist, and employed one who knew his ways, all that was necessary for the operator to do was to tell the anæsthetist the nature and probable extent of the operation, and to leave the rest to him.

Dr. SILK observed that if the term "best anæsthetic" could be used as being synonymous with "safest anæsthetic," he thought that there could be no doubt as to the advantages of gas or gas and ether. But he thought that the comfort of the patient and the convenience of the operator were points which ought likewise to be taken into consideration. Dr. Silk thought that there were three methods of operating in vogue:—1. The rapid operation; the patient being seated, anæsthetised, the mouth opened, and the post-nasal space thoroughly scraped with the finger. For these cases, which could be completed in a few seconds, or, at any rate, under the minute, gas and ether was sufficient and satisfactory. 2. The deliberate operation; the patient being recumbent, and the adenoids removed by means of instruments of some sort. For these cases Dr. Silk much preferred to commence with A. C. E. mixture, and, if need be, to maintain the anæsthesia by means of chloroform blown through the tube of a Junker's inhaler. Dr. Silk objected to the use of ether in these operations, partly because of the additional bleeding, and partly because it was not at all easy to maintain the continuity of the anæsthesia by means of chloroform. He thought that the dangers which had been ascribed to the use of chloroform were due mainly to faulty administration. He insisted very strongly upon two points: 1. The desirability of the surgeon being accustomed to the particular anæsthetist. 2. That the anæsthetist should remember that the presence of blood, the surgeon's finger, instruments, &c., in the mouth tended to obstruct the respiration, consequently the heavy chloroform vapour might accumulate at the back of the throat. A strong, and may be fatal strength of vapour was thus liable to be suddenly inhaled. Hence he would insist upon the importance of not administering more of the vapour than was absolutely necessary. The third method of operating might be termed the intermediate method, *i. e.* the patient was seated, and a somewhat extensive and rapid operation was performed, including the removal of both tonsils. It was said that for this form of operation gas or gas and ether was sufficient; but he thought it probable

that under such circumstances the patient would be simply asphyxiated for three parts of the time.

Dr. Scanes Spicer, while granting the immense advantage to the patient, both as to safety and to freedom from after effects of gas alone, thought that it was a lesser evil to induce ether or chloroform anæsthesia than to operate imperfectly, and leave behind hyperplastic tissue, or to run risk of neglecting a smart hæmorrhage from tonsils in cases in which the double operation had to be performed. Adenoids alone might be removed with gas only in most cases. For simple tonsillotomy with the guillotine, gas also would suffice, or in adults or non-neurotic children even cocaine might render the operation painless. On the other hand, if abnormal adhesions rendered a careful dissecting operation necessary with scalpel and forceps, it was better in adults to anæsthetise with cocaine, and in children to give ether or chloroform preceded by gas. Rapid operations might be performed if no smart hæmorrhage took place, and if the tumours were soft and easily removed; but these conditions could not be foretold, and he was of opinion that if the combined operation was to be done thoroughly, the prolonged anæsthesia obtained by chloroform or ether, preceded or not by gas, was necessary. Rather than risk an imperfect operation he would infinitely prefer the small increase in danger, for the risk was very small in the hands of an experienced anæsthetist.

Mr. Davis gave chloroform in young children under six or seven years of age, but he never put them off very deeply, always keeping the cough and swallow reflex present, and when once the patient was ready for the operation, did not give, as a rule, any more anæsthetic. Above the age of six or seven years Mr. Davis administered nitrous oxide and ether, afterwards continuing with the latter drug. He preferred that the patient should lie on the back with the head drawn well over the table, so that the roof of the mouth acted as a cup to receive the adenoid fragments and blood, which could be sponged out at will. In that position the air-passages were free, and the epiglottis was raised from the larynx, as Dr. Howard had so clearly proved.

Dr. Dundas Grant wished to approach the question without prejudice, although he had more or less identified himself with the advocacy of the use of nitrous oxide with or without a few whiffs of ether. Referring to the fatal chloroform cases, he thought the quantity used was by no means a negligible one. He had in his hands references to nine cases in which death had occurred under chloroform, given for operations in the nose and throat within the last eighteen months. The risk in nitrous oxide anæsthesia with or without a whiff of ether was insignificant. The combination of oxygen with nitrous oxide obviated the tendency to asphyxia without detracting from the anæsthetic effect, and gave the most perfect result. The objection to nitrous oxide was the shortness of the time allowed. This was to be neutralised (1) by practice on the part of operators, (2) by the adoption of a rapid method, (3) by systematic employment of skilled assistants, (4) by repeating the administration if necessary. Dr. Grant considered the quickest mode of operation to consist in *commencing* with the finger-nail to scrape the growths out of the fossæ of Rosenmüller and up off the posterior wall, so as to collect

them into a heap in the vault, whence they could be rapidly removed with the forceps. Gottstein's curette was often of use, and should be at hand. He failed to find any evidence that recurrence took place with any frequency after such an operation as he had described. He had seen recurrence of symptoms without recurrence of the growths, the return of nasal obstruction being really due to such conditions as hypertrophic rhinitis, or to the development of follicular granulations on the back of the pharynx, below the level of the hard palate. Recurrence of symptoms might sometimes be the result of neglecting the practice of nasal respiration.

Mr. Richard Gill thought that too empty a stomach was as mischievous as too full a one, and that it was most important to observe the interruption of breathing brought about by the operator's finger, &c., in the naso-pharynx. He laid great stress upon regulating the anæsthetic according to respiration; as the latter became shallow the agent should be diminished, whether chloroform or a mixture containing it be in use. He generally employed chloroform, sometimes preceding it by ether. He measured the degree of anæsthesia by the state of the pupil, which usually remained contracted throughout. He classified the dangers under three heads: (1) from excessive hæmorrhage; (2) from sickness; and (3) from fainting. He quoted two cases, one of hæmorrhage and another of fainting, which had occurred to him in an experience of over two thousand cases.

Dr. Whistler advocated prolonged and complete anæsthesia by chloroform, sometimes preceded by gas and ether, although in exceptional cases nitrous oxide might suffice for the simplest operations. He called special attention to the fact that almost all the patients requiring these operations were "bad breathers" to start with, and hence additional care should be taken to block the pharynx as little as possible with the fingers. He preferred Löwenberg's forceps, supplemented by Gottstein's curette, and always employed skilled assistance. In seventeen years he had had no fatal cases in his own practice.

Mr. Bailey observed that it was clearly impossible to lay down dogmatic rules as to the best anæsthetic. Each preferred his own, and would probably continue to do so. There was no absolute safety under any form of anæsthetic, but it was very desirable that the exact facts of reported deaths should be made known. Children might die under chloroform just as well as adults, but no one who was subject to fainting should inhale chloroform in the first instance. It was usually at the onset of the inhalation that accidents had occurred. Operations on the naso-pharynx took, as a rule, a much shorter time than was supposed, but anæsthesia ought to be complete and all reflexes abolished before the operation was begun. He preferred the use of gas and ether, but agreed that every anæsthetist must follow his own liking in the choice.

Mr. Walsham mentioned cases of recurrent adenoid disease, and spoke in favour of complete removal, however much time might be expended. He objected to the induction of complete anæsthesia.

Mr. Parker recorded the results of his experience as Resident Officer at the Throat Hospital, which went to prove that cases operated

on under chloroform and with forceps had been more satisfactory in their results than others in which the curette was used without anæsthetic or with gas only, the operation being rapidly performed. In many instances the latter cases recurred, or more probably were from the first incomplete. He though that, as long as the operation was done thoroughly, it did not matter what instrument was used, but to insure thoroughness chloroform must be given.

The PRESIDENT wound up the discussion, and pointed out that it had served to show the impossibility of laying down compulsory laws on the subject. The habit of every operator must, to some extent, determine the best method of inducing anæsthesia for his operation. Some preferred to work slowly, others rapidly, but in any case the safety of the patient and the completeness of the operation must be the chief care. He disapproved most strongly of the practice of operating upon out-patients, since no control could be exercised over them either before or after the operation, and the most precise instructions were very often neglected. The anæsthetic should always be given by a skilled man, and the surgeon should be free to attend only to the operation. He was very strongly opposed to the induction of complete anæsthesia. The experiments made by Mr. Horsley and himself had proved that the cough reflex was the last to go; after its abolition, however, nothing could prevent the entry of blood into the larynx. The administration should cease when the conjunctiva was insensitive. The initial stages of the anæsthesia might be taken slowly. Time was not of importance at that stage, but no further anæsthetic should, if possible, be given when the operation was once begun. He had reason to believe that a rapid operation was not always a complete one, and he urged the necessity for thoroughness as a means of limiting the number of so-called recurrent cases. Lastly, he thought that the debate had proved that the choice of the particular anæsthetic must be free, and that no blame or "criminality" could attach to the selection of any one of them.

Dr. DUDLEY BUXTON, in the name of the Society of Anæsthetists, expressed his thanks for the invitation extended to them, and his appreciation of the value of the discussion that had taken place.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *May 9th*, 1894.

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

E. CLIFFORD BEALE, M.B., SCANES SPICER, M.D., } Secretaries.

Present—16 Members and 3 Visitors.
The minutes of the previous meeting were read and confirmed.

LUPUS OF NOSE AND LARYNX.

Clinical case exhibited by Dr. DUNDAS GRANT.—Edna H— came under observation on the 23rd of April complaining of "hoarseness" of two years' duration, which came on gradually and painlessly after a slight cold, with increasing obstruction in the left nostril of the same duration. Within the last four months the left half of the tip of the nose had become red and swollen, and a few spots had appeared on her left cheek near the nose, which were of a semi-translucent appearance, the smallest ones being of a red colour, the larger ones brownish yellow. They varied in size from that of a pin's head to a hempseed.

She had always been somewhat "delicate," but had not lost flesh, and had no cough except in winter. Her chest was normal. She was subject to chapped hands in winter, but not to chilblains. There was no family tendency to phthisis. The mouth and fauces were normal, with the exception of a cicatricial-looking patch at the junction of the left posterior pillar with the soft palate. The palate was thickened, and behind the uvula showed a transverse cicatricial band going from one posterior pillar to the other, and causing the uvula to point forwards. The back wall of the pharynx was occupied by a number of granular masses, chiefly in the lateral halves, the intermediate mucous membrane being dry and scar-like.

The epiglottis was symmetrically thickened and covered with pale,

dry, tubercular granulations of considerable size. The ary-epiglottic folds were also thickened and irregular, and the ventricular bands, especially the right one, were so much swollen as nearly to conceal the vocal cords, the congested edges of which were alone visible. In the interarytænoid space was a mass of very pale moist granulations, which prevented the complete approximation of the cords.

In the nose the interior of the left vestibule was occupied by a soft granular mass covered with crusts, and a slight sticky discharge. This mass was found to grow from the walls of the vestibule and the anterior portion of the inferior turbinated body.

The lupous tissue in the nose had been scraped away with a sharp spoon under cocain, and lactic acid had been applied with benefit. The same treatment had been adopted in the larynx. Internally she was taking Liq. Arsenicalis.

Probable Epithelioma Laryngis.

Clinical case exhibited by Dr. Dundas Grant.—John C. R—, æt. 67, a retired schoolmaster, complained of hoarseness and want of voice, which came on three years ago after a cold. At first this was was only troublesome after talking for some time, but for a year it had been constant, and had been worse during the last six months.

He had no cough, very slight discomfort in swallowing, with the singular feature that "eating hard or hot things seems to do him good." There was no pain except a slight occasional pricking, and no sign of reflex otalgia. He had no dyspnœa, but his family observed an audible blowing sound accompanying his breathing. He had no pain in his chest, where there was no sign of aneurism or other disease. The patient had been a schoolmaster and an inordinate voice user. The thyroid cartilage was not definitely expanded, and there was no enlargement of lymphatic glands. The whole length of the left vocal cord was occupied by a pale pink, slightly granular ulcer, the surface of which was somewhat convex in its middle part. This cord was fixed immoveably near the middle line during inspiration and phonation alike. There was a small granulation below the anterior commissure. At the same time there was considerable mobility of the capitula, and the rest of the larynx was relatively normal.

The case was thought to be one of intrinsic carcinoma, but further

opinions were desired in view of the absence of many of the usual symptoms of the disease. At the same time the appearance of the cord, the fixation of the arytænoid cartilage, and the age of the patient left little doubt as to the nature of the case, which seemed a favorable one for thyrotomy and hemilaryngectomy.

The PRESIDENT agreed as to the diagnosis, and thought that in such a case it would be right to perform thyrotomy, in order to find out the extent of the disease, and to remove it by a major or minor operation, according to the result of the inspection.

Dr. GRANT pointed out that it was not possible to remove any part endolaryngeally for examination, and agreed with the suggestion of the President.

PARALYSIS OF THE THYRO-ARYTÆNOID MUSCLES.

Dr. DUNDAS GRANT showed the case of H. A. J—, æt. 24, a post office clerk, who had suffered from hoarseness of three years' duration, unaccompanied by cough, dysphagia, or dyspnœa.

He had no illness beyond the hoarseness, which had continued almost stationary up till the present, and was attributed to "catching cold." There were no symptoms or signs of phthisis, his family history was good, and there was no evidence of specific infection, nor any history of specific disease. The patient had been a player on wind instruments from boyhood. He formerly sang as soprano in a church choir, and later had used his voice as a high tenor. His chest was normal.

On inspection of the larynx during quiet breathing there was nothing abnormal to be seen except a slight congestion and duskiness of the vocal cords. The respiratory movements of the cords were normal, but on phonation there was a very marked elliptical gap between the edges of the cords, except at their most anterior and at their arytænoid portions. The arytænoids met with striking promptness and completeness, while the middle portions of the cords seemed rather to recede under the expiratory blast. The ventricular bands approximated to an extreme degree, especially during forced efforts at vocalisation. They were hypertrophied, and probably shared in the production of some of the tones.

The voice was, for speaking, continuously hoarse and low-pitched, but he could produce husky whispering tones ranging through nearly

three octaves. This range of voice seemed to indicate activity of the crico-thyroid tensor muscles, which was confirmed by the obvious approximation of the cricoid and thyroid cartilages during the singing of musical intervals, as felt by means of the finger in front of the neck in the crico-thyroid space.

The laryngeal picture was that of paralysis of the apposing muscles, the thyro-arytænoids. He proposed to try the effect of intra-laryngeal electrisation.

Dr. SPICER suggested that the case might be one of pachydermia laryngis. There seemed to be a definite swelling at the tip of one of the vocal processes, which on phonation was received into a corresponding depression on the other. He thought that the hoarseness and loss of voice were to be accounted for by the mechanical interference with the movements of the cords.

The PRESIDENT had not observed any such swelling, and agreed with Dr. Grant in regarding the case as paralytic. He would treat it by vocal rest and local astringents.

Dr. BEALE had noticed a very definite pink fleshy swelling at the point where the vocal processes came together on attempted phonation.

Dr. GRANT expressed his intention of bringing the case forward again at a future meeting.

REMOVAL OF RIGHT LOBE OF THYROID FOR GRAVES' DISEASE.

Mr. R. LAKE showed a case of removal of the right lobe and isthmus for Graves' disease. The patient, a young woman of nineteen years of age, who always had prominent eyes, first developed symptoms of Graves' disease in August, 1893, especially exophthalmos, fainting, and palpitation; her evening temperature was 100° F., and her pulse-rate 100. She was uninfluenced by drugs. On February 11th, 1894, the right lobe, which was the larger, was removed. The temperature fell immediately after the operation, being normal in ten days' time; the the pulse fell to 80 in ten days. The exophthalmos was almost gone except when she vomited, as she did frequently from some gastric trouble, and both palpitation and faintness had disappeared; she declared herself to be in very good health. The left lobe was certainly smaller, and had fallen away from the trachea more under the sterno-mastoid. Microscopically the goitre was partly composed of small cysts, and partly of acini, showing active cell formation as described by Greenhill.

Mr. LAKE, in reply to the President, said that he had removed the portion of the gland with a view of checking the further progress of the disease, as success had thus been obtained by others. He regarded the morbid condition of the gland as being the primary cause of the train of nervous symptoms that were characteristic of the disease.

The PRESIDENT suggested the possibility of the subsequent occurrence of myxœdema.

Mr. LAKE, at the suggestion of Mr. Stewart, promised to keep the case in view, and to show it again later in the year.

Dr. SPICER commented on a case of Graves' disease in which the use of tablets of thyroid extract had done much more harm than good.

Mr. LAKE, on the other hand, recorded a case in which the use of the tablets had had very good results.

LUPUS OF PHARYNX AND LARYNX.

Clinical case exhibited by Dr. FELIX SEMON.—E. C—, æt. 10, complained of loss of voice for three months, and ulceration of gums and palate for two months. Family history good. No syphilis, tuberculosis, or rheumatism. The patient's voice began gradually to get weaker, and finally disappeared about three months ago. About two months ago, the gums were noticed to be ulcerated and to bleed frequently. The roof of the mouth got into the same condition, but did not bleed. Slight cough.

Patient was a fair, somewhat strumous-looking child. The gums are unequally ulcerated, and in one or two places bleeding. On the hard palate, and stretching back to the soft, was a roughened worm-eaten patch, which consisted of a number of small ulcers, clumps of granulation tissue, and minute cicatrices. The same appearance was seen on the posterior palatinal arches. On laryngoscopic examination the epiglottis was seen to be pale, worn away by ulceration, and presenting a rough nodular appearance; the ventricular bands were similarly affected, and their free borders were uneven; the right band completely covered the vocal cord; the left cord was visible, and about its centre presented an excavation. The arytænoids were swollen but not ulcerated, the mucous membrane was pale.

The patient had not had the slightest pain from either larynx or mouth, and there were no traces of affection of either skin or nares. There was slight flattening of chest on left side, and the percussion note was slightly impaired. On auscultation a few râles and rhonchi

were heard over the left lung, especially at the apex; the right lung was normal. No other abnormalities.

Remarks.—The patient was shown because lupus of the pharynx and larynx was in itself rather rare, but more especially when unaccompanied by nasal or epidermidal manifestations. No local treatment had as yet been adopted, because it was desired to show the patient without any local interference having taken place. The case would now be treated with scraping and subsequent application of lactic acid, and, if necessary, with the galvano-cautery, whilst internally cod-liver oil and arsenic would be given, and it was intended to show the result of the treatment at some future time.

Two Cases of Doubtful Malignant Disease of the Larynx treated by Thyrotomy and Radical Removal of the Growths.

Exhibited by Dr. Felix Semon.—The two following cases have this in common, that neither clinical observation nor histological examination had established the diagnosis of malignancy beyond doubt. Still in both cases it was deemed prudent to perform a radical operation.

Case 1.—Mr. M. H—, æt. 63. In this case an ill-defined papillary growth occupied the anterior half of the right vocal cord, the anterior commissure, and the front part of the left vocal cord. The disease had commenced several months previously, and the voice was quite aphonic. Repeated recurrences taking place after intra-laryngeal removal, thyrotomy was performed on July 12th, 1893, after consultation with Mr. Butlin. The front part of both vocal cords and the anterior angle of the thyroid cartilage, which appeared to be infiltrated, were removed, and the wound treated in the usual way with iodoform insufflation and packing with iodoform gauze. The patient recovered after a violent attack of bronchitis, and left the home six weeks after the operation. No recurrence had taken place, but the voice remained aphonic, owing to a large gap in the anterior part of the glottis, caused by removal of the front parts of both vocal cords. The fragments of growths originally removed were apparently papillomatous, but distinguished by very unusual thickness of epithelium, which gradually became more and more horny as subsequent pieces were removed and exa-

mined, there being at the same time an increasing quantity of small round cells visible in the specimens. It was on Mr. Shattock's urgent recommendation that the radical operation was decided upon. Even the examination of the pieces removed by radical operation left it still doubtful whether this was a case of commencing malignant disease, possibly in what was called in growths of the tongue the "precancerous stage."

Case 2.—Colonel G. W. H—, æt. 55, first seen on April 28th, 1893. Patient had been suffering from hoarseness for about a month past, and a small reddish growth was observed on the free margin and underneath the middle of the left vocal cord. It was semi-globular, about the size of a split pea, slightly granular and broad-based, so as to pass over very gradually into the congested left vocal cord, the movement of which was unimpaired There was at first nothing to suggest malignancy, but in the course of the next twelve months the growth gradually spread, infiltrating more and more over the left vocal cord, with which it became intimately blended, and finally in April of this year an almost uniform thickening of the whole vocal cord had taken place, the movements of which also had become a little more sluggish. From the uniform nature of the infiltration it was quite impossible to remove a piece for microscopic examination. The whole development, however, taken in conjunction with the patient's age, rendered the nature of the growth very suspicious, and after consultation with Mr. Butlin on April 26th, thyrotomy was performed. When the larynx was opened the left cord appeared as a cylindriform, slightly irregular and granulated body, which was much thickened, especially in its middle third, but not adherent to parts in the neighbourhood. It was removed *in toto* and the basis scraped. In accordance with the suggestions recently made by Mr. Butlin (see 'Proceedings,' pp. 27, 28), Hahn's tube was removed immediately after the operation, no other tube was introduced, the patient was placed in an absolutely horizontal lateral position in bed, and the wound merely dusted with iodoform. He made an uninterrupted and rapid recovery. He was able to drink milk by the mouth three hours after the operation; the temperature never rose above 99°; he got up on the third day; the external wound now was closed and the voice was fairly strong, whilst the place of the left vocal cord was occupied by a freely granulating surface. The

microscopic examination of the removed vocal cord was not yet completed. So far it appeared to be what Mr. Shattock calls a "continuous fibroma," *i. e.* a new growth which insensibly passes over into the normal structure of the matrix, just as in molluscum fibrosum. There was also considerable thickening of epithelium, with very slight tendency to ingrowth of the same. A further report on the results of the microscopic examination would be given.

These cases illustrated the difficulty of deciding on the treatment when it was impossible to remove a portion of the growth for examination. The suggestions made by Mr. Butlin as to the slow use of Hahn's tube, its removal after the operation, the patient remaining in the horizontal lateral position with the wound quite open, had made exploratory thyrotomy so much simpler and easier that it might safely be adopted as the operation of the future for dealing with such cases as those shown.

Sequel to a Case of Obscure Ulceration of Pharynx in a Case of Arrested Pulmonary and Laryngeal Tuberculosis.

Exhibited by Dr. Felix Semon.—The patient was shown to the Society at the February meeting of the present year (see 'Proceedings,' p. 74). After his return to Bournemouth Dr. Davison scraped the pharyngeal ulcerations, and submitted the scrapings to a bacteriological expert, Mr. Turner, who on careful examination of three different specimens did not discover any tubercle bacilli. The view expressed by Dr. Semon in his paper and in the discussion, viz. that the pharyngeal condition was due to some other cause besides tubercle, had therefore received some further corroboration. The ulceration has now healed under further use of lactic acid, but as the patient stated that he had once before had a similar ulceration which gradually disappeared (see 'Proceedings,' p. 75) the relation of the *post hoc* and *propter hoc* was by no means fully settled.

The President commented on the fact that the patient had throughout been treated by creasote internally, and expressed the opinion that it was most useful in its action on such cases, especially when given in large doses.

Dr. Dundas Grant had also found it very useful.

Dr. Clifford Beale had watched its use for many years at the Chest Hospital, where it had been given in large and small doses, and

in very concentrated vapour. It was exceedingly well borne by the delicate stomachs of tubercular persons, but as yet there was no evidence to show that it exercised any effect upon the cases of active or progressive tuberculosis. Chronic cases did very well under it.

Fixation of Left Vocal Cord.

Dr. Scanes Spicer showed a patient, Mrs. C. D—, a widow in service, who had complained of hacking cough and hoarseness, lasting over seven years, with shortness of breath on exertion. Symptoms were all worse when she had a cold, and she had at times completely lost her voice.

History.—Syphilitic infection soon after marriage. Right basic phthisis, chest otherwise normal. Never had rheumatic fever. No source of pressure on nerve discoverable.

Laryngoscopic examination.—Left vocal cord immoveable, fixed in cadaveric position; right vocal cord moved freely; slight congestion of larynx. Cause of immobility of cord assumed to be ankylosis of left crico-arytænoid articulation, in absence of other discoverable lesion.

Treatment being pursued—internally, iodide of potassium; locally, inunction of mercurial ointment.

Unilateral Laryngitis.

Mr. W. R. H. Stewart showed the following case. Mrs. L— had suffered from her throat off and on since the winter of 1892–3. Voice was reduced to a whisper. No history of syphilis could be made out. Chest and sputum normal. When seen last November, the right vocal cord was red and swollen, and the right arytænoid puffy, and there was some hypertrophic rhinitis. About a week afterwards there was a pyriform œdematous swelling, such as is seen in tubercular laryngitis. On inquiry it was found that the patient had used the inhalation ordered for her at boiling-point. This swelling soon went down and had completely disappeared; the cord, too, was less thick, but was still red. She was taking iodide of potassium gr. xxv three times a day, and the larynx had a daily application of zinc chloride (gr. xxx to ℥j). The points of chief interest were the unilateral condition of the trouble, and also the fact that the boiling steam seemed to have acted on that one side of the larynx only, and to have caused the temporary arytænoid swelling.

Dr. DUNDAS GRANT thought that the disease had probably been syphilitic perichronditis, with ulceration of the vocal cord.

The PRESIDENT agreed with this diagnosis, and thought that the effect of the steam had been to irritate the diseased parts only.

CARCINOMA LARYNGIS.

Mr. W. R. H. STEWART showed the case of P. H—, æt. 50, a gardener, who had had a sore throat since Christmas, which came on after a cough. Two months ago the breathing became bad, and for the last month he could not lie down in bed. He had difficulty in taking solid food and in getting up phlegm. He had slight dull, aching pain; no history of syphilis. There was considerable swelling of the right side of the larynx, and some slight granular enlargement on both sides.

The PRESIDENT would limit operative treatment to the intrinsic cases. Luschka had shown that the lymphatics of the larynx do not anastomose with other groups of lymphatics, but open into the two small glands on either side of the thyroid. Hence the lymphatic enlargement was always less in the purely intrinsic cases. Where other sets of glands also were involved the disease was generally extensive, and attempts at removal were generally followed by rapid recurrence.

Dr. BOND expressed his concurrence in this view.

Dr. SPICER observed that cases which appeared to be intrinsic were sometimes found to have extended more deeply than was supposed.

CONGENITAL ABNORMALITY OF THE LARYNX.

Dr. J. B. BALL exhibited the following case. F. E—, æt. 25, clergyman, came under observation complaining of symptoms due to enlargement of the right tonsil, the crypts of which contained cheesy plugs, and to adenoid hypertrophy in the naso-pharynx. In the larynx the left arytænoid appeared larger than the right, the latter seeming to be abnormally small. The left arytænoid appeared to be tilted over towards the right side, and when the cords were in the position of rest the left capitula Santorini lay to the right of the middle line, and the left ventricular band was drawn inwards towards the middle line at its posterior part. When the cords were adducted the the left arytænoid passed in front of the right, the two arytænoids lying

one in front of the other instead of side by side during complete adduction.

There was no peculiarity of the voice except that it was not powerful, and was said to be easily fatigued.

An Intra-laryngeal Syringe for Submucous Injections.

Dr. Watson Williams (Bristol) exhibited a syringe for submucous injections in the treatment of laryngeal tuberculosis, which had been made to his design about three years ago by Messrs. Down Bros., and its employment had given very satisfactory results in properly selected cases.

It was simply a hypodermic syringe with a long curved needle, the curve of the needle being the same as that of Mackenzie's laryngeal forceps. Three eighths of an inch from the point of the needle was a rounded shoulder, which served the double purpose of preventing the needle suddenly piercing the tissues too deeply, and of rendering the position of the needle more readily followed when in the larynx.

The use of the syringe involved no ulcerating surface, and was especially useful in cases of early localised tubercle. Solutions of pyoktanin, 2 per cent. aristol with menthol, $\frac{1}{1000}$ solution of iodide of mercury had been the most serviceable, especially the 2 per cent. solution of aristol in almond oil.

Sarcoma of Nose and Tonsils.

Cases shown by Dr. Bond.—1. A woman of 71, first seen in December, 1893, with both sides of nose and naso-pharynx filled with gelatinous vascular growth. The tonsils were not affected. There was much thickening of left posterior pillar. Large masses of enlarged glands extended on both sides from the angles of jaw to the clavicles.

Under ♏iv doses of Liq. Fowleri the growths in nose and naso-pharynx and the enlarged glands in neck disappeared. Simultaneously the left tonsil became affected, and steadily grew larger, till at the present time the sloughing mass practically filled all the central part of pharynx. Larger doses of Liq. Fowleri could not be tolerated.

Epithelioma of Cervical Glands.

2. Patient came to Golden Square on account of a large, knobby fixed mass of glands the size of half a cricket ball on left side of neck. He had no discomfort in throat internally, though on examination the corresponding side of pharynx and larynx was found affected. The patient had remained singularly comfortable under the combined use of large doses of iodide and morphia. Tracheotomy had been performed to relieve dyspnœa. The skin over the glands was on the point of giving way.

INDEX.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY

OF

LONDON.

VOL. II.

1894–95.

WITH

LISTS OF OFFICERS, MEMBERS, ETC.

LONDON:
PRINTED BY ADLARD AND SON,
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1896.

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OF THE

Laryngological Society of London

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THE ANNUAL GENERAL MEETING,

JANUARY 9TH, 1895.

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1893	Sir George Johnson, M.D., F.R.S.	
1894	Felix Semon, M.D., F.R.C.P.	
1895	,,	,,

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *October 10th*, 1894.

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

E. CLIFFORD BEALE, M.B., }
SCANES SPICER, M.D., } Secretaries.

Present—18 Members and 3 Visitors.
The minutes of the previous meeting were read and confirmed.
The following candidates were proposed for election:
Dr. J. M. Hunt, Liverpool.
Mr. A. E. Shaw, Wandsworth.
Mr. E. F. Potter, Kensington.

ADENOMA OF TONGUE.

Clinical case exhibited by Mr. CRESSWELL BABER.—E. W—, æt. 16, came as out-patient to the Brighton Throat and Ear Hospital on July 2nd, 1894, with a history of difficulty in swallowing and thickness of speech for nine months. A tumour was found at the base of the tongue about the size of a small walnut, which hid the larynx from view. There was no dyspnœa. On July 16th she was admitted into the hospital as in-patient, and the following notes were made:—"The affection of voice and deglutition began in September after a 'sore throat,' and for a week before she first applied she is said not to have been able to eat anything. The tumour is globular, now about the size of a walnut, in the median line of the tongue, attached by a large base just in front of the epiglottis. It has a smooth surface, of a mottled red and white colour, with numerous veins coursing over it. It is seen on depressing the tongue forcibly, and when retching is induced it starts up filling the whole faucial space. The tumour, which presents the appearance of a cyst with thick walls, can be well seen in the laryngeal mirror. It hides the epiglottis, and only the posterior half of the cords (which

are clear and pale) can be seen when the patient phonates a high '*e*.' On palpation the tumour also gives the impression of a cyst, and below it the epiglottis can be indistinctly felt." On July 19th the growth was seized with catch forceps which caused rather free venous hæmorrhage. This was arrested with the galvanic cautery. The tumour was then punctured in the centre with a galvanic cautery point, and a probe passed in nearly one inch, but no contents escaped, and the growth became only slightly, if at all, reduced in size. The opening was kept patent with probe and cautery for a short time, but as no appreciable diminution in size took place, the tumour was removed on August 31st with the galvanic snare, which was adjusted without any difficulty. There was no hæmorrhage of consequence, and the growth came off on a level with the surface of the tongue. No untoward symptoms occurred beyond slight hæmorrhage ten days afterwards. Before she left the hospital on September 24th the surface had quite healed, but had become rather more raised into an irregular flat growth, which was reddish at its posterior part. It felt firm to the touch. The epiglottis, which was clearly seen, was so pendulous that only a glimpse of the cords was obtainable. There was no pain or difficulty in swallowing, but the voice remained about the same, partly hoarse and partly nasal in character. There was no swelling in the median line of the neck or enlargement of the thyroid gland. On October 2nd the remains of the growth appeared rather flatter, though still raised at the back part, and the epiglottis was somewhat less pendulous.

Remarks.—This case closely resembles those described by Mr. Butlin in the 'Transactions of the Clinical Society of London' for 1890, vol. xxiii, p. 118, under the head of "Glandular Tumours of the Tongue." Mr. Butlin could only find eight cases of this description, two of which were under his own care. In one of the eight the tumour was situated on the under surface of the tongue near the tip, in the remainder, as in this case, its position was on the back of the tongue just in front of the epiglottis. As in Butlin's first case, in the present one the growth felt so elastic that it gave the impression of being cystic. All the cases mentioned by Butlin occurred in females, whose ages varied from extreme infancy to thirty-two years.

The *microscopical examination* was kindly made by Mr. H. H. Taylor, who reported as follows:—"The minute structure of the growth closely resembles that described by Mr. Butlin in the 'Clinical Society's

Transactions,' vol. xxiii. Round or oval spaces of small size, lined by a single layer of cubical epithelium, and containing in some cases granular, in others hyaline material. The interstitial tissue is made up of fine nucleated fibres. Towards the capsule the spaces are larger and more irregular in outline. Here and there (but very few in number) some of the spaces are elongated and flattened, somewhat resembling ducts, but I do not think they are of this nature. I cut vertical and horizontal sections to see if ducts were present, but failed, with the exception of the appearances mentioned above, to find any.

"The growth closely resembles thyroid tissue, and may well be connected with some fœtal remains of the lingual duct. There are no cysts, nor does the tumour present any tubular structure."

This case, therefore, seemed to support the theory advocated by Bernays and Bland Sutton, that these tumours are of the nature of accessory thyroid glands.

Mr. LAKE mentioned a similar case.

The PRESIDENT, replying to Mr. Baber, advised that the growth should be again removed by the snare, but no more radical operation undertaken unless the symptoms became serious.

IMMOBILITY OF THE LEFT VOCAL CORD.

Dr. BENNETT showed the case of Mrs. C—, æt. 47. Onset about two years ago. Loss of voice had been progressive, but more rapid since influenza some ten months ago.

First seen three months ago. There was no congestion, no ulceration, and no symptoms which pointed to any other affection. There were no certain signs of chest mischief either in the lungs or in the vessels. There was no difficulty in swallowing. There was at first a sensation of aching over the larynx, but this soon disappeared. She took iodide of potassium for a short time but without any benefit. There was no suspicion of syphilis.

Dr. DUNDAS GRANT thought it difficult to account for the immobility. There seemed to be no special cause within the larynx, and no evidence of pressure upon the nerve-trunk unless by a deep-seated gland. The further history of the case might explain it.

Dr. TILLEY suggested that the spasms might be indicative of tabes. He had seen a similar case in a male whose pupils had subsequently been contracted and the knee-jerks lost.

Dr. SPICER had noticed some fulness in the left pyriform fossa, and thought that there might possibly be a local lesion.

The PRESIDENT could not tell the exact cause of the lesion in the present case; fixation of one cord was often seen and was not incompatible with good health. Such cases ought to be carefully kept in view, and *post-mortem* as well as clinical evidence recorded. Gouguenheim had suggested that some enlargement or inflammation of one of the chain of glands accompanying the recurrent laryngeal nerve might account for such cases. It was very desirable that the whole course of the recurrent laryngeal and vagus should be closely examined when opportunities occurred. The first case of paralysis preceding tabes had been shown in 1878, two years after the onset of the paralysis. The patient lived for eight years afterwards. Many cases had been reported since. He had examined many cases at Queen Square Hospital and found some without paresis of any kind, unilateral or bilateral. The relative frequency was difficult to determine. In his first twelve cases he had found seven cases of paralysis or paresis, but not another case in the next fifty or sixty cases of tabes. Hence the discrepancy of frequency among different observers.

CYSTIC FIBROMA OF THE LEFT VOCAL CORD.

Dr. ADOLPH BRONNER (Bradford) showed microscopical specimens of a tumour removed from a clergyman aged 76. The veins were very distended and numerous, and there were several large cavities lined with endothelium.

Drawings of similar growths were shown as demonstrated by Professor Chiari in 'Archiv für Laryngologie,' ii, 1.

The growths were situated on the upper surface of the cord, and had been first noticed three years ago. Fibromata of the small cords were rare in old age.

EPITHELIOMA OF THE EPIGLOTTIS.

Dr. BRONNER also showed a man of 78, suffering from a growth of three years' duration. There were unmistakable symptoms of secondary affections of the liver and lungs. The growth was partly removed by cutting forceps, and the patient could now eat and speak without any difficulty. It was very rare indeed to find secondary deposits in cases of epithelioma of the larynx.

CASE OF (?) CHRONIC TUBERCULOSIS OF THE LARYNX.

Dr. DE HAVILLAND HALL showed the case of R. M. V—, æt. 51. The patient stated that he had had syphilis twenty-six years ago. He first began to be troubled with his throat ten years ago,

but he was not much inconvenienced until five years ago. For the last three years he had been under the care of Dr. Valentin of Berne.

He first consulted Dr. de Havilland Hall on May 26th, 1894. The epiglottis, ary-epiglottic folds, and arytenoids were found to be greatly tumefied, and the glottis was reduced to a mere chink, the vocal cords not being visible. The mucous membrane of the posterior wall of the pharynx was replaced by cicatricial tissue. The septum nasi was completely destroyed. At the apex of the left lung posteriorly there was impaired resonance, with bronchial breathing and occasional râles.

On making a forcible expiration with the mouth closed, two tumours appeared on each side of the larynx. ? Dilated ventricles of Morgagni. A distinct "pop" accompanied the appearance of the tumours.

As the symptoms of laryngeal stenosis steadily increased, the patient was admitted into the Westminster Hospital, and tracheotomy had to be performed rather suddenly on June 3rd by the house surgeon, Mr. S. A. Bull.

At the present time the patient was taking carbonate of guaiacol internal, and the galvano-cautery was being applied to the larynx. The patient had gained weight and improved generally since the tracheotomy, and the application of the galvano-cautery had been followed by marked diminution of the swelling of the epiglottis, so that the vocal cords were now visible.

Dr. de Havilland Hall regarded the case as having been of a syphilitic nature at the commencement, but thought that the present condition was due to chronic tuberculosis.

Dr. Beale referred to a somewhat similar case shown in 1893, in which the laryngeal conditions had remained unaltered for a twelvemonth. The patient had taken iodide persistently, and believed that it kept the disease in check. The passive, swelled, and congested condition, occurring in association with tubercle and syphilis, as in Dr. Hall's case and his own, seemed to be due to the combined processes.

Dr. Bronner suggested the use of mercurial inunction.

Dr. Hall had found that the most relief was given to the dysphagia by cauterisation of the swollen epiglottis, which was tough and leathery.

Dr. Dundas Grant thought that in the combined cases of tubercle and syphilis, there was generally ulceration. The dry appearance of the larynx in the present case was very striking.

Tonsillar Mycosis.

Mr. R. Lake showed two cases of tonsillar mycosis, both females. He wished to raise the question, whether there was any more rapid method of dealing with these cases than that of galvano-cautery? One of these cases had been freely and carefully cauterised once a week for three months, and was not yet cured; the second had not had more than one application.

Dr. Hall advised continued use of the cautery, as that treatment gave relief at any rate.

The President thought that these cases might well be left alone if they gave rise to no distress. He had quite given up the use of the cautery to the disease on the base of the tongue, and had seen disastrous results ensue where it had been used. Patients as a rule only became aware of the disease by seeing the white patches in the mirror, which they described as "ulcers," and often declared that no discomfort was caused by them. To destroy the colonies of mycosis on the surface was easy, but it did not cure the disease. Change of air and general treatment gave better results than operation.

Mr. Cresswell Baber thought it best to leave the milder cases alone. When the growth was extensive he had seen good results from the application of absolute alcohol.

Dr. Spicer had used the galvano-cautery in such cases very frequently without permanent benefit. He preferred to cut away the tonsillar tissue, and so to destroy every crypt that could harbour the growth. At the base of the tongue he preferred to apply antiseptic remedies.

Dr. Bennett advocated forcible syringing out of the crypts and application of pure carbolic acid to the openings.

Dr. Dundas Grant pointed out that pharyngo-mycosis was very distinct from pharyngitis with accretions, but the distinction was not always recognised, and the condition was sometimes mistaken for syphilis. He had used the galvano-cautery in each individual crypt, but had found very good results from the daily use of a lotion of tincture of iodine with fifteen grains of bicarbonate of soda. In one case it had completely checked recurrence.

Mr. Lake, in reply, thought that patients generally complained of subjective symptoms and sought relief, without always being aware of the white patches in the throat.

Lupus of the Nose treated by Thyroid Extract.

Mr. Lake also showed the two following cases:

The first, a boy of 11 years of age, had suffered for fourteen months. The soft palate and posterior pillars of the fauces were also affected.

He had been taking 7½ grains of thyroid extract daily since July 14th, and was very much improved.

The second case, that of a girl of 16 years, had been affected for three years, and when put on thyroid treatment at the same time as the boy, also had a patch of lupus below the right eye over the nasal duct; this was now almost healed, and the nose was very much improved; she was now taking 17½ grains daily. Mr. Lake wished to show these cases to the Society in order that, if successfully cured by this treatment, the result might subsequently be verified.

Dr. Dundas Grant expressed some doubt as to the nature of the disease in the girl's case. He pointed out that the thyroid extract had not been the sole treatment.

Dr. Jessop related a case in which marked improvement had followed the use of three hundred tablets in a case where the disease had existed for thirty years.

Tonsillar New Growth.

Dr. Scanes Spicer showed Thomas H—, æt. 70, who had a vascular tumour the size of a large walnut, spreading from the lower part of the right tonsil on to the base of the tongue. Two years ago thorough tonsillotomy was performed for growths which were too large to lie laterally in pharynx, so that one passed upwards, the other downwards; the symptoms were dysphagia, dyspnœa, and unintelligible articulation. The reappearance on the right side had been very gradual, and its growth was slow. Microscopically, it was made up of closely packed round cells. Repetition of removal was proposed, but suggestions were invited.

Dr. Bronner referred to the value of arsenic in large doses in such cases.

Dr. Tilley mentioned the case shown to the Society by Mr. W. R. H. Stewart last session, in which arsenic had given very marked relief for a time.

Dr. W. Hill thought that such cases showed varying degrees of malignancy, but they all tended to spread if left alone. He would not use the guillotine, but preferred enucleation.

Dr. Pegler regarded the case as one of lympho-sarcoma and not ordinary hypertrophy.

The President remarked that after the age of forty such cases were generally lympho-sarcoma or adenoma.

Dr. Dundas Grant suggested that the tumour chould be enucleated

by snipping through the mucous membrane and turning the growth out by means of the finger.

Mr. DE SANTI thought that such a growth might be removed by external incision, and referred to two cases thus treated.

Dr. SPICER replied.

LARYNGEAL STENOSIS SUPERVENING ON TYPHOID FEVER.

Dr. SCANES SPICER showed a young man æt. 20, who was under Dr. Cheadle in St. Mary's Hospital six months ago for typhoid fever. Acute stenosis of larynx supervened and tracheotomy was performed. Some weeks afterwards he was sent to the throat department for examination. The vocal cords were found to be adherent at anterior fourth, and on attempting breathing with finger on trachea tube, a red subglottic mass was seen to almost completely occlude lumen. He could phonate, but a probe could not be put through stricture after cocainising, nor was intubation, attempted with some force, successful. The case was shown preliminary to division of stricture under general anæsthesia by Whistler's dilators and use of O'Dwyer's intubation tubes.

The PRESIDENT agreed that an attempt should be made to divid the stricture and dilate it, but he was not sanguine as to the result in such a case.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *November 14th*, 1894.

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

E. CLIFFORD BEALE, M.B., }
SCANES SPICER, M.D., } Secretaries.

Present—30 Members and 6 Visitors.
The minutes of the previous meeting were read and confirmed.
The following candidates were balloted for and duly elected:

Mr. E. F. Potter.
Mr. A. E. Shaw.
Dr. J. M. Hunt.

The following candidates were proposed for election as ordinary members:

Dr. C. C. Cripps.
Mr. A. L. Roper.
Dr. George Mackern.
Dr. Henry Sharman.
Mr. A. E. Hill-Wilson.
Dr. W. J. Horne.
Mr. Reginald Poulter.

SWELLING OF LEFT SIDE OF LARYNX, WITH PARALYSIS AND ATROPHY OF LEFT HALF OF TONGUE AND SOFT PALATE, AND PERICHONDRITIS.

Mr. A. A. BOWLBY showed this case. John T—, æt. 52, a meat porter, had had good health previous to December, 1893, when he began to suffer from a painful lump about the size of a walnut on the left side of the front of the neck. There were no other symptoms. Under treatment he improved; the pain left him, but the lump remained.

When seen again, in August last, there was a large and extremely indurated mass, nearly as large as an orange, in front of and

to the left of the larynx. There were pain, dysphagia, and blood-spitting. With fomentations the mass softened, and an incision let out about an ounce of pus. He improved for a while. On October 2nd he again came under observation. Then there were inability to swallow solids, constant cough with glairy expectoration but no hæmoptysis, and some loss of weight. There was still a hard mass, softening near site of old scar. He was admitted to the hospital. On October 10th some pus was discharged through the old scar, and patient was relieved. There was also some hæmoptysis. He then came under observation in the Throat Department, and examination found—

Externally, an old scar situated over and adherent to the thyroid cartilage, discharging pus, but no tenderness on manipulation. Beneath the left maxilla there was felt an enlarged stony hard gland, with the superjacent skin intact. Some slight loss of facial symmetry noticed. The tongue was protruded with difficulty and pushed over to the left. The left half was in an advanced state of atrophy. The left half of the soft palate was also atrophied, and hung lower than right; it had but little movement, being only dragged up by right half. Slight rigidity of soft palate noticed in attempting to raise it up on back of a throat mirror. No scars on soft palate or tongue. Larynx: epiglottis twisted out of the median line, so that the tip was looking towards the left. Occupying the greater part of the left half of the larynx there was a smooth reddish mass, obscuring the posterior two thirds of the left cord and ventricular band. The right cord was fixed and partly hidden by the overhanging ventricular band. No ulceration or scar.

Since this examination the mass referred to had increased in size, and now only part of right cord was to be seen.

Examination of chest yielded no definite morbid signs. No history of syphilis.

Remarks.—Much of the swelling was evidently due to perichondritis; but the question was, whether this, in its turn, was due to a malignant growth. In favour of this event was the extreme hardness and fixity of the glandular swelling. It was, further, a very rare thing for paralysis of nerves to be caused by any merely inflammatory swelling. The atrophy of the tongue was probably due to pressure on the hypoglossal by the mass of glands which lay just over its course. On the other hand, the prolonged history, and the fact that

the patient had improved under treatment, seemed to point to perichondritis without new growth. The only operation which appeared at all likely to be useful was one for exposing the thyroid cartilage opposite the swelling, and seeing if there was any necrosed portion to be removed.

The PRESIDENT thought that there was no evidence that the growth was causing the paralysis. There were no other symptoms of disturbance of the vagus. It must be remembered that both centripetal and centrifugal fibres had been demonstrated in the pneumogastric, but in the recurrent laryngeals the existence of centripetal fibres had never yet been shown, although many observers believed in their existence. Unilateral pressure on the recurrent laryngeal did not cause bilateral paralysis or spasm.

TUBERCULAR DISEASE OF SOFT PALATE, LARYNX, PHARYNX, AND LUNGS.

Mr. A. A. Bowlby showed the case of P. R—, æt. 22, a bootmaker, seen first on October 24th, 1894, on account of a sore throat he had had five weeks. When first seen, there was spreading over the soft palate and uvula and on the pharynx, a greyish membranous-like deposit, which at a glimpse was suggestive of diphtheritic membrane; but there was no swelling nor œdema of the parts, the tonsils were eaten into and excavated, and appearing through the secretion were a number of small pin-head glistening nodules, which clustered thickly around the base and tip of uvula. On cleaning the part a bleeding surface was left, which was irregularly ulcerated. The pulse was quickened, and the temperature raised between 101° and 102°.

The tongue was free from disease; by depressing it the tip of the epiglottis could be seen thickened and reddened. The epiglottis was turban-shaped, and on the tip one or two whitish pin-point nodules, but no ulceration. The arytænoids were somewhat reddened and enlarged, the left more so than the right, but their surfaces intact. The cords and ary-epiglottic folds were very slightly affected, and presented no ulceration, the cords moving well and equally. No particular change in voice.

There were well-marked signs of chronic but progressive disease in the lungs.

November 9th.—Some scrapings from the soft palate, and also the sputum, yielded tubercle bacilli.

Since the 24th of October, when he was first seen, there had been no very appreciable increase in the extent of the ulceration of the soft palate, but what there was had become deeper. The laryngoscope showed further epithelial changes along the tip of the epiglottis and on the summit of the left arytænoid.

In his general health the patient had improved, and the disease in the lungs was not so active.

There was no history of syphilis, nor any family history of phthisis.

Mr. Bowlby observed that there seemed to be no doubt of the nature of the affection in this case, and it did not appear that any radical treatment of an operative nature could be undertaken, considering that the disease was very widely spread. He had, however, seen one similar case of even greater extent, which recovered under the use of iodoform locally and cod-liver oil internally, and he proposed to continue the same lines of treatment in this case.

Pachydermia with Perichondritis.

Dr. Adolph Bronner (Bradford) showed a specimen of diffuse pachydermia of the larynx with perichondritis of the right arytænoid cartilage. The man, a brushmaker of 72, had been hoarse for four years, and there had been difficulty in breathing for three or four weeks. He was admitted into the Bradford Infirmary; tracheotomy was performed on the following day, but the patient died of broncho-pneumonia in eight days. No tubercle bacilli could be found in the sputum or lungs. There was a scar on the glans of the penis, probably specific. The long duration of the hoarseness and loss of voice, and the short duration of the dyspnœa, seemed to point to the pachydermia as the primary condition, and that the perichondritis was due to the pachydermia. It was possible, however, that the perichondritis had caused the pachydermia. The vocal cords were very thick, and showed several small growths. The ventricular bands were also much enlarged, and the mucous membrane of the right ventricle was so enlarged as to project to some extent.

Similar cases have been recorded by B. Fraenkel in the 'Archiv für Laryngologie.'

Mr. Butlin observed that so-called perichondritis was frequently neither more nor less than syphilis, and he thought that it was so in the present case. It was always difficult to distinguish at first sight between pachydermia and flat epithelioma.

Dr. MILLIGAN (Manchester) commented on the difficulty in determining whether perichondritis or pachydermia was the primary condition when both were present.

CASE OF LYMPHADENOMA WITH OBSTRUCTED BREATHING.

Dr. JAMES DONELAN showed a patient, J. B—, æt. 43, first seen at the Italian Hospital four weeks ago. His father died of "cancer of the throat." His health has been always good, except a slight tendency to bronchitis.

On November 9th, 1893, a discharge from right ear began almost painlessly, and continued for two months. A swelling next appeared on the right side of the neck, followed by a similar swelling on the opposite side. Dyspnœa soon set in, and he was obliged to give up his trade of baker. There was marked enlargement of the cervical glands along both borders of the sterno-mastoids, with dulness over the sternum. A small group of enlarged glands could also be felt near the xiphoid appendix. There was bronchial catarrh and considerable venous congestion of the head, neck, arms, and hands, from which gradual closure of the superior vena cava was to be inferred. The spleen was moderately enlarged but painless; there was, however, some pain over the liver. No microscopic examination of the blood had yet been made, but there appeared to be little anæmia. Up to the present the patient had been taking three minims of Liq. Arsenicalis three times daily, but the stomach did not seem able to stand any larger dose.

Mr. W. G. SPENCER mentioned a case in which there had been marked intolerance of arsenic until a portion of the adenomatous mass was removed, after which the patient was able to take the Liquor Arsenicalis Hydrochloricus with marked benefit.

Dr. DE HAVILLAND HALL pointed out that where intolerance of arsenic was present, it was advisable to change the form of administration, since patients could sometimes assimilate one preparation while quite unable to bear another.

PAPILLOMA NASI WITH RODENT ULCER IN AN AGED PATIENT.

Mr. P. DE SANTI showed a patient, David P—, æt. 82, who was admitted to Westminster Hospital June 6th, 1894, with a growth in left nostril. Five years previously he had noticed a small pimple on the inner and upper part of the left nostril. It had gradually in-

creased in size, and interfered with nasal breathing. It had never been painful. About one year ago he noticed that he had a fœtid discharge occasionally from left nostril, perceptible to himself as well as to others.

About one year ago he noticed a similar kind of pimple on the skin over the right side of the nose. It increased very slowly in size, was painless, but itched. He therefore scratched it, and it ulcerated and then became covered with a scab.

On admission the left anterior naris was occupied by a pear-shaped growth which occluded the passage, and protruded slightly from the nostril. The part protruded was rather dry and blackish, but not ulcerated. The part within the naris was of a pinkish colour, and a pedicle could be easily traced up to the septum nasi at the junction of bone and cartilage. The attachment of the pedicle was small, there was no hardness or sense of infiltration at its base. No ulceration anywhere. The growth resembled a small cauliflower, and was freely moveable. The man's general health was excellent. There had been no loss of flesh, there were no enlarged glands; no history of syphilis. The rodent ulcer was about the size of a Spanish nut, raised and hard, its surface was covered with a scab; there was no attempt at cicatrisation.

The growth in the nostril was removed with a pair of scissors, and its base cauterised on June 19th; the rodent ulcer was excised on July 10th.

Congenital Fistula of the Neck.

Mr. W. R. H. Stewart showed the case of C. G—, æt. 19. First noticed a slight enlargement over the apple of the throat five years ago, quite in the middle line. Was then taken to a general practitioner, who pronounced it a goitre, and after some external treatment with no result, consulted with another general practitioner, who agreed with the diagnosis, and decided to remove the growth. The wound did not heal, and when seen by Mr. Stewart, in November, 1893, there was a veritable rabbit warren of sinuses running in every direction, and the scar tissue was bound down to the thyroid cartilage. He slit up the sinuses and thoroughly scraped them with a sharp spoon and freed the larynx, but could not, with the finest probe, find any further channel. The wound not healing he dissected out the whole scar

tissue, following it up as far as it went. The wound healed, but some weeks afterwards broke out again. After trying remedies such as nitrate of silver, chromic acid, and the galvano cautery without avail he again operated, following the new track as far as the hyoid bone. This was once more unsuccessful, except that the new sinus was much shorter and straighter. He was now trying the injection of a 40 gr. solution of chloride of zinc. The first injection went into the throat, and created a large amount of inflammation there. The second did not reach the throat, and now there was next to nothing in the way of a discharge, and the probe would only go about a quarter of an inch. There was a difficulty in obtaining a correct history of the earlier stages of the trouble, but he looked upon this as one of those cases of congenital branchial fistula which are very rarely met with, and still more rarely cured.

Mr. Butlin thought that the fistula had probably begun as a cyst in connection with the lower part of the thyro-lingual duct.

Mr. Bowlby believed that as a general rule these cases were not really benefited by operation. The difficulty of removing the whole sinus, and the impossibility of keeping the parts at rest, led to alternate healing and breaking down, but not to cure.

Dr. Dundas Grant mentioned a recent case in which he had obtained a successful result.

The President would avoid operative treatment if possible. The operation in itself seemed simple, but was sometimes very troublesome and often incomplete.

Mr. Stewart observed that the operation in the present case had given marked relief.

Disease of Tongue (for Diagnosis).

Clinical case exhibited by Mr. C. A. Parker. E. W—, æt. 8, a schoolboy.

History.—In August last the child began to be poorly, lost his appetite, and was languid, but improved under treatment. About this time the mother noticed a rash on the patient's body and thighs, which consisted of dull red spots; the largest was about as big as a pin's head, and it only lasted three days. Shortly after its disappearance the child began to complain of soreness of the tongue, the surface of which looked rough and uneven. This trouble had got steadily worse until the present date.

Family history.—Father and mother both alive and well. The

patient was the youngest but one of thirteen children, eight of whom are alive. Scarlet fever, diphtheria, and measles had caused the five deaths. After the third child mother had three miscarriages. No history of syphilis could be obtained as occurring in either parent, and the patient showed no signs of congenital syphilis about his teeth or eyes, etc. There was no history of tuberculosis.

The patient's personal history was good.

Present condition.—The whole of the posterior two thirds of the tongue was covered with large bosses, about the size of an elongated sixpence, the surfaces of which were [illegible], uneven, and rather paler than the rest of the tongue. They were all firm to the touch. There was no ulceration and no discharge, and no marked pain, but some tenderness. On the soft palate there were one or two smaller patches with an area of congestion around them, less raised than those on the tongue. There were some enlarged, hard, and slightly tender glands beneath the chin and in the neck. About the buttock a few small pigmented spots, and a larger scaly spot behind the right knee. These were said to be the result of boils.

The child was otherwise in good general health. He had all the signs of post-nasal adenoid vegetation.

Mr. Butlin thought that the case was one of macroglossia. The youth of the patient, the papillated appearance of the central lump on the tongue, and the presence of enlarged glands all pointed to it. He did not think that any treatment was advisable at present.

Mr. Spencer regarded the growth as an abnormal extension of the lingual tonsil. He suggested that it should be gradually destroyed at several points.

? Angioma of Vocal Cord.

Mr. Ernest H. Crisp showed a patient æt. 36, who had been primarily inoculated with syphilis ten years ago. He was religiously under treatment for two years, and the secondary symptoms, which were mild in character, entirely disappeared.

Three years after discontinuing treatment, *i. e.* about five years from the primary inoculation, he complained of pain in the larynx about the level of the left vocal cord. He was again treated constitutionally and rapidly recovered, and had no recurrence of symptoms until on December 30th, 1892, *i. e.* ten years after origin of disease, he consulted Mr. Crisp.

On examination the pharynx and soft palate were in a red irritable condition. There was subacute laryngitis, and both cords were deeply congested. Treatment with large doses of iodide of potassium and green iodide of mercury rapidly reduced the more acute inflammatory processes, but both vocal cords were left congested and showed defective movement. The voice was husky, but there was no particular pain. Under the influence of local application the congestion of right vocal cord entirely disappeared, but no treatment up to the present had cured the red raised condition of the left vocal cord.

The diagnosis lay between chronic congestion and angioma of the cord. Could it be improved by means of the galvano-cautery?

Mr. Cresswell Baber thought that the swelling was simply syphilitic thickening, and that cauterisation was not called for.

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Dr. F. W. Bennett (Leicester) demonstrated the case of A. B—, æt. 47, saddler. He had always lived a temperate life. There was no history of syphilis or of tuberculosis. He became slightly hoarse about May last, and with slight variations this had been progressive. On examination about six weeks ago there was a general congestion of the larynx. The anterior extremity of the right cord was thickened and red, and there was a slight thickening of the tissue below the level of the cord. The movements were slightly tardy, but equally so on the two sides. This redness did not subside with the treatment adopted. The opinion of members of the Society was invited as to the nature of the case, and especially as to whether this slight fulness was more than could be accounted for by a catarrhal process.

The President thought that much of the impairment of movement was of a neurasthenic character. He suggested that the patient should be taught to speak in a deeper tone than normal, a mode of treatment often successful with boys at the period of "broken voice." The congested condition was probably catarrhal.

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Mr. Charters Symonds exhibited a man æt. 48, who had complained of a little hoarseness at times during the last two months. He had taught for some years in a board school, and now was an

inspector. In addition to this he used the voice a good deal on Sunday. In July the larynx was examined by Dr. Warner of Woodford, who saw nothing amiss, but in September observed the condition now present. On the left cord at the processus vocalis was a nodular elevation with a depressed summit. It resembled pachydermia laryngis closely, but seemed to differ somewhat from this affection in its nodularity. The colour on the whole was pale. The cord moved freely and the voice was clear. The opposite cord was free.

The condition was either an early epithelioma or a stage of pachydermia, and Mr. Symonds had advised rest of the voice and further observation, in the hope that it would prove to be pachydermia laryngis, and not epithelioma. The special point in favour of the latter diagnosis appeared to be the nodular character of the growth.

Dr. MILLIGAN thought that the case was either pachydermia or epithelioma. He thought that the latter was the correct diagnosis, and would advise thyrotomy and removal of the cord.

Dr. SPICER suggested endolaryngeal removal, and if that should prove unsuccessful he would perform thyrotomy.

Dr. HILL observed that if the condition was pachydermia the amount of swelling indicated long duration of the disease.

The PRESIDENT felt absolutely certain that the case was simply pachydermia. A malignant growth on the inner side of the arytænoid cartilage was not compatible with such free movement. The patient was not suffering in any way, and there could be no need to operate unless the condition got worse. He would simply advise rest to the voice, and a course of iodide of potassium.

Mr. SYMONDS intended to pursue a waiting treatment, as he did not regard the case as malignant.

TUBERCULAR DISEASE OF THE LARYNX.

Mr. CHARTERS SYMONDS also showed a man of 35, with extensive swelling of the left arytænoid and ulceration extending down to the cord. The noticeable features were the small amount of distress and dysphagia, and in this particular the resemblance of the disease to syphilis.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *December 12th*, 1894.

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

E. CLIFFORD BEALE, M.B., SCANES SPICER, M.D., } Secretaries.

Present—28 Members and 4 Visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were elected members of the Society:

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A. L. Roper, M.B., Lewisham.
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The following candidates were proposed for election:

Dr. Barclay J. Baron, Clifton.
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DOUBLE ABDUCTOR PARALYSIS OF UNCERTAIN ORIGIN, ASSOCIATED WITH CYSTIC BRONCHOCELE AND DYSPNŒA; OPERATION; IMPROVEMENT.

Mr. A. A. BOWLBY showed a patient, a man æt. 60, who was admitted into St. Bartholomew's Hospital on March 17th, 1894, on account of dyspnœa and bronchocele.

He said that the enlargement of the thyroid gland had existed for about two years; that for about three months he had suffered from

some difficulty in swallowing, and for a month from difficulty in breathing. He had had several attacks of sudden and urgent dyspnœa.

Examination showed a very large thyroid cyst, situated on the left side of the neck, and about as large as a cocoa-nut. The larynx and trachea were a good deal displaced to the right of the middle line. The thyroid gland was not itself hypertrophied to any appreciable extent. Voice not affected, except that it was not strong; swallowing decidedly difficult and slow. Laryngoscopic examination showed double abductor paralysis, the cords not separating in respiration more than one eighth of an inch.

On March 22nd the cyst was removed by operation without trouble, and the wound healed throughout by first intention. The dyspnœa and dysphagia were immediately relieved, and three weeks later the patient was discharged. He had one slight attack of dyspnœa a few days afterwards, but since then had had no return of such attacks.

His breathing was now quiet, but on exertion he was "short of breath." His voice was normal. There was no alteration in the condition of the cord. During inspiration there was a lozenge-shaped aperture between the anterior attachments of the cords and the vocal processes, and a smaller and similar shaped aperture between the vocal processes and the interarytænoid mucous membrane.

There was no evident cause for the paralysis, and no sign of tabes dorsalis or of any cerebral affection.

Aneurism of the Aortic Arch compressing the Left Pneumogastric and Recurrent Laryngeal Nerves and the Trachea, and associated with Abductor Paresis of the Right Cord.

Mr. A. A. Bowlby showed a specimen taken from a patient, W. S—, æt. 60, sent by Dr. Furber of Oxted on November 24th, 1893.

Patient had had some difficulty in breathing for a year, but it had not prevented him from doing his work. Four weeks before he came to the department for diseases of the throat at St. Bartholomew's Hospital he had partially lost his voice, and since that time he had continued to be hoarse, and his difficulty in breathing had increased. There had been no difficulty in swallowing.

The patient was a very large, heavily built man of about seventeen stone in weight. His breathing was not hurried when he was sitting still, but he said that he could not walk without suffering from shortness of breath. There was slight stridor.

No swelling was visible in the region of the air-passages, and the fauces and pharynx were natural. The left vocal cord was almost fixed in the cadaveric position, neither abduction nor adduction being complete. The right cord was but little affected, although it was thought that abduction was sluggish. Otherwise the larynx appeared quite normal. No cause for the paralysis, and no evidence of either disease of the central nervous system or of any thoracic tumour or aneurism could be detected. As respiration was not dangerously interfered with, no operation was advised, and the patient was not seen again until December 8th. He was then much worse, the breathing being very laboured and stridor well marked, with a good deal of cough and expectoration of a considerable quantity of mucus.

The left cord was found to be completely paralysed and fixed in the cadaveric position, while the right cord was very imperfectly abducted, the abduction movement failing to place the cord quite as far from the mid-line as its paralysed fellow. The dyspnœa appeared more than could be accounted for by the deficiency of space in the larynx, but no evidence could be detected of any pressure on the trachea.

The patient was put to bed and kept on fluid diet, with steam inhalation and expectorants, but without real relief to the dyspnœa. Two days later he had several severe attacks of dyspnœa which were transient, and on December 12th, after consultation with Mr. Butlin, tracheotomy was performed without anæsthesia.

The operation gave but slight relief, however, but it was now concluded that there must be some intra-thoracic pressure, such as had been suspected from the beginning. Two days later the patient had an attack of syncope, and suffered from similar attacks on subsequent days. Death occurred suddenly from cardiac syncope on December 17th.

The post-mortem examination was made by Mr. James Berry, to whom he was indebted for the great care with which all the affected parts have been removed and dissected. The abdominal viscera were normal. The right lung was œdematous and congested. The whole aorta was dilated, and just beyond the origin of the left subclavian artery a sacculated aneurism commenced, involving about 4 inches of the length of the vessel. The sac itself was about 4 inches wide

by 2½ inches broad, and extended chiefly in a backward direction and a little to the left side. It had slightly eroded the third and fourth dorsal vertebræ, and had pushed its way between the trachea and œsophagus, displacing the latter considerably to the left, and flattening it. The trachea was compressed from a point about 2 inches below the cricoid to the bifurcation of the bronchi, the seat of maximum pressure being just behind the manubrium sterni, where the tracheal walls were only a quarter of an inch apart.

The right pneumogastric and recurrent laryngeal nerves were found to be quite free from all pressure, separated from the sac by an interval of about three eighths of an inch; they lay in normal loose connective tissue.

The left pneumogastric and recurrent laryngeal nerves lay stretched, flattened, and adherent over the front of the sac. They had evidently been subjected to very severe compression.

The interest of this case is mainly in the paresis of the right cord as a sequel to pressure on the left pneumogastric nerve. The dyspnœa was chiefly the result of tracheal compression, but the laryngeal aperture was also certainly diminished. The aneurismal sac did not touch any part of the thoracic parietes with the exception of two vertebræ, hence the absence of physical signs during life could be easily understood.

Mr. DE SANTI suggested that intubation might have been employed with advantage in this case in lieu of tracheotomy.

The PRESIDENT observed that the case taught several lessons. Double paralysis caused by pressure upon one vagus was very rare, but the course of events in this case had borne out the truth of the law as to the earlier affection of the abductor fibres. Where the source of pressure was within the chest it was advisable not to commit oneself to a promise of relief by tracheotomy, owing to the possibility of mechanical pressure obstructing the trachea at a lower level.

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The patient had syphilis, primary and secondary, five years ago, but without sore throat, and the skin showed definite signs of former syphilitic lesions. In his throat he complained of occasional choking sensations, and difficulty of breathing, coming on at night, about twice a week. The disease affected the true cords, which were red and thickened. There were several outgrowths on each cord, especially towards the commissure. One of these which hung below the glottis flapped up and down during inspiration.

The question of diagnosis lay between syphilis, of which there was a past history, tubercle, of which there was no history and no other symptom, and multiple papilloma.

Tracheotomy Tube worn for Eleven Years.

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The President showed several cases of foreign bodies removed or expelled from the air- and food-passages. These were—

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The history of all these cases, some of which had previously been reported, were detailed.

Mr. Butlin mentioned a case of pleuro-pneumonia, following the impaction of a foreign body, which had recently ended fatally.

Dr. Bronner observed that the rule given in the text-books did not

patient was the youngest but one of thirteen children, eight of whom are alive. Scarlet fever, diphtheria, and measles had caused the five deaths. After the third child mother had three miscarriages. No history of syphilis could be obtained as occurring in either parent, and the patient showed no signs of congenital syphilis about his teeth or eyes, &c. There was no history of tuberculosis.

The patient's *previous history* was good.

Present condition.—The whole of the posterior two thirds of the tongue was covered with large bosses, about the size of an elongated sixpence, the surfaces of which were flattened, uneven, and rather paler than the rest of the tongue. They were all firm to the touch. There was no ulceration and no discharge, and no marked pain, but some tenderness. On the soft palate there were one or two smaller patches with an area of congestion around them, less raised than those on the tongue. There were some enlarged, hard, and slightly tender glands beneath the chin and in the neck. About the buttock a few small pigmented spots, and a larger scaly spot behind the right knee. These were said to be the result of boils.

The child was otherwise in good general health. He had all the signs of post-nasal adenoid vegetation.

Mr. Butlin thought that the case was one of macroglossia. The youth of the patient, the papillated appearance of the central lump on the tongue, and the presence of enlarged glands all pointed to it. He did not think that any treatment was advisable at present.

Mr. Spencer regarded the growth as an abnormal extension of the lingual tonsil. He suggested that it should be gradually destroyed at several points.

? Angioma of Vocal Cord.

Mr. Ernest H. Crisp showed a patient æt. 36, who had been primarily inoculated with syphilis ten years ago. He was religiously under treatment for two years, and the secondary symptoms, which were mild in character, entirely disappeared.

Three years after discontinuing treatment, *i. e.* about five years from the primary inoculation, he complained of pain in the larynx about the level of the left vocal cord. He was again treated constitutionally and rapidly recovered, and had no recurrence of symptoms until on December 30th, 1892, *i. e.* ten years after origin of disease, he consulted Mr. Crisp.

On examination the pharynx and soft palate were in a red irritable condition. There was subacute laryngitis, and both cords were deeply congested. Treatment with large doses of iodide of potassium and green iodide of mercury rapidly reduced the more acute inflammatory processes, but both vocal cords were left congested and showed defective movement. The voice was husky, but there was no particular pain. Under the influence of local application the congestion of right vocal cord entirely disappeared, but no treatment up to the present had cured the red raised condition of the left vocal cord.

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Dr. Bronner observed that the rule given in the text-books did not

seem to be justified. They generally advised waiting until definite symptoms appeared, but he thought there should be no delay after the diagnosis was once made certain.

The PRESIDENT agreed that no foreign body ought to be allowed to remain in the air-passages, but it was sometimes better to try the effect of complete inversion of the patient if the foreign body was round and likely to be expelled by gravitation.

FIBROSIS OF THE THYROID; PARTIAL THYROIDECTOMY, TRACHEOTOMY, AND DILATATION OF THE STENOSED TRACHEA.

Mr. WALTER G. SPENCER exhibited a patient, a pale, thin domestic servant who had always lived in London. More than seven years ago her parents had noticed a soft swelling in the region of the thyroid, which gradually got smaller and harder. With this decrease difficulty in breathing came on.

Her mother had had for years a soft thyroid tumour at the junction between the isthmus and the right lobe, which was either a flaccid cyst or an adenoma. When she first attended as an out-patient at the Westminster Hospital the thyroid gland appeared of normal shape and size, but it was of stony hardness. The pulse was 130 to 140 per minute, but without exophthalmos. There was stridor, loudest in the trachea at the level of the isthmus, but heard over the whole chest. There were no signs of phthisis. The stridor gradually increased, cyanosis became marked, and the pulse was never less than 130.

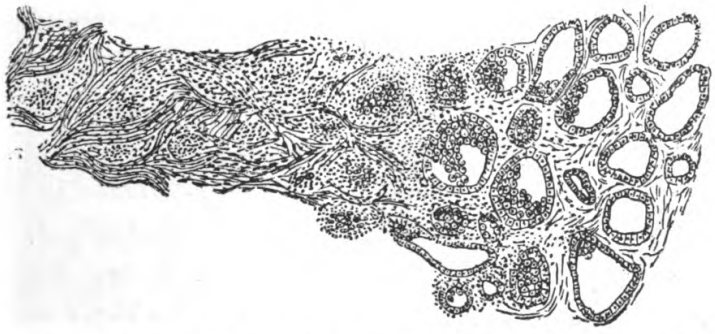
The duration of the affection and the decrease in the size of the thyroid supported the diagnosis of calcification of a formerly enlarged bronchocele.

On April 11th, 1894, a median incision was made down to the isthmus. The texture of the isthmus when cut into was that of the hardest fibrous tumour, but there was no calcification. In spite of careful attempts no line of demarcation could be made out between the isthmus and the trachea; therefore the isthmus and the adjacent parts of each lateral lobe were shaved off from the trachea, leaving a portion of the gland on either side about as large as the end joint of the thumb. The trachea thus exposed felt like a soft tube, and was sucked in and blown out by inspiration and expiration. The cartilaginous rings had softened or disappeared. As the breathing was none the better for the removal of the isthmus, the trachea was opened immediately below the cricoid cartilage, where the rings were natural. On retracting its sides the lumen was seen to be narrowed

to a chink below, and so the trachea was incised longitudinally downwards through the part which had been in contact with the thyroid until cartilaginous rings were again reached. The mucous membrane appeared normal, being merely thrown into folds in the narrow part. A Parker's silver tracheotomy tube was inserted, and the breathing became free. After the patient had worn the tube for a fortnight she was gradually able to discard it, so that at the end of a month from the operation the wound in the neck had entirely closed. Six months after the operation the girl was in better health, although still thin; her breathing caused her no trouble, but a little stridor could be heard in the trachea. The remainder of the gland had not altered. The pulse was still 120 per minute.

On examination of the tissue removed a part showed, under the microscope, thyroid alveoli in no way dilated, and containing normal colloid matter, but the alveoli were separated from one another by an increased amount of fibrous tissue. In the rest of the material removed all glandular structure had been replaced by dense fibrous tissue without any sign of sarcomatous elements or of cysts, but showing vessels with well-marked walls.

Between these two parts the thyroid alveoli were smaller in size and filled with epithelial cells, or clumps of epithelial cells surrounded by small cells marked the position of a former alveolus, or lastly groups of small round cells alone were visible. The fibrosis seemed to have spread inwards from the capsule of the gland.



The longitudinal division of the stenosed trachea might possibly result in a persistence of the dilatation, as in the case of other strictured tubes, and the unaltered condition of the mucous membrane might be considered as favorable to the maintenance of the dilatation. The rapid pulse would seem to date from the time when an enlarged bronchocele was present. It was remarkable that it should remain

rapid when so much of the gland had been put out of action. On the other hand, no myxœdematous symptoms had supervened, for doubtless there was some active thyroid tissue still left, and the stony hardness of the gland differed widely from the soft and withered gland in myxœdema.

The most important feature, from a surgical point of view, was the fact that the trachea had become intimately included in the disease and the cartilaginous rings softened, whereas the clinical and microscopical features of the case presented no signs of malignancy.

Fibrosis or fibrous degeneration of the thyroid gland must be a very rare disease, for no case of the kind appeared to have been yet put on record. Ziegler alone simply mentioned the occurrence of the disease. Fibro-sarcoma had been met with, *e. g.* by Mr. Bowlby ('Lancet,' 1884, ii, 1001), from which this case was distinguished by the clinical course of the disease and by the microscopical appearances of the portion removed.

Paralysis of Left Vocal Cord associated with Paralysis of Soft Palate (? of Diphtheritic Origin).

Dr. Scanes Spicer showed the case of C. H—, æt. 34, stableman, who had complained of hoarseness and regurgitation of fluids through nose on attempted swallowing since the middle of September, 1894.

Illness commenced with an "ordinary cold." There were no patches or ulcers on the throat at the time, but little soreness and pain on swallowing at first. The voice was distinctly nasal in character, and patient had dyspnœa on exertion. Hand-grasp good and equal on both sides. Knee-jerk, elbow reflex, and pupil reflexes normal. Mechanical stimulation of palate felt, but no reflex contraction. Laryngoscope showed left vocal cord in cadaveric position almost entirely immobile. Nothing abnormal detected in chest. No history of syphilis, influenza, or diphtheria to be obtained.

The patient was gradually improving under five drops of Liq. Strychniæ, large doses of iodide of potassium for some weeks having had no effect.

Dr. Ball considered that the paralysis of the soft palate and left vocal cord was probably diphtheritic in origin.

Dr. Hale White had seen somewhat similar conditions associated with lead poisoning.

Dr. McBride thought it possible that some changes might have been set up in the muscles supplied by the spinal accessory nerve.

Aneurism of the Aortic Arch with Paralysis of the Right Vocal Cord.

Dr. Scanes Spicer showed a specimen obtained from a sailor, W. S—, æt. 48, who was under treatment at St. Mary's Hospital under the charge of Dr. David B. Lees and the reporter, for severe attacks of spasmodic dyspnœa, hoarseness, and breast pain.

The laryngoscope disclosed paralysis of right vocal cord, while left vocal cord remained freely moveable throughout the illness. Physical examination of the chest showed undue prominence of right upper chest front, dulness, and stridulous breathing.

Intubation, venesection, and injections of morphia and atropine gave relief from time to time. The patient died from cardiac syncope of gradual onset.

The specimen was a saccular aneurism of aortic arch involving the second and third parts, and due to the yielding of the posterior wall of the vessel. The *left* recurrent nerve appeared stretched over the back of the sac. The tumour had displaced the lower part of the trachea backwards and to the right, in such a way that the convexity of the deflected trachea pressed on the *right* recurrent and pneumogastric nerves. The tumour also bulged into the trachea and opened into its lumen. The large vessels were not involved in the aneurism, as their site of origin was anterior to that part of the wall forming the tumour.

Ankylosis (?) of the Left Arytænoid Joint.

Mr. Symonds showed the case of Eliza P—, æt. 56, seen at Guy's Hospital for hoarseness in May, 1894. The condition had existed more or less for a year, and when seen again in November it was unchanged.

The whole of the left half of the larynx was fixed, the arytænoid and cord showing no movement on phonation. The cord lay in the median line, and the right moved up to it. The right arytænoid moved up to, but did not cross the left. The line of the glottis where the cords were in contact was oblique.

There was no evidence of destructive ulceration of the cord or arytænoid, and no cause of pressure could be discovered in the neck or elsewhere. The patient could swallow ordinary food with ease. A bougie passed readily without encountering obstruction. There was

no sign of syphilis. The patient was stone deaf and of an excitable temperament.

The diagnosis lay between paralysis and fixation of the arytænoid, and Mr. Symonds inclined to the latter view on account of the position of the arytænoid, the oblique line of the glottis, and the fact that the moving arytænoid did not displace the immoveable one.

Dr. Percy Kidd had seen this case at an earlier stage, and thought the fixation of the cord was mechanical rather than paralytic, due to ankylosis of the crico-arytænoid joint.

Tubercular Ulceration of the Epiglottis treated by Curetting and Lactic Acid.

Mr. Symonds exhibited a patient, Mr. E. S—, æt. 29, who complained in August, 1891, of some pain in swallowing, the expectoration of much frothy mucus, alteration of voice, and nocturnal cough. On examination the epiglottis was thickened, red, and shiny, especially on the right side; mucus entirely concealed the laryngeal view. On the posterior surface of the epiglottis was extensive ulceration, more particularly on the right half and edge. The change of voice was due to the presence of mucus only. He had lost two stone in two years, but considered himself in good general health. There was no family history of tubercle and no evidence of pulmonary disease.

The disease seemed so extensive that at first he was treated with sedative powders and general remedies. In five weeks he had improved a good deal, and had gained in weight. A better view obtained showed that the left arytænoid was involved and the ary-epiglottic fold.

October 31st.—The epiglottis was freely curetted and lactic acid at once applied.

November 24th.—The local condition was much improved; he could swallow well and eat anything. He had been curetted four times. All expectoration had disappeared. He had gained 9 lbs. in the three months.

December 5th.—Some recurrence took place, giving rise to dysphagia due to increased swelling of the ary-epiglottic fold. This was scraped well and rubbed with lactic acid.

January 12th, 1892.—Both cords were well seen owing to the greater mobility of the epiglottis, and were healthy. A small smooth swelling

remained in front of the left arytænoid. The epiglottis looked irregular and nodular from cicatricial contraction.

November, 1892.—A small grey surface appeared in the left side of epiglottis. This was curetted off and lactic acid applied.

The treatment never interrupted the patient's business engagements. Since the last date he had continued well.

Dr. Clifford Beale referred to the occasional occurrence of spontaneous healing of localised tubercle of the epiglottis without any special treatment.

Mr. Butlin mentioned the case of a boy with destructive ulceration of the epiglottis, which healed completely under the simple application of iodoform.

Dr. McBride quoted a case of spontaneous cure, in which the pharynx had been affected with a pale bluish œdema similar to that seen in the larynx in tubercular cases. Lactic acid was applied, but not very regularly, and the swelling disappeared. No bacilli were found in the case.

Mr. Cresswell Baber referred to a case of apparently tubercular disease of the epiglottis, and commented on the great variety in the course taken by laryngeal tubercle in different cases.

Mr. Symonds pointed out that in his case relief was rapid after the conditions had remained unaltered for six weeks.

The President observed that without the presence of bacilli it was not always possible to be sure of the tubercular nature of some cases.

Pachydermia Laryngis.

Mr. C. J. Symonds brought forward the patient shown at the last meeting (*vide* 'Proceedings,' vol. ii, p. 17). Some change had taken place since the previous examination, but the condition was still characteristic of pachydermia in the opinion of the President, Dr. Kidd, Dr. McBride, and Dr. Ball.

Dr. Bronner and Dr. Spicer advocated the removal of a small piece of the projecting tissue for microscopic examination.

The President thought that the diagnosis was sufficiently clear without the use of the microscope. Changes took place very rapidly in these cases, and the results of microscopic examination were not always positive, but sometimes brought confusion into a simple case.

Venous Angioma of Pharynx.

Dr. P. McBride showed a sketch taken from this case. The patient, a young married woman with tendency to varicose veins,

noticed the tumour accidentally one day on looking into her throat. The angioma consisted of tolerably large veins, and occupied the whole palatal margin from the uvula inclusive of the left side. Smaller separate patches were seen on the anterior and posterior pillars of the fauces, while a bluish tinge was communicated to the anterior portion of the soft palate of the corresponding side.

As the tumour produced no symptoms it was not intended to apply any treatment.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ANNUAL GENERAL MEETING, *January 9th*, 1895.

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

E. CLIFFORD BEALE, M.B., }
SCANES SPICER, M.D., } Secretaries.

Present—27 Members and 7 visitors.

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

Dr. W. Law and Dr. George Mackern were appointed as Scrutineers of the ballot for Officers and Council for the ensuing year, 1895.

The Report of the Council for the past year, 1894, was then read, as follows:

During the past year, 1894, the Society has held the full number of meetings, all of which have been well attended. Sixteen new members have joined the Society, and the Council have only to report the loss of one member by the lamented death of Dr. Ernest Jacob of Leeds.

In response to a request from the House Committee of the Royal Medical and Chirurgical Society, the Council have entered into a new and inclusive agreement as to rent, accommodation for the Society's Library, and supply of electric current through the lamps used in the clinical examinations. An inclusive annual rent of £31 10*s.* has been agreed to.

It having been suggested by some of the country members of the Society that a scale of compounding fees should be established in lieu of annual subscriptions, the Council, having carefully considered the matter, have to submit the following propositions for confirmation by the Society:

1. That it is undesirable to establish a compounding fee for town members at present.

2. That country members should be allowed to compound for the sum of ten guineas (£10 10*s.*) on entrance, which sum should include the entrance fee.

3. That country members who have not paid five annual subscriptions should be allowed to compound for the sum of nine guineas (£9 9*s.*).

4. That these fees should entitle the compounding members to

enjoy all the privileges at present accorded to ordinary members of the Society.

It was then proposed, seconded, and carried unanimously—"That the Report be received and adopted, and that the Recommendations with respect to Compounding Fees be approved, and that the Council be empowered to alter Rule 10 of the Society's Rules in accordance therewith."

The Treasurer's Report was then presented as follows:

THE LARYNGOLOGICAL SOCIETY OF LONDON.

BALANCE-SHEET, 1894.

Income.	£	s.	d.	Expenditure.	£	s.	d.
By Balance in hand from 1893	15	13	4	To Rent, 20, Hanover Square	20	0	0
„ Subscriptions—				„ Adlard for Printing and Postage	36	13	10
49 members at £1 1s. . £51 9 0				„ Corbyn and Co., Spirit Lamps, &c.	1	18	0
17 members at £2 2s. . 35 14 0				„ Cheque-book, 4*s.* 2*d.*; collecting two Cheques, 3*d.*	0	4	5
	87	3	0	„ Petty Cash—			
				Dr. Spicer . £1 18 2			
				Dr. Beale . . 0 15 0			
				Attendant . . 2 0 0			
				Waterlow — Diploma of Hon. Membership . . . 0 9 6			
					5	2	8
				„ Balance in Treasurer's hands, Jan. 1, 1895 . .	38	17	5
Total . .	£102	16	4	Total . .	£102	16	4
				Expenditure of the year .	£102	16	4
					38	17	5
					£63	18	11

The 17 subscriptions at £2 2s. include 15 entrance fees and 2 subscriptions for the coming year, 1895.

Audited and found correct, January 4, 1895. WALTER G. SPENCER. RICHARD LAKE.

The Report was unanimously received and adopted.

The Report of the Librarian was read as follows:

Numerous monographs, pamphlets, periodicals, and a few books have been received during the year. Amongst the latter are 'Medical Essays and Lectures,' and an 'Essay on Asphyxia' by Sir George Johnson, presented by the Author. Additional accommoda-

tion has now been provided in the Library of the Royal Medical and Chirurgical Society for the Society's Library, and negotiations are in progress which, it is hoped, will render the use of the Library more available to the members of the Society.

The Report was unanimously received and adopted.

The President then called attention to the first bound volume of the Society's 'Proceedings,' to which a complete index had been added, and stated that the Society's printers, Messrs. Adlard and Son, 20, Hanover Square, were prepared to bind any sets of 'Proceedings' sent to them by the members, together with the new title-page and index, in the same manner as the specimen volume exhibited.

The Scrutineers then presented the result of the ballot for Officers and Council, as follows:

President.—Dr. Felix Semon, M.D., F.R.C.P.
Vice-Presidents.—Charters J. Symonds, M.S., F.R.C.S.; E. Cresswell Baber, M.B.
Treasurer.—H. T. Butlin, F.R.C.S.
Librarian.—E. Clifford Beale, M.B., F.R.C.P.
Secretaries.—Scanes Spicer, M.D.; W. R. H. Stewart, F.R.C.S.Ed.
Council.—J. Dundas Grant, M.D.; Adolph Bronner, M.D.; Percy Kidd, M.D., F.R.C.P.; J. W. Bond, M.D.; F. W. Bennett, M.D.

The President briefly returned thanks for the election of himself and the other members of the Council.

The following recommendation of the Council was then considered, and after some discussion agreed to:

The Council propose that a Reception should be given to the Foreign and Provincial Laryngologists attending the Annual Meeting of the British Medical Association in London in July, 1895.

They suggest that a Conversazione should be held in the rooms of Messrs. Erard in Marlborough Street at 10 p.m. on the night of July 29th, and that the expenses should be borne by voluntary contributions from the members, the amount of subscription not to be limited.

It was agreed that a small Sub-Committee should be appointed at a later date to make arrangements for the Conversazione.

Ordinary Meeting.

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

The following gentlemen were elected Members of the Society:

Mr. Percy Warner, Woodford.
Dr. Barclay Baron, Clifton.
Dr. J. Walker Downie, Glasgow.

Moriform Growths springing from the Posterior Border of the Nasal Septum.

Dr. William Hill showed this case.—C. H—, æt. 40, presented himself at St. Mary's Hospital in July, 1894, suffering from slight catarrh of the Eustachian tube and tympanum; he had a congenital cleft in the hard and soft palate. On post-rhinoscopic examination two elongated moriform tumours were observed, about the size of broad beans, springing symmetrically from the posterior border of the septum. As these were not large enough to cause obstruction it was decided to watch their growth. Since that date the right one of the two tumours had nearly doubled in size.

Growths in this situation must be comparatively rare, though the exhibitor of this case had removed two such tumours, springing from the *same site*, from a patient whose posterior nares were quite blocked by them; their removal by snare, scissors, and knife had proved by no means easy. As far as Dr. Hill was aware, the only recorded case was the one shown some time since at this Society by Dr. Dundas Grant, in which moriform tumours sprang from the same site.

Ulcerative Disease of the Left Nasal Fossa of Undoubted Tubercular Nature followed by Lupoid Disease of the Left Ala.

Dr. William Hill showed this case.—E. H—, æt. 30, sought advice in May, 1893, for a blocked and ulcerated condition of the left nasal fossa. There was no evidence of syphilis. The patient had been dismissed from the army four years previously for tubercular disease of the lung with hæmorrhage, but there had been no active pulmonary disease for three years.

Granulations and exposed bone were found on the middle fossa in the region of the uncinate body. Dr. Semon saw the case in consultation, and whilst advocating the administration of iodide of potassium he concurred in the view that the disease was probably tubercular, and required energetic local treatment as well. The diagnosis was eventually confirmed by bacteriological examination. The granulations were frequently curetted, and applications of lactic acid, chromic acid, sulphoricinate of phenol, and trichloracetic acid were tried, the last apparently with most benefit; a small sequestrum came

away, and after this the ulceration was found to be practically healed at the end of two months, though the patient was recommended to continue to medicate the nose daily with an alkaline douche.

When seen again on December 15th, 1894, there was an abundant purulent discharge from the nostril and ulcers on the floor and on the outer wall of the middle meatus, together with excoriation and swelling of the upper lip near the anterior naris, and evidently extending by continuity from the vestibule; in spite of appropriate treatment the disease had extended to the ala, which at the present time presented a tuberculated appearance, and looked just like lupus. The patient had recently been under the care of Mr. Stanford Morton for purulent ophthalmia, probably caused by the irritating nasal discharge having been conveyed accidentally to the eye. The case was of interest, inasmuch as an undoubted tubercular disease of the nasal mucosa had been followed after nearly two years by extension to the cutaneous covering of the ala, and this more recent lesion would have been unhesitatingly diagnosed as ordinary lupus had not the course of the disease and the continuity of the lesion been known. Ichthyol ointment was now being applied locally, but it was proposed to scrape the affected skin.

Dr. EDDOWES thought that the disease was probably lupus. He suggested getting rid of infection by means of mercurial plasters and ointment, and then attacking the diseased surface by the cautery, using great care to keep the wound aseptic.

Dr. HILL still regarded the case as tubercular.

Dr. ALEXANDER HODGKINSON (Manchester) exhibited—

1. A throat mirror for laryngoscopic purposes in which quartz was substituted for the glass of the ordinary mirror. It was thus rendered far more durable.

2. A magnifying laryngoscope. This consisted of a magnifying throat mirror and an ordinary frontal reflector to which were adapted magnifying lenses. The throat mirror consisted of a plano-convex lens mounted in the usual way, and having the convex surface silvered so as to constitute a concave reflector when seen through the plane face. The magnifying power was varied by having two such mirrors with focal lengths of eight and eleven inches respectively. The frontal mirror, of the ordinary size and form, was fitted with four double convex lenses, two for each eye, and capable of being used separately

or together, so as to allow of further varying the amplifying power. The focal length of each of these lenses was twenty inches. When properly constructed for varying width of eyes it was easy to use, and gave excellent results.

Laryngeal Stenosis; Polypoid Growth from Left Vocal Cord, (?) Syphilitic.

This case was shown by Dr. Percy Kidd.—William I—, æt. 44, polisher, admitted into the Brompton Hospital December 15th, 1894, on account of dyspnœa.

Patient had syphilis sixteen years ago, followed by a rash, and was treated at the Middlesex Hospital for eighteen months. His tongue has been cracked and covered with whitish patches for thirteen or fourteen years. Hoarseness began three years ago, and he ultimately lost his voice. For the last four months he had suffered from gradually increasing dyspnœa with cough and slight expectoration, which he found much difficulty in expelling. Slight hæmoptysis (one teaspoonful) occurred a fortnight ago. He stated that he had lost much flesh.

On admission marked stridor and dyspnœa, mainly inspiratory. Nutrition of body poor. Chest slightly hyperresonant; breath-sounds weak generally. Tongue showed leucoplakia and some scarring. Larynx moderately congested. Glottis represented by a mere chink bounded by two motionless fleshy bands, which showed a kind of fusiform swelling at their middle two thirds. Just below the posterior third of the left band a pale pink, irregularly rounded, polypoid outgrowth projected inwards, and almost touched the opposite side of the larynx. The posterior wall was marked with numerous coarse nodular elevations; no definite ulceration. Sputum examined for tubercle bacilli with negative result.

The case was regarded as one of laryngeal syphilis, and was treated with large doses of iodide and mercury.

The stridor and dyspnœa had diminished slightly, but there had been no change in the larynx beyond a slight decrease in the nodular appearance of the posterior wall.

The case resembled somewhat that of C. H—, shown at the March meeting of the Society in 1894, which proved to be syphilitic.

Mr. W. G. SPENCER thought that thyrotomy should be performed, as the larynx was very narrow.

Dr. HALL considered that the disease was undoubtedly syphilitic, and that it would be best to perform tracheotomy, and to attack the larynx with the forceps at a later stage.

The PRESIDENT thought that the possibility of malignant disease should not be disregarded. There seemed to be an excessive outgrowth for a simply syphilitic condition, but antisyphilitic treatment should be tried.

Dr. KIDD, in reply, stated that no attempts had yet been made to remove the growths with the forceps. He had, at first, thought that the disease was tubercular, but now regarded it as syphilitic. He proposed to treat the case by tracheotomy, and subsequently to try removal of the outgrowths with the forceps.

ŒDEMATOUS SWELLINGS OF THE PALATE AND PHARYNX.

Dr. EDWARD LAW showed a patient, Mrs. S. B—, aged 62, widow, first seen on November 20th, 1894, on account of the sudden occurrence of great difficulty in respiration and deglutition, associated with much discomfort and swelling at the back of the throat. The patient had been under the care of Dr. Alfred Eddowes for nine months suffering from so-called Quincke's disease or acute circumscribed œdema, a malady which had been also described as urticaria tuberosa, nodosa, or gigans.

During childhood she was said to have suffered from one attack of nettle-rash, and her father is reported to have been very gouty.

The patient had always enjoyed fairly good health with the exception of occasional dyspepsia. Three years ago she lost her husband, and suffered from severe and lasting shock, but it was not until eighteen months later that the disease began from which she now suffered. Before the rash appeared she took chillies for indigestion, but neither Dr. Eddowes nor the patient had been able to ascertain that the ingestion of any particular condiment or food had any influence in the causation of the eruption.

The patient was now practically never free from the disease. She described the lesions as coming on with little hard isolated lumps under the skin, which were about the size of a pea or bean and very irritable. The redness and œdema appeared later, and were apparently accompanied by a feeling of heat, tension, and smarting rather than of true itching. No factitious urticaria could be produced by scratching,

although a little excessive congestion followed the irritation of the nail, but no distinct urticarial wheals had been observed in her case, either from the disease or from artificial excitement.

The appearance of a patch when the œdema was well established and the redness at its height was somewhat similar to erythema nodosum, but it differed from that affection in the history of the case and in many other respects.

The size and shape of the patches varied greatly, sometimes involving nearly the whole of a limb. They caused most distress when they affected the mouth, throat, or face. Occasionally the eyelids had been so swollen as to be completely closed for one or two days.

She had had previous attacks of a less urgent character in the throat and mouth, with and without swelling of the lips and tongue.

The patient gave the following history on the occasion when first seen by Dr. Law. She woke up suddenly in the early morning with the feeling of a lump at the back of the throat, which she was unable to dislodge by coughing or swallowing. There was great discomfort and uneasiness, but little or no pain. She noticed, by means of a looking-glass, that her throat was so much swollen that the uvula was in contact with the two sides of her mouth. The difficulty in swallowing greatly increased, and the sense of suffocation became so oppressive that the patient was very nervous and alarmed through the fear of impending death. This critical condition lasted for two or three hours, when the symptoms gradually subsided and the swelling rapidly disappeared.

On examination a few hours later an œdematous swelling of the uvula was found with slight serous infiltration of the left half of the palate and of the left aryepiglottic fold. The left ventricular band appeared to be more prominent and congested than the one on the opposite side. The neighbouring parts of the pharynx were only slightly hyperæmic, and a few enlarged follicles were visible upon the posterior pharyngeal wall. There was increased redness of the epiglottis and laryngeal mucous membrane, but the vocal cords moved freely, and, with the exception of streaky redness, were normal in appearance.

No active treatment was called for, as the urgent throat symptoms had evidently already passed away. Dr. Eddowes stated that the following internal and local remedies had been employed with only questionable advantage:—arsenic, quinine, ichthyol, colchi-

cum, iron, citrate and chlorate of potash, bromide of potassium, creoline, tincture of iodine, and solution of alum.

Brocq, Riehl, Unna, Crocker, Pringle, and others had reported similar cases in which the tongue or mucous surfaces of the eye, throat, or stomach were affected by the disease. Strübing had also probably described the same disease as an angioneurotic œdema.

The PRESIDENT observed that these cases were excessively rare. He had been watching a case for some time, but had never been able to see it while the local swellings were visible. In that case the swellings came on without warning on the soft palate, and lasted for a few minutes or sometimes for an hour. The condition had been well described by Strübing as angioneurotic œdema.

Dr. HALL suggested that 10 or 20 per cent. solution of cocaine might afford temporary relief if applied to the swellings directly they appeared.

Mr. BUTLIN objected to the term "Quincke's disease" as being altogether unknown. These temporary œdematous swellings, when causing obstruction to the respiration, might very well be overcome by means of intubation.

Mr. ROPER mentioned a case in which œdematous swellings of the lips, tongue, soft palate, arms and back occurred to an old lady of seventy-five without any warning. The swellings were of short duration, and seemed to call for no treatment.

Dr. LAW, in reply, had not been able to find any reference to "Quincke's disease" as such in any text-book, but a case was reported in the 'Archiv für Laryngologie.'

LUPUS OF PHARYNX AND LARYNX.

The PRESIDENT showed the little girl affected with lupus of the pharynx and larynx whom he had demonstrated at the April meeting 1894 ('Proceedings,' p. 103). The treatment then proposed, viz. curetting and application of lactic acid locally with the internal administration of cod-liver oil and arsenic, had been carried out methodically in such a way that the local applications had been limited to the pharynx, and the larynx had not been treated at all locally. Nevertheless a very general improvement had taken place, also in the condition of the larynx. The patches of lupus from the gums, palate, and pharynx had entirely disappeared; the larynx was much less ulcerated, though still swollen, and the previously aphonic voice was now loud and strong. The case offered a fresh illustration of the fact that certain cases of lupus will get better or even temporarily well under almost any medication.

Dr. Hennig's Oil Studies of Laryngeal and Nasal Disease.

The President also demonstrated Dr. Arthur Hennig's (of Königsberg) admirable studies in oil for teaching purposes of normal and diseased conditions of the upper air-passages. These studies represented forty illustrations very considerably enlarged from nature. It was mentioned that the artist greatly wished that these paintings should be reproduced for teaching purposes, but that the great cost of such reproductions stood in the way, and that it would only be possible to take the matter into serious consideration if a large number, at least 300 subscribers were found.

Dr. Scanes Spicer proposed a vote of thanks to Dr. Arthur Hennig for the trouble he had taken to bring the pictures to the notice of the Society, and expressed the opinion that they should be reproduced if possible for teaching purposes.

Mr. Cresswell Baber seconded the resolution, which was carried by acclamation.

At the invitation of the President, several members offered criticisms on the drawings.

Mr. Cresswell Baber, whilst complimenting Dr. Hennig on some of his excellent paintings, thought that the representations of the nasal cavities as seen from the front were not satisfactory, owing to their not showing the parts in perspective. In the drawings made and published by him some years ago this point was specially attended to, and therefore, in his opinion, they gave a true idea of what was actually seen. Dr. Hennig's drawings also did not show the neck of the middle turbinated body.

Dr. Ball did not think that the reproduction of some of the commoner affections would be worth while, especially as they were by no means typical.

Dr. Hill pointed out that in these pictures, as in many of the text-books, the post-rhinoscopic image was represented in the ideal manner, but not as it was actually seen. The upper turbinal was, as a rule, quite invisible, while the position of the middle turbinal was quite inaccurate.

Dr. Bronner observed that for teaching purposes a good set of typical conditions was required.

The President undertook to convey these criticisms to the artist. The method of reproduction proposed was chromo-lithography, but the cost as at present estimated was almost prohibitive. It was intended by the artist that the pictures should be made useful for teaching purposes by means of pieces of frosted glass which could be laid over the pictures, and variations sketched upon the glass by means of coloured chalks.

Radical Cure of Obstinate Suppuration of the Antrum of Highmore, combined with Intra-nasal and Intra-antral Polypi.

Dr. Scanes Spicer showed F. H—, lawyer's clerk, æt. 30. Sent by Dr. J. Q. Bown in autumn, 1890, for fœtid suppuration in the right nasal cavity. On examination polypi were seen in region of ostium maxillare, and were removed. Suppuration continued, and antral empyema was diagnosed, and confirmed by transillumination. On December 27th, 1890, the antrum was tapped through the socket of a tooth which had been previously removed, and a gold tube fitted to a plate by Mr. Boyd Wallis. Irrigation was practised, and there was temporarily much improvement. After some months the tube caused pain and irritation, and had to be several times altered, and finally removed altogether, and purulent nasal discharge became worse than ever. In May, 1892, patient desired to have something more done, and he was operated on in St. Mary's Hospital by a large opening made with chisel and mallet through the canine fossa into the antrum, and its cavity was well curetted, much thickened granulation tissue being removed. Subsequently drainage apparatus was used, lead spigots, vulcanite plugs, rubber drainage-tubes, and Ellis's tube. All these from time to time caused local pain, and the suppuration, though at first less, finally relapsed to its former condition. In April, 1893, the drainage of the antrum being still deficient, patient was advised to have a further operation, in which an attempt should be made to render drainage better. With this view the opening in the anterior wall was opened up and enlarged, the cavity again curetted, and a large naso-antral opening made from inferior meatus (well behind entrance of nasal duct) into antrum with a Krause's trocar, the index finger being introduced into antrum through anterior opening to act as a guard. The antrum was *flushed* out with boracic lotion, and was then tightly packed with creolin gauze, and especially so as to distend the bucco-antral opening. After forty-eight hours the gauze was removed, and from that time irrigation practised thrice daily. No drainage apparatus was used. The patient was directed to blow frequently from nose through antrum to mouth, and *vice versâ*, so as to move on any secretions tending to loiter in antral recess, and also to force boracic lotion from mouth through antrum into nose. The result of this was that the discharge gradually subsided, and soon ceased entirely. The

patient had now seen no pus for eighteen months, and at the present time the nasal cavity looked healthy, and he could blow air through the antrum from mouth to nose or *vice versâ*.

Dr. Scanes Spicer also showed the *débris* which he had curetted from other cases of chronic maxillary empyema, and which were seen to consist of fungous granulation tissue, mucus polypi, cholesteatomatous cysts, and in one case a portion of necrosed ethmoid.

He advocated the adoption of the double opening into the antrum in chronic cases in which there was reason to suspect the above complications, in which drainage was defective, and in which drainage apparatus caused irritation, or in which there was marked intra-nasal disease, under which category all his cases heretofore had come, for none of them had yielded to the simple method of alveolar puncture and drainage-tube.

Mr. Butlin had had several such cases. He generally scraped the antrum, but called attention to the necessity for making the opening in the floor and not at the side of that cavity in order to ensure perfect drainage.

Dr. Rees doubted whether such operations were necessary in every case. They caused considerable deformity, and many cases could be simply relieved by removal of a tooth. The large openings were often an annoyance to patients who were smokers.

Dr. Dundas Grant had been able to cure a few cases without operation. He thought that the extent of the operation must depend upon the condition of the lining membrane of the antrum. He had obtained good results in patients who possessed a good set of front teeth by the use of Krause's trocar.

Dr. Spicer had not tried dry treatment in these cases. In the present case all simpler methods had already been tried and found unsuccessful.

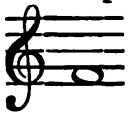
"Recurrent" Tumour at the Back of the Tongue; Operation, June, 1889.

Mr. Butlin showed this patient, whose case is described in the 'Clinical Transactions' for 1889.

The tumour stood up in front of the epiglottis; it was cut off with a galvano-cautery loop in June, 1889. Its structure was similar to that of the thyroid gland.

At present there was a prominent lump far back in the left half of the tongue.

Hoarseness confined to the Lower Register of the Voice.

Dr. Dundas Grant showed a patient, Miss D—, æt. 30, a school teacher, who had for about three years been the subject of hoarseness characterised by a "bleating" or "croaking" vibration accompanying her ordinary speaking voice and her singing in the lower part of its range. This entirely disappeared above the note  where, when she sang softly, the change of register occurred, and the tones became perfectly clear. On laryngoscopic examination the vocal cords were seen to approximate imperfectly in their posterior thirds during the utterance of the lower notes. (On subsequent more close observation the inner portions of the cords were seen to be thrown into loose visible vibrations.) During the emission of the higher notes the cords appeared to act normally. Dr. Grant attributed the condition to inactivity of a portion of the internal thyro-arytænoid muscle. The chest was normal, and the patient, though spare, was fairly muscular. He had recommended instruction in the use of the breath under Mrs. Emil Behnke.

The President pointed out that the condition was one of diplophonia. So long as all the elastic fibres in the cords were acting they might act unequally, and an imperfect tone was produced; but if only certain bundles of fibres were acting they might, within their own range, produce a clear tone as in Dr. Grant's case. He advised rest to the voice, electric stimulation both inside and outside the larynx, and a course of strychnia.

Fixation of Right Cord.

Dr. Willcocks showed a patient, R. M—, a boatman, who had had a severe blow on nose about thirteen weeks ago, and felt as if his backbone was broken in pieces. Eight weeks after he woke up one night complaining of his throat. On speaking he noticed his voice was hoarse. Since then he had got no better and no worse.

Present condition.—Right cord somewhat oblique and immoveable. Right arytænoid cartilage prominent. No evidence of intra-thoracic tumour. No history of syphilis.

Dr. BRONNER and Mr. STEWART expressed the opinion that the case was one of perichondritis, causing mechanical interference with the movement of the cord.

The Annual Dinner of the Society was held after the meeting at the Café Royale. The President occupied the Chair, and was supported by Sir Russell Reynolds, President of the Royal College of Physicians, the President of the Pathological Society, Sir George Johnson, Señor Manuel Garcia, Sir W. McCormac, Dr. Ord, and a large gathering of members and guests.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *February 13th*, 1895.

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

SCANES SPICER, M.D.,
W. R. H. STEWART, F.R.C.S., } Secretaries.

Present—23 Members and 8 visitors.

The minutes of the previous meeting were read and confirmed.

Before the usual business of the meeting, the President referred in feeling terms to the loss laryngology had sustained by the death of Professor Gottstein of Breslau.

Mr. Arthur Reginald Poulter, M.R.C.S., L.R.C.P., was called to the table, and admitted a member of the Society by the President.

The following candidates were proposed for election:

George C. Cathcart, M.B., C.M., London.
Alec H. Gordon, M.B., B.C., London.
Bruce Hamilton, M.R.C.S., L.R.C.P., London.
Percy Jakins, M.R.C.S., London.
T. E. Foster Macgeagh, M.D., M.R.C.S., London.
G. Calwall Stephen, M.D., L.R.C.P., London.

The following gentlemen were nominated as a committee to carry out the arrangements for the entertainment of the Laryngological Section of the British Medical Association in July:—The President, the Secretaries, Dr. St. Clair Thomson, Dr. Hill.

The President stated that the subject for discussion at the next Ordinary Meeting was the diagnosis and treatment of empyema of the maxillary sinus, and that an invitation would be sent to the members of the Odontological Society, asking them to be present and to join in the discussion.

A Case for Diagnosis, whether Tuberculous, Malignant, or Syphilitic.

The President asked the opinion of the members on the following case. J. F—, æt. 55, a porter, came to the Throat Department of St. Thomas's Hospital on September 28th, 1894, complaining of hoarseness, which commenced fourteen days previously, a slight cough which came on after the hoarseness, with dryness, and a tickling sensation in the throat, causing frequent "hawking;" expectoration scanty; no blood; complains of drawing pain at left apex. Family history good. Past history good. No history of syphilis.

Examination.—Fauces and pharynx congested. Posterior pharyngeal wall granular, with distended veins and adherent secretion. *Larynx:* considerable congestion of larynx, and some swelling of ventricular bands.

November 9th.—Ventricular bands more swollen, some ulceration of both vocal cords. Was put on iodide of potassium, grs. v, three times a day.

December 21st.—More ulceration spreading to interarytænoid commissure. Patient says he feels as if he were going to be choked. Complains of pain on swallowing.

February 8th.—Voice slightly improved; has been taking Pot. Iodidi three months. Cough worse, and has pain in right side in region of hyoid bone on deglutition. *Larynx:* ventricular bands irregularly swollen; ulceration on posterior end on the right side. Vocal cords: posterior end of right side considerably thickened; left side similar, though in a less degree. Movements free both sides. Distinct superficial ulceration in the considerably tumefied interarytænoid fold. *Chest* at first normal, but on February 8th was in the following condition. Resonance slightly impaired, but equal. Breath-sounds, right apex, harsh, with a few râles; left apex, the râles more numerous; breath-sounds almost inaudible over rest of lung. No loss of flesh. No night sweats. No hæmoptysis. *Sputum:* no tubercle bacilli found after repeated examination.

Dr. Cresswell Baber thought it was a case of syphilis, and inquired if large doses of iodide of potassium had been given.

Dr. Dundas Grant thought it was a case of tubercle of the dry warty kind. Had seen a case of this sort, in which there were no

physical chest signs during life, but post mortem pulmonary tubercle had been discovered. He thought there was too much movement for epithelioma. Suggested curetting and lactic acid applications.

Dr. PERCY KIDD had seen two or three cases where the disease was situated in the angle formed by the vocal cords and arytænoids, which had proved to be tubercle.

Mr. CHARTERS SYMONDS had one in which the vocal cords were fringed with growths in a tuberculous case.

Dr. HILL asked if the use of tuberculin was justifiable in such a case for the purpose of diagnosis.

The PRESIDENT, in reply, stated that he had used large doses of iodide of potassium with no result. He had given up the use of tuberculin, but considered it quite justifiable for the purpose of diagnosis, and also the removal of a portion of the growth for microscopic investigation.

PATHOLOGICAL SPECIMEN OF ADENOID GROWTHS AND ONE OF PERFORATION OF THE NASAL SEPTUM.

Dr. KANTHACK showed these specimens, and pointed out that the growths were not in the position usually depicted in books, but were situated on the walls of the naso-pharynx and around Luschka's tonsil.

The PRESIDENT in the name of the Society expressed their indebtedness to Dr. Kanthack for bringing before them such excellent pathological specimens.

Drs. CRESSWELL BABER and DUNDAS GRANT suggested that if Dr. Kanthack was able to obtain another specimen of adenoid growths, the anterior wall should be removed so as to give a view from the front.

Dr. BALL thought the perforation in the nasal septum was a case of simple perforating ulcer, as the voice was not affected.

Dr. DUNDAS GRANT suggested that frequent epistaxis was diagnostic of simple ulcer.

Dr. TILLEY quoted a case where a perforation occurred without local symptoms during an attack of typhoid fever.

Dr. LAW had a case of perforation caused by the removal of a cartilaginous spur by means of the galvano-cautery.

Dr. CRESSWELL BABER frequently removed cartilaginous spurs by the galvano-cautery, and had never seen a perforation follow; he always attacked the apex of the spur.

Dr. SCANES SPICER had never seen perforation follow the application of the galvano-cautery to the spur; he thought Dr. Kanthack's case was one of simple ulcer from the shape.

Case illustrating Various Morbid Conditions of the Nose and Ears.

Dr. E. Law showed this case. A patient, æt. 26, came to the London Throat Hospital complaining of deafness. Had suffered from ear and eye troubles during childhood, and had contracted syphilis four years ago. Examination showed general catarrhal conditions of the upper air-passages—deflected nasal septum—a papillomatous-looking growth from the anterior third of the left inferior turbinate bone, extensive polypoid proliferation of the left middle turbinate, enlarged Luschka's tonsil, sequelæ of otitis media superior (perforation cicatrices, &c.), hyperostosis of external auditory meatus, eczema of both auricles, and various affections of the eyes. Dr. Law asked if the papillomatous-looking growth was a true papilloma, or a simple enlargement of the anterior extremity of the turbinate.

Dr. Pegler considered this a case of papilloma.

Mr. Stewart and Dr. Cresswell Baber thought it was a simple hypertrophic condition.

Mr. Santi, Dr. Hill, and Dr. Scanes Spicer also thought it was not papillomatous.

Dr. Law, in reply, stated that he would remove a portion and have it microscopically examined.

Laryngeal Stenosis, probably Lupus.

Case shown by Mr. Parker. M. D—, a girl æt. 16, first suffered from hoarseness and loss of voice a year and eight months ago, was treated by Dr. Macdonald at the Throat Hospital, Golden Square, and soon got quite well for the time, but has since then lost her voice off and on. Present attack followed influenza eight weeks ago, became steadily worse, causing complete aphonia and much dyspnœa until February 11th. The aphonia and dyspnœa were now very marked, there was loss of flesh and general debility.

Examination.—Distinct scars on the soft palate, and considerable loss of substance of the epiglottis were found; the aryepiglottidean folds were much distorted, and covered by a number of small pale irregular nodules. The arytænoids, seen with great difficulty, were swollen and œdematous. Cords and ventricular bands could not be made out; base

of tongue was covered with small nodules. On account of the scars on soft palate was put on iodide of potassium; has been taking it for one month in gr. v doses, but the condition of the parts has remained unaltered. Family history good. No suggestion of tuberculosis or syphilis, congenital or acquired. Lungs normal.

Mr. SANTI thought the case more like syphilis than lupus.

Mr. MILSOM REES considered it a case of lupus, and very like some cases he had seen treated with tuberculin.

Mr. PARKER, in reply, said he would try lactic acid applications.

The PRESIDENT suggested that arsenic should be given internally.

ANTERIOR NASAL STENOSIS FROM CICATRICIAL CONTRACTION AFTER ULCERATION, WITH CONSECUTIVE CHRONIC LARYNGITIS.

Dr. SCANES SPICER showed a patient, Mrs. I. K—, æt. 52, a monthly nurse, who contracted "blood-poisoning" two years ago while attending a case. She had suffered from glandular enlargements, rash, frontal headaches, and showed scars on arms and legs resembling those left by rupial sores, and ulceration about anterior nares and vestibula narium. These latter had healed, but had been followed by such narrowing as to give rise to subjective distress. Mouth breathing and obstinate laryngitis with thickening of the posterior wall of the larynx. Suggestions were invited as to the treatment of the cicatricial stenosis, which did not appear to the exhibitor to be capable of material improvement.

Mr. STEWART referred to a case he had shown at a previous meeting, where the alæ of the nose were completely drawn in and the throat was secondarily affected; had tried all sorts of forms of dilatation without success, but the patient was kept fairly comfortable by the use of menthol. Thought Dr. Spicer's case was one of syphilis, did not think any operation would be successful.

Dr. MILSOM REES and Mr. SYMONDS thought Dr. Spicer's case was syphilitic, as she had nodes on legs and arms.

The PRESIDENT suggested iodide of potassium and mercurial inunction; he thought an operation might be successful if the stenosis was incised, pyoktanin applied, and the wound stuffed with slips of iodoform gauze. He drew attention to the fact that in cases of syphilis of the upper air-passages it was peculiar that the disease attacked intensely one part and passed quite over another.

In reply, Dr. SCANES SPICER thought that the laryngitis presented no syphilitic characters, but was of that form seen in simple catarrhal conditions.

Paralysis of the Left Vocal Cord.

This was shown by Mr. Charters Symonds. J. C—, æt. 40, a butcher sent to Guy's Hospital by Dr. Dodwell, complaining of alteration in his voice. Up to October, 1894, resided in California; at the commencement of that month, while still there, he "caught a cold" and had a severe "chill," but does not seem to have had any cough or even nasal catarrh. Woke up one morning with altered voice as it is now. Had no previous hoarseness. No joint pains, though says he has had rheumatism. No history of injury or debauch.

Family history excellent. Married with healthy family. Declares he never had a day's illness in his life, and now feels perfectly well. He is a strong-looking, healthy man. Voice exactly the same as when first noticed to be different from the normal. No dysphagia, but he cannot drink large gulps of anything—all his fluid he is obliged to sip. Eyesight good, pupil reflexes normal; knee-jerks normal. Can stand perfectly with eyes shut. Chest normal. No dulness. No dyspnœa. When first seen, on January 25th, mucous membrane of larynx healthy. No swelling anywhere. The left cord fixed and moveable, quite on the middle line. The cord itself appeared quite healthy. The right moved well, and was in all respects normal. The voice is somewhat gruff, but is loud and fairly strong. There is no evidence of perichondritis nor of intra-thoracic disease.

The case seems to be one of paralysis of the cord without a discoverable cause. May it be an early stage of some central disease?

Dr. Milsom Rees thought the case was one of simple rheumatic paralysis from cold.

Dr. Scanes Spicer considered the paralysis due to intra-thoracic trouble, as there was no abnormality in the larynx.

Mr. Symonds, in reply, stated that he had not examined the chest himself, but would do so. It had been examined by his clinical assistant and pronounced normal.

Paralysis of Left Vocal Cord after Injury.

This case was shown by Mr. Symonds. L. H—, æt. 56, came to Guy's Hospital, January 11th, 1895. One week before was looking after a steam elevator, which was above him. As he was speaking to some one below it came down, crushing him severely about the upper

part of the chest. Does not think his neck was hurt. Immediately on recovering he found his voice had disappeared. No hæmorrhage. No pain. No dysphagia. No history of syphilis, phthisis, or rheumatism.

Examination.—Left cord red and fixed on phonation, not quite in middle line, nearer adduction than abduction. The arytænoid did not move at all. Nothing found in chest to account for symptoms. No sign of external injury. Right cord normal. On January 25th the left cord has approached the middle line and occupied a mid-position; is immoveable. Some dysphagia the last ten days.

February 8th.—Larynx remains the same. A full-sized bougie passed is caught at the cricoid, evidently from muscular spasm. The man speaks in a whisper, but can copy a low laryngeal note; the aphonia is presumed to be nervous. No sign of aneurism or malignant disease.

Mr. SYMONDS was disposed to think that the paralysis may have existed before the injury.

The PRESIDENT said it was difficult to say if it was caused by the injury, but as the position of the cord had altered at different times he would say yes. He considered the aphonia to be neurotic.

PACHYDERMIA LARYNGIS.

Mr. SYMONDS again showed the case of Mr. H—. The swelling on the left cord was still present. It has gradually diminished in size; the nodular character has nearly all disappeared. At the present time the swelling is more marked posteriorly, where it is abrupt and elevated while in front it is flatter and smoother. The cord itself is fairly normal, and the opposite side is free. The cord moves freely. The voice is strong and clear for the most part, but at times is gruff. The patient at first took iodide of potassium, but has for some weeks taken mercury. No local treatment beyond rest has been employed.

Drawings illustrating the various stages, which had been made by Dr. Waggett, were shown.

Dr. WARNER said this case had more or less redness of the throat for some time, but this had increased considerably two days ago. Some years ago he suffered from granular pharyngitis.

Dr. WAGGETT suggested absolute silence as treatment, and mentioned a case he had seen in conjunction with the President which under this treatment had greatly improved; Leiter's tubes and iodide

of potassium had also been used. He thought in Dr. Symonds' case the vocal cords had become much redder, and over an increased area.

Pachydermia Laryngis.

This case was shown by Dr. Tilley. Mrs. S—, æt. 52, came to the London Throat Hospital complaining of a feeling of suffocation in the throat, more especially at night, occasional darting pain in left ear, and hoarseness. Complaint came on twenty years ago, six months before a confinement, and some sixteen years after coming to England—was born in Germany. Has been twice married; first husband died of cancer, second husband had suffered for five years from ulcers on the legs. Has drunk beer freely since childhood, and latterly has taken in addition a half quartern of rum when the suffocating feelings come on, which is pretty frequently. Had tonsils removed at Middlesex Hospital two years ago. At London Throat Hospital some varicose veins at the base of the tongue were burnt, and gave great relief for two or three months.

Examination.—Vocal cord congested and thickened; outward movements limited. Shreds of dry adherent mucus in various parts of larynx. In interarytænoid fold is a large and well-marked swelling of somewhat triangular outline; traversing this mass in a direction from above downwards is a fissure. The points of interest are the rarity of the affection in women; the important ætiological factor of alcohol; the position of the disease in the interarytænoid fold; the fissure through the growth, which probably accounted for the pain; and the slight immobility of the vocal cords, probably due to chronic inflammation.

Dr. Waggett had seen the case at the London Throat Hospital, had painted it regularly with perchloride of iron, and the voice was quite recovered for three weeks.

The President said these cases were extremely rare here, but very common in Vienna, and in answer to Dr. Law attributed this frequency to beer-drinking.

Mr. Hill supposed that attrition must be present in pachydermia.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *March 13th*, 1895.

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

SCANES SPICER, M.D.,
W. R. H. STEWART, F.R.C.S., } Secretaries.

Present—19 Members and 10 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were elected members of the Society:

George C. Cathcart, M.B., C.M., London.
Alex. H. Gordon, M.B., B.C., London.
Bruce Hamilton, M.R.C.S., L.R.C.P., London.
Percy Jakins, M.R.C.S., London.
T. E. Foster Macgeagh, M.D., M.R.C.S., London.
G. Calwall Stephen, M.D., L.R.C.P., London.

The following candidate was proposed for election:

Arthur Sandford, M.D., M.Ch., Cork, Ireland.

DISCUSSION ON THE DIAGNOSIS AND TREATMENT OF EMPYEMA OF THE ANTRUM OF HIGHMORE.

The PRESIDENT in the name of the Society offered a cordial welcome to the members of the Odontological Society present, and stated that, although the diagnosis and treatment of empyema of the antrum had of late years been frequently discussed, yet at a recent meeting of the Laryngological Society such a difference of experience with regard to the results of treatment and to the methods employed had become apparent, that the Council of the Society had considered it desirable to choose this subject for general discussion. What was required was not any academic discussion of the whole subject of empyema of the maxillary sinus, but brief and practical statements as to the methods employed by various observers, and as to the final results they had

obtained, together with such points of diagnostic importance as they had found of particular value. He invited remarks to be made in this spirit.

Dr. Adolph Bronner thought that one ought to distinguish between the mild and severe cases. The former were mostly due to nasal disease, and could be cured by treatment through the middle or inferior meatus, as suggested by Mikulicz. If syringing with boric acid did not effect a cure, the insufflation of powder was to be recommended. At first boric acid and iodoform should be used, and then the iodoform should be discontinued and aristol be used. Iodoform often caused abnormal growth of granulation tissue. If a diseased tooth were found, this should be removed, and the antrum opened through the alveolus. The patient could syringe or blow in powder through a small eustachian catheter. In cases where there was a polypus or much granulation tissue the canine fossa should be opened and the finger introduced, and if necessary the antrum scraped with a sharp spoon. It was not always necessary to introduce through and keep a tube in the alveolar process when this was opened. In answer to the President he stated that 40 per cent. of his cases were cured, the length of time taken being under five or six months. In answer to Dr. Spicer, he stated that the deformities caused by a large opening in the canine fossa were a falling in of the face, which thus did not present a symmetrical appearance, and the growth in a wrong direction of the teeth.

Dr. Greville MacDonald maintained that it was the custom to trust for diagnosis too implicitly on the replacement of pus in the middle meatus on bending forward the head. He had seen at least a dozen cases, some of them associated with antrum disease, others not, where suppuration in the frontal sinus produced the same phenomenon. He likened the condition of the latter case to a narrow-necked bottle, which, held in an inverted position, would not allow its contents to escape without ocaasionally being placed on its side to allow the air to enter. As far as treatment was concerned, and his remarks did not refer to cases with co-existent nose disease, he believed that the exploratory opening through the alveolar border, and drainage with the smallest size drainage-tube, were sufficient for the cure of recent cases, *i. e.* of not more than six months' duration. In those of longer existence he had occasionally found it necessary to make the large opening for the insertion of the finger, and after scraping away granulations, &c., he had always secured a cure. But in speaking of cure he would have it undertsood that he did not mean more than the cessation of suppuration, believing that chronic catarrh frequently remained in spite of all endeavours; and he maintained that such a catarrh would often make it desirable that some form of drainage should be permanently secured.

A letter was read from Dr. Cresswell Baber, who stated that in his opinion transillumination was a valuable aid in the diagnosis of empyema of the antrum. He attached special importance to the illumination of the outer half of the infra-orbital region, this being the part least accessible to rays transmitted through the nose and not through the antral cavity. Certainty of diagnosis could

only be arrived at by flushing out the antrum through the socket of a tooth or other opening, or aspirating through the inferior nasal meatus after the method of Moritz Schmidt. With regard to treatment, he always tried the alveolar method, first allowing the patient to syringe out himself with an antiseptic solution through a metallic eustachian catheter attached to a Higginson's syringe; and only when this method failed to arrest discharge did he resort to a larger opening in the same position or though the canine fossa for the purpose of exploration, and if necessary scraping and packing the cavity.

Dr. WILLIAM HILL read part of a letter from his colleague, Mr. Ernest Lane, who had been associated with him in the treatment of several cases of antral disease at St. Mary's Hospital, and who was unavoidably prevented from taking part in the discussion. Mr. Lane wrote, "From the experience gained, and on reviewing our cases, I am led to the conclusion that the most appropriate and rational method of treatment is that of opening the antrum *above* the alveolar process through the canine fossa, and thoroughly clearing out the cavity with Volckmann's spoon or other appropriate instrument. Bearing in mind the fact that in the majority of our cases—six out of seven—the walls of the maxillary antrum were covered with either soft and polypoid granulations or with genuine polypi, in addition to caseous débris, it seems to me to be an essential point in the treatment that the antrum should be thoroughly inspected, digitally explored, and radically treated by an adequate opening at a dependent part of the cavity, through which efficient drainage can afterwards be carried out." Dr. Hill, whilst endorsing Mr. Lane's remarks, explained that in the cases referred to the ordinary method of drainage and syringing, by a hole drilled through the socket of a tooth, had been first carried out for many months, and in one case for two years, with most unsatisfactory results. He felt certain that the morbid contents of the antral cavities in these cases could *never* have been cured by the application of any lotions or powders at present in surgical use. It was as futile to expect such a result in the case of antral polypi and granulomata as in the case of similar disease in the nose and ear. Instrumental removal was the only rational treatment. If a case with obvious antral disease associated with nasal polypi, granulations about the uncinate body, came under his care, and was unrelieved after two months' treatment by the ordinary alveolar method, he would have no hesitation in recommending the thorough exploration of the antrum through a large opening in the canine fossa. He believed an additional opening in the nasal cavity, as recommended by Dr. Spicer, was often useful, especially when the *ostium maxillare* was blocked by an hypertrophied granular condition of the uncinate process. The radical operation he advocated was devoid of danger; he had never seen any deformity result. The œdema and pain in the cheek occasionally observed rarely lasted more than a week or two; certainly in one patient, an early case, the nasal duct had been slightly injured, either by a too vigorous curetting of the nasal wall of the antrum, or else from the counter opening into the nose having been made too far forward.

In answer to a question from the President as to the proportion

of cases in which the canine fossa operation had been resorted to, Dr. Hill admitted that his experience had not been large, but that the seven cases operated on radically had been very marked ones, and due to nasal disease; in three others he had been content with the alveolar method, but inasmuch as they had not long remained under observation he could only say they were relieved. Perhaps it was accidental that he had seen so large a proportion of cases in which the antrum was choked by growths, and which therefore could only be treated by a large opening; but it might be that he had failed to attach much importance, and even failed to diagnose the milder cases which had been described by members of the Society as yielding so readily to applications syringed into the cavity through a small hole.

Mr. WALSHAM said he considered that in empyema of the antrum, as elsewhere, the only absolute sign was the actual detection of pus on exploration. He, however, held that transillumination was of much value, and had practised it as a matter of routine in all cases in which pus in the antrum was suspected. In some cases in which pus had been detected, there had been merely a shadow below the eyelid of the affected side, the rest of the face lighting up. In two or three instances of what turned out subsequently to be empyema of the antrum no pus could be discovered in the nose, the only symptom calling attention to the affection having been intermittent fœtor, and this in one instance was only evident to the patient himself. A marked dulness to percussion on the affected side has been observed in a few cases. He had practised exploration through the inferior meatus, an empty alveolus, and the canine fossa. The first method he considered a useful one in nervous patients, since the puncture could be made under cocaine. As he was accustomed, however, to drain either through an alveolus or canine fossa, he preferred as a rule to puncture at one of these situations under gas, as the one operation then sufficed. Of the two last methods, he only punctured through an alveolus when a tooth was absent or carious. He would on no account remove a sound tooth for the purpose. He generally succeeded by merely washing out, leaving the small spiral tube *in situ* during the intervals. In exceptional cases he had had to make a larger opening through the canine fossa, introduce his finger, and scrape out the cavity. In answer to Dr. Hill, he said the material removed was granulation-like matter. He had not had to remove anything like true polypi from the cavity. He had met with an instance in his own practice where the large opening thus made had not closed, but remained as a discharging sinus, and he had seen another case in which such an opening had been made by a distinguished rhinologist several years previously, which had also remained open and continued to discharge. He wished to know the experience of others on the subject. He had not found patients had been troubled, where the spiral tube had been used either in an alveolus or in the canine fossa, by food passing into the antrum. Dr. Hill said that so far from having to complain of the hole in the canine fossa remaining patent, the difficulty in his experience had been to prevent it healing too soon. Dr. Greville Macdonald, on the other hand, stated that in his experience the wound never healed.

Dr. DUNDAS GRANT agreed with Dr. Greville Macdonald that the presence of muco-pus in the middle meatus was in itself quite insufficient evidence on which to found a diagnosis of empyema of the antrum. He considered transillumination of the greatest value; by its means we could sometimes eliminate antrum empyema absolutely from the presence of translucency, and thus prevent unnecessary operative interference. Opacity was not of equally positive significance. He relied chiefly on the exploratory puncture and irrigation of the antrum by the introduction of Lichtwitz's fine trocar and cannula through the outer wall of the inferior meatus. The revelation of pus by this method was very convincing to the patient, the temporary comfort obtained inducing greater readiness to undergo further remedial treatment. He had not found irrigation through the natural orifice, as Garel had described, at all easy, even when he employed a cannula of Garel's own pattern. He thought it of great importance to diagnose the cause if possible. He attributed the disease to nasal causes in the absence of the characteristic dental fœtor, and of obvious dental disease, especially if the affection appeared to originate in a well-marked coryza, or there were some other intra-nasal cause, such as a frontal sinusitis. (He had a case of frontal sinus suppuration without at first any antral disease. The nasal suppuration persisted in spite of the apparent cure of the frontal condition. On re-investigating the antrum a secondary suppuration of that cavity was detected, which yielded readily to internasal treatment by means of Krause's trocar.) In presence of a diseased tooth in the appropriate position, or with a history of dental pain preceding the nasal dischage, he would ascribe the antral empyema to dental disease. His cases had, as a rule, been treated by the alveolar method, but some by means of a small perforation in the canine fossa. Those cases seemed to have done best in which a tube was carefully fitted by the dentist, and in which peroxide of hydrogen was the antiseptic employed. He thought it possible the alveolar puncture was too exclusively employed, for although the opening was in the lowest position it was not used for drainage, but as an orifice of entrance for the irrigating fluid. It was a possible source of infection of the antrum by some of the numerous bacteria inhabiting the mouth; and in those cases in which pus did not appear at the time of the puncture, but later on, he thought that in some instances at least this process of infection would account for it. Alveolar puncture was not always easy, as the antrum was sometimes very small and situated far inwards, while the alveolar process extended far outwards. Under such circumstances it was easily possible to miss the antrum, and he had seen even in the hands of an experienced operator the puncture so made that the fluid used for irrigation was extravasated into the tissues over the antrum, causing a large painful swelling of the cheek. The great facility with which the patient could practise irrigation for himself was the crowning advantage of the alveolar operation. He had, however, seen several cases in which, after long-continued alveolar irrigation, a degree of improvement was obtained which remained stationary. Rapid advance took place when there

was superadded the method of treatment by means of Krause's trocar, and still more as soon as the alveolar opening was got to close. Dr. Grant had by latter method of treatment effected cures in two cases in a few weeks. The irrigations were practised thrice, then only twice a week. After each irrigation, air was blown in to dry out the cavity, and europhen or iodoform insufflated. He recommended the adoption of this method in cases in which (1) there was no evidence of dental origin or the presence of diseased teeth, (2) when the patient could easily attend for irrigation by skilled hands, or (3) in which the alveolar opening had been maintained for a long time and the disease had reached a stationary stage, before resorting to the more extensive operation through the outer wall of the antrum. In cases where alveolar puncture was badly borne or unsatisfactory the nasal operation was certainly advisable.

Dr. Scanes Spicer said that transillumination was in many cases of decided value and clinched the diagnosis. Relative opacity of one side combined with positive rhinoscopic and symptomatic evidence afforded the strongest presumption of antral empyema, and justified exploratory puncture. Taken alone, however, transillumination was not conclusive, since the bones may not be bilaterally symmetrical in thickness, or the antra in size, shape, and partitioning—circumstances which must affect the transmission of light through the face. He attributed more value to the comparison of the areæ below the lower lids than to the lighting up or not of the pupils, which latter phenomenon appeared to be much less common normally than the former. On the other hand, bilaterally symmetrical opacity of cheek tissues and non-illumination of pupils do not indicate double antral empyema, nor do they exclude empyema of one or both cavities. In a large number of healthy subjects such opacity is found. With reference to the subjective perception of light on transillumination, a dull red glow may be felt on the healthy side to contrast strongly with the absence of such on the side of the empyema. This observation was made for the first time, it is believed, by a former colleague when the latter was transilluminated four years ago for antral empyema. He had not had a single *cure* on treating *chronic* antral empyema by the usual openings through the alveolar ridge. He had, with the co-operation of skilled dentists, for some time made these openings, and had had adapted to them gold tubes fitted to artificial palates, or to small plates attached to adjacent teeth. Such tubes (and plates), in his experience, always caused, sooner or later, irritation, pain, and perpetuated suppuration, The cases went on washing out for many months or years, and were not followed by cure. He had treated all his earlier cases in this way. It is true they were chronic cases, and had well-marked intranasal disease, polypi, granulations, necrosis, or fœtid purulent rhinorrhœa. He had therefore been led to look about for some method of shortening the period of treatment, and that of Dr. Robertson appeared to meet some of the indications, in removing the membrane secreting the pus and in providing freer drainage; but it had the disadvantage of requiring a mechanical drain. He had therefore conceived the idea of adding to the canine fossa opening a large one from the inferior

nasal meatus, well behind nasal duct, opening into the antrum with a Krause's trocar and cannula, so that the patient could keep the antrum clear, after curettement, by blowing air from nose through antrum to mouth and *vice versâ* constantly, and also washing antrum out frequently by forcing antiseptic washes through from mouth. This addition largely diminishes the tendency of the bucco-antral opening to close, though should it do so the passage is easily restored after cocainisation by incision and dilating forceps, and renders abolition of drainage apparatus practicable. After curettement suppuration diminishes *pari passu* with contraction of bucco-antral opening, and often entirely ceases, leaving a small permanent potential bucco-antral nasal fistula which gives rise to no symptoms, and is rather to be treasured as an emergency exit for antral secretions, or safety-valve through which the antrum can be blown out. The objections which had been raised against this operation were its severity, that deformity was caused, that chronic toothache followed, and that smokers could not draw their pipes properly. As to the severity, the temperature frequently never rose at all, and patients need not usually be confined to their room more than a few days. In all the cases in which he had operated by this method (now about twenty) he had never on any occasion found any approach to either of the other objections which had been raised, and he could only regard them as theoretical as applied to the operation he had described. The real objections to the operation lay in the time and patience requisite to effect it thoroughly and without injury to nasal duct, infra-orbital nerve, or dental nerves, and the impossibility of guaranteeing in every case that the bucco-antral opening would not require incision and dilation owing to growing over of soft parts too soon. These appeared to him small inconveniences compared with the positive advantages of measuring the period of cure of antral empyema by weeks instead of by months or years, which was what he claimed for it.

Dr. BALL considered the important practical point was whether any very radical treatment should be employed at the outset, or whether this should be deferred until simple means had failed. His own opinion was that simple means should be tried first. An opening should be made in the alveolar border whenever this was possible; otherwise in the canine fossa, and irrigation of the cavity should be practised in the usual manner. He had followed this plan in sixteen cases. In all these cases the opening was made in the alveolar process. Of these sixteen cases, six had got well after a varying number of months, and had remained well after removal of the tube and closure of the orifice. Of the remaining ten cases, three were abroad, and one had been lost sight of, and he could not say what their condition was. Three declined any further interference, as they were satisfied to keep themselves comfortable by washing out the antrum daily. In three cases he had enlarged the alveolar opening sufficiently to pack the cavity with iodoform gauze, and had kept it packed for a week or two, changing the gauze daily, until the opening had contracted so much that it was no longer easy to pack the cavity. After that the cavity was washed out daily. Two of these cases got

well, the third was not in any way benefited. He therefore quite agreed that there would always be a residuum of cases which would require very radical treatment, and probably in these cases Dr. Spicer's method would prove the most effectual.

Mr. Walter Spencer mentioned three cases of pus in the antrum which differed widely from those upon which the discussion had taken place, since the pus was formed in connection with acute necrosis of the jaw. In one case he removed the alveolar process of the superior maxilla, which had become necrosed, thus taking away the floor of the antrum. The case was shown some time ago at the Clinical Society, when the whole dome of the antrum could be easily seen. Another case had been previously treated by an incision through the cheek, and several attempts had been made to remove portions of the maxilla. When first seen by Mr. Spencer, a most ugly puckering of the cheek had been produced without any relief to the suppuration. A wide alveolar opening was made, and the case soon got well. A third case seen post mortem had died of septicæmia from acute necrosis of the maxilla, and pus was found in the antrum and in the spheno-maxillary fossa. All three cases were considered to be syphilitic in origin.

The President observed that the discussion had clearly shown how widely the experiences and opinions of various members differed in this question, and how impossible it was as yet to draw from it any general lessons. He must range himself decidedly by the side of Dr. Ball in believing that the more heroic measures ought only to be adopted after the failure of the milder means. He may perhaps have been fortunate in his own results, but, having treated in conjunction with Mr. England between twenty and twenty-five cases in private practice during the last few years, in the overwhelming majority of cases the alveolar method, with subsequent insertion of a golden tube and washing out the antrum through that tube by means of a Christopher Heath's apparatus, had answered admirably. He wished, however, to lay particular stress upon the necessity of giving most minute directions to the patients as to the after-treatment which they had to carry out themselves. One always was between the Scylla and Charybdis of their doing either too little, and thereby allowing pus to decompose in the antrum itself, or of their overdoing the washing out, and thereby never allowing the mucous membrane to come to a condition of rest. The rules which he had adopted were as follows:— The operation having been performed, and the tube having been inserted, he saw the patients once again after the operation. On that occasion he prescribed for them a weak solution of some astringent, usually sulphate of zinc, not stronger than ten grains to the ounce, of which solution one teaspoonful was to be added to a tumblerful of tepid water for each injection. The patient was to sit before a mirror, so as to be able to see the fluid come out from his nose. As soon as the patient observed that the fluid returned clean from the nostril, *i. e.* neither being turbid nor having flecks of pus mixed with the water, he was to stop injecting immediately. This proceeding was to be adopted at first twice daily; later on, as soon as the pus diminished, once daily. When, after the lapse of twenty-four hours, hardly any

pus was evacuated on syringing, the washing out was only to be performed on alternate days; on further diminution occurring every third day, and so on, until finally a week's interval was reached. When, after the lapse of a full week, on injection no pus was evacuated, the patient was directed to make an appointment with him (the speaker) a week afterwards, and meanwhile to leave the part quite alone. On the occasion of the interview he (the speaker himself) washed the antrum out, and if then no pus came out, the time had come for removing the tube. In this manner he had not merely succeeded in curing the great majority of his patients, although amongst them cases had been in which the disease had in all probability existed for a great many years, but he had been able to convince himself of the actual fact that the cure had been obtained, and he therefore warmly recommended this method. Should it fail, as no doubt occasionally it must if there were either necrosed bone or formation of granulations or polypi, &c., in the antrum, more energetic measures were of course indicated. But he regretted to say that in the few cases in which he had been compelled to resort to a broad opening through the canine fossa, with scraping out of the cavity and subsequent packing with dry iodoform gauze, &c., his results had not been very satisfactory.

Mr. England showed the tube he always made for these cases fitted to a cast of the mouth. It consisted of a plain straight gold tube, attached to a plate which fitted to the alveolus and round the teeth on either side. The mouth of the tube was closed with a split plug, which could be removed easily by the patient.

Erratum.

Dr. Pegler desires to correct an error appearing under his name in the last report of 'Proceedings' with reference to Dr. Law's case of nasal obstruction. He intended to imply at the time that he disapproved of the term papilloma as applied to anterior hypertrophies of the inferior turbinal, since after making a number of microscopical sections of such growths he had never succeeded in tracing any analogy between that structure and that of a true papilloma.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *April 10th*, 1895.

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

SCANES SPICER, M.D.,
W. R. H. STEWART, F.R.C.S., } Secretaries.

Present—29 members and 4 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentleman was elected a member of the Society:

Arthur Sandford, M.D., M.Ch., Cork, Ireland.

The following candidate was proposed for election:

David Moore Lindsay, L.R.C.P., L.R.C.S.I., Salt Lake City, U.S.A.

Dr. Foster Macgeagh and Dr. A. Knyvett Gordon were called to the table, and having signed the Register were admitted members of the Society by the President.

PAPILLOMA OF THE NOSE.

Mr. CRESSWELL BABER showed this case. Rev. —, æt. 36, first noticed a growth in his left nostril two years ago. In August, 1894, it was removed by another surgeon, and pronounced after microscopic examination to be a papilloma. It grew from the floor of the nose, and was entirely removed, the left ala being slit up for the purpose. Two months after the operation it appeared again as a small papilla on the floor of the nose. Condition when seen on March 7th, 1895, was as follows:—In the left nasal cavity there is a firm mammillated growth, like a small mulberry, projecting into the vestibule, and extending backwards about three quarters of an inch.

It is attached by a broad base to the floor of the nasal cavity and to the septum. Just behind the tumour is a deflection of the septum, through which there is a clear-cut perforation about one eighth of an inch in diameter. Right nasal cavity normal except that it shows the concavity of the deflection and the perforation. By posterior rhinoscopy (with palate hook) the parts are found normal excepting a slight swelling on the left side of the septum, probably unconnected with the growth. There are no enlarged glands. There is no history of syphilis. A small piece from the upper part of the growth was removed for microscopical examination with the cold snare, but it proved so firm that the screw of the snare had to be brought into requisition. The microscopic examination showed only hyperplasia of structure, and no malignant elements. The patient has a flat wart on his head, which he is in the habit of picking, and it has been suggested that the nasal cavity may have been directly inoculated by means of the finger.

Mr. Baber wished to have the opinion of the members with regard to the nature of a further operation.

Mr. Butlin advised the free excision of the growth, and the destruction of the remains with the galvano-cautery. He considered the growth extremely active for an innocent one.

Case of Lupus of the Throat and Nose.

This case was shown by Dr. J. B. Ball. Emma K—, æt. 14, was admitted to the West London Hospital on March 5th, 1895, suffering from hoarseness and laryngeal dyspnœa. She first complained of her throat about eighteen months previously, and had attended at a London hospital for some months, when she was told that she was suffering from lupus of the palate. Has had no treatment during the last nine months. Has suffered from obstruction and crusting in the nose for some months. Two months previous to admission had a sore patch on the left side of the neck. The hoarseness commenced about the end of December, 1894, and for two or three weeks previous to admission the breathing had been noisy, especially at night.

Patient was a fairly healthy-looking girl, though rather thin. No history of phthisis. The voice was husky, and there was well-marked laryngeal stridor and slight cough; no pain or dysphagia. There was some enlargement of the glands under the angles of the jaw, especially

on the right side. On the left side of the neck, a little below the ear, was a patch of lupoid ulceration about the size of a florin, covered with crust. The gums were normal. The whole of the anterior aspect of the soft palate presented a coarsely granular surface, with here and there some fine cicatricial striæ. The granular appearance extended forward on to the hard palate for a little distance. The pillars of the fauces, especially the right, were thickened, and studded with fine granules. Epiglottis appeared to be partially eaten away; it was thickened, and its free edge presented some large pale nodules. The aryepiglottic folds and arytænoids were swollen and pale. The ventricular bands thickened, slightly nodular, especially the left, and the edges of the cords, which were just visible, seemed uneven. On deep respiration the cords were not freely abducted. Both nostrils were blocked with crusts. On removal of these an ulcerated surface was exposed, occupying both sides of the septum nasi, extending from a little above the columna for about three quarters of an inch, and involving the floor of the nose and the fore-part of the inferior turbinated body on each side. About half an inch above the columna there was a small perforation through the septum. Chest normal. Patient has been in the hospital since March 5th, and has taken cod-liver oil and arsenic. The ulcerated patch on the neck has been scraped, and has cicatrised. The nose has also been scraped, and is much improved. The laryngeal dyspnœa has quite disappeared, apparently owing to a diminution of the nodular thickening of the ventricular bands, and there is a freer mobility of the vocal cords. The general condition of the throat is improved.

In view of the apparent improvement, and of good results obtained in a similar case recently exhibited by the President, under the administration of cod-liver oil and arsenic, it is intended for the present not to apply any active local treatment to the throat.

Mr. C. Symonds inquired if thyroid extract had been given, as he had seen cases in which remarkable results had followed its administration.

In reply, Dr. Ball stated that he had not yet used the extract, as the case was doing so well without it.

A Case of Nasal Deformity of Traumatic Origin.

Shown by Dr. J. B. Ball. May M—, æt. 15, a healthy-looking girl, came to the West London Hospital with a view to having an operation done to improve the appearance of her nose. When four and a half years old she had received a violent blow on the nose with the fist. The nose bled very much, the under part was severed from the face, and it was a long time before the parts were healed. At present the nose is broad and flattened, the nasal bones being depressed and spread out. There is a transverse groove across the nose at the line of junction of the nasal bones and lateral cartilages. The plane of the anterior nares is directed somewhat forwards. The anterior part of the septal cartilage is destroyed, as well as a portion of the columna, only a stump of the latter remaining in front and behind. There is a communication running from the anterior part of the floor of the nose into the mouth, between the upper lip and the alveolar process.

The general appearance of the parts rather suggests some destructive disease, such as syphilis, as the cause, but the history of a traumatic origin is very definite, and there is nothing in the family or personal history to indicate syphilis. My colleague, Mr. Keetley, proposes to operate, and the case is shown partly on account of the peculiar deformity of traumatic origin, and partly with a view of eliciting suggestions as to the best means of remedying the deformity.

Mr. Knyvett Gordon showed—

1. A section of a middle turbinate body with polypus formation.

Though there was no dead bone to be seen or felt in the nose, and no operation had been performed n that situation, yet there was, microscopically, well-marked caries of the bone, as shown by the destruction of tissue with well-marked small-celled infiltration and numerous osteoclasts.

Dr. Hill thought the specimen was exactly like that described by Woakes.

Mr. Symonds asked how the specimen differed from normal bone. He could see some change at the edge of the specimen, but none in the bone itself.

Dr. S. Spicer said that clinically this was a case of ordinary polypus; was he to infer that ordinary polypi lead to absorption of bone?

Mr. Gordon, in reply to Dr. William Hill, stated that he was inclined to regard cases such as this as an early stage of Dr. Woakes's "cleavage."

In reply to Mr. Charters Symonds, he said that the presence and position of the osteoclasts with the small-celled infiltration had led him to the diagnosis of caries.

2. Sections of masses curetted from the antrum maxillare in cases of empyema, by Dr. Scanes Spicer.

These showed marked proliferation of the mucous glands in the lining membrane, the epithelium of which was in a state of active secretion. The proliferation was so great as almost to justify him in describing the growth as an adenoma.

Empyema of Antrum entirely cured by Treatment by means of Krause's Trocar.

Shown by Dr. Dundas Grant. Diagnosis was made by means of transillumination and Lichtwitz's exploratory irrigation in June, 1894, while under care of Dr. Wallis Ord for epileptic fits. The nasal discharge and obstruction had existed for some years.

A perforation was made through alveolus on July 9th, when fluid came through the nose, but pain and swelling occurred in the cheek. It was later determined to try intra-nasal treatment only.

Krause's trocar was used in September, and through it the antrum was washed out twice or thrice a week with sanitas lotion. In a few weeks the discharge had completely stopped, and has not since returned. Since the improvement in the condition of his nose the epileptic fits have almost entirely disappeared, though of course he has not left off his regular bromide.

Empyema of the Antrum of Highmore, complicated with Suppuration of (probably) the Frontal Sinus.

Shown by Dr. Dundas Grant. A young Scotchman, who for about two and a half years had a fœtid nasal discharge on the left side, and had suffered a good deal of treatment at various hands, came to me in October last.

Empyema of the antrum was diagnosed by means of transillumination and Lichtwitz's trocar. Krause's trocar treatment was instituted and some relief afforded, but still more when the alveolar perforation

was made and daily irrigation practised. The discharge fluctuated in amount to an unusual degree, and it was observed that after washing out the antrum with apparent completeness a return of discharge occurred within a few minutes. On inspection this could be seen to spring from the upper part of the semilunar hiatus, and more could be washed out by means of Hartmann's frontal sinus tube. Puncture of the bulla ethmoidalis revealed no ethmoidal pus. I have recommended external opening of the left frontal sinus, but the patient is unwilling to submit to it.

Case of Empyema of the Antrum under Treatment by means of Krause's Trocar.

Shown by Dr. Dundas Grant. A young married woman, suffering from nasal suppuration of old standing.

Her antrum was opened through the alveolus of an extracted tooth two years ago, and she practised irrigation with soda solution, followed by the injection of a little peroxide of hydrogen. Irrigation was to be practised twice or thrice a week, and in seven months she seemed well, the condition remaining apparently stationary till five months ago. She returned to me about two months ago.

Krause's trocar was ntroduced about five weeks ago; the antrum was freely washed out and inflated, so as to blow out the remaining moisture, and europhen was insufflated through the cannula.

Great diminution in the amount of discharge has taken place, and she can get on comfortably with much less frequent irrigation, though at present she is unable to go for a week without it.

Case of Empyema of the Antrum greatly benefited by the Use of Krause's Trocar and Cannula, and Closure of the Alveolar Perforation.

Shown by Dr. Dundas Grant. A gentleman æt. 55, who first suffered from nasal discharge about 1884. Numerous polypoid growths were removed from time to time down to 1894.

Antral empyema was diagnosed in February, 1894, and alveolar irrigation was carried on up till the last two months, when no further improvement seemed to accrue.

In October, 1894, Krause's trocar was used, and irrigation followed by drying and insufflation of antiseptic powders (of which europhen was found to be the best) was continued at gradually increasing intervals. Alveolar irrigation was gradually left off, and the discharge diminished. The alveolar opening was allowed to close in February of this year, and still greater improvement took place.

He left town five weeks ago, and omitted all treatment, the nasal condition causing hardly any inconvenience. He has just returned, but on irrigation fetid muco-pus could be evacuated.

Empyema of the Antrum secondary to Suppuration in the Frontal Sinus treated by means of Krause's Trocar with Good Result.

Shown by Dr. Dundas Grant. Referred to him by Dr. Graham Grant in July, 1892, on account of pain in left front region and discharge of fetid pus from the left nostril. Antral disease was excluded by means of transillumination and Lichtwitz's puncture.

A small external opening was made in February, 1893, and pus revealed. Drainage and irrigation were practised with very slight improvement. The anterior part of middle turbinal was removed, but even then the discharge persisted in spite of apparent improvement of the condition of the frontal sinus.

The sinus was widely opened by means of gouge-forceps in June, 1894, and the granulating lining was thoroughly scraped. The nasal discharge continuing, the antrum was again examined, and proved to be the seat of an empyema. In a few weeks the suppuration entirely disappeared under treatment by means of Krause's trocar.

A Case of Tubercular Laryngitis.

Previously shown at an early meeting of the Society by Dr. Dundas Grant. The ulceration was on the former occasion almost entirely confined to the region of the right vocal process, and may be remembered as presenting, on a mass of pale granulations at that point, a white spot where the galvano-cautery had been applied. Since that time the patient has been residing in Jersey, his voice has got more hoarse again, and his cough more frequent. Tubercle

bacilli have been detected (though formerly absent) but no pulmonary lesion can be demonstrated. The granulations in the region specified have become more exuberant, and there has developed a shallow longitudinal fissure just below the edge of the opposite (left) vocal cord.

The laryngeal symptoms are diminishing, and the local signs becoming less marked under almost daily application of pure lactic acid.

The PRESIDENT said he had been asked how long his cases treated by the simple methods lasted. He would say, taking them in the broadest sense, an average of three or four months. He had a letter for Dr. Brady about one case which had gone to Australia, and which had lasted between one and two months.

Dr. HALL suggested that in this case the pure air of the sea voyage had operated beneficially.

Mr. C. SYMONDS said that as it was presumed the good effect in these cases was due to drainage, he did not see that the meatal opening was superior to the alveolar.

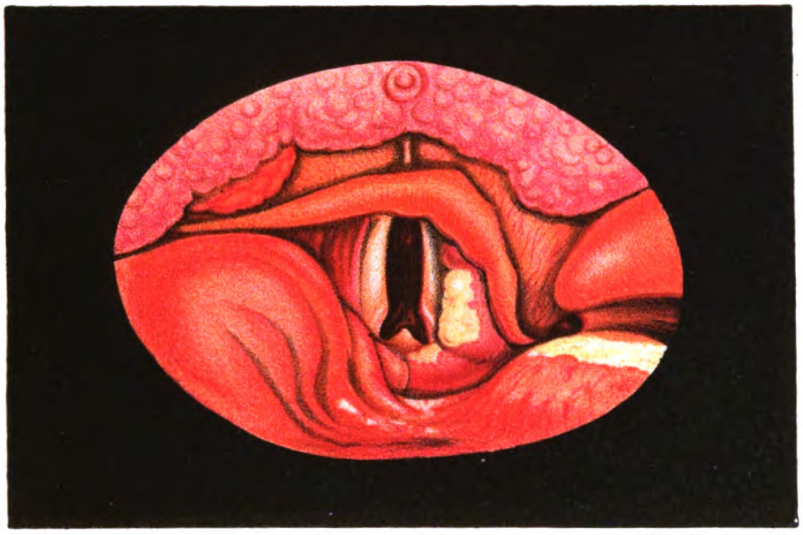
Dr. BALL thought the advantages of Krause's trocar depended on whether it was better to use the dry treatment with powder once a week, or fluid daily.

Dr. LAW asked if europhen was more efficacious than iodoform.

Dr. GRANT, in reply, said he had been led to try the meatal plan on a patient who had a beautiful set of teeth, and would not agree to the alveolar operation. Also many cases operated on by the alveolar method became stationary, and one case improved greatly when the alveolar opening closed. He also thought it was possible for infection to spread through the opening. He would suggest it, too, as an alternative method of treatment. He had not given iodoform such a trial as he had europhen, but it was much better than any of the substitutes for iodoform, and had not the distinctive odour.

A CASE OF MYCOSIS FUNGOIDES.

Shown by Dr. DE HAVILLAND HALL. A man æt. 52, suffering from mycosis fungoides. The disease had existed for about two years and a half. There are numerous tumours all over the body and limbs. In October, 1894, he complained of sore throat, and has had more or less pain in the throat since, but the speech has not been affected. On the posterior and lateral walls of the pharynx there are small oval tumours, and on the left arytænoid cartilage there is a tumour about the size of a hazel-nut; the surface is superficially ulcerated. This is thought to be the first case in which the larynx has been attacked by mycosis fungoides.



DR. DE HAVILLAND HALL: CASE OF MYCOSIS FUNGOIDES.
(See page 70.)

The PRESIDENT suggested, and it was agreed to by the Society, that as Dr. Hall's case was unique, a drawing of it should be made for insertion in the 'Proceedings,' and Dr. Waggett was asked to make it.

DISEASE OF THE FRONTAL, ETHMOIDAL, AND MAXILLARY SINUSES IN ASSOCIATION WITH NASAL POLYPI.

Dr. WILLIAM HILL showed a patient, A. K—, æt. 34, who recently sought his advice at St. Mary's Hospital for pain in the nose and chronic headache. Nasal polypi had been removed fifteen years before. She suffered from a profuse purulent discharge, and the left nostril was blocked with mucous polypi; these were removed, and pus was then seen issuing from under the anterior extremity of the left middle turbinal, which was enlarged and bulbous; this end of the turbinal was cut off, and an ounce and a half of pus immediately came away, giving the patient instant relief. Granulations could then be seen and diseased bone felt in the neighbourhood of the ethmoidal cells. The left frontal sinus was tender on percussion, and the skin over it was red, and at times puffy; the left maxillary sinus was dark when tested by transillumination.

Whilst the amount of discharge in the neighbourhood of the hiatus semilunaris was not now abundant, a profuse flow of matter was constantly to be seen coming down between the middle turbinal and septum from the superior meatus, presumably from the posterior ethmoidal cells. The middle turbinal was very enlarged, but not cystic, and Dr. Hill thought that nothing short of removal of this bone would relieve the ethmoidal disease which was the prominent factor in the case. He was also prepared to open the frontal sinus by a vertical incision, and the antrum through the canine fossa. He hoped to show the patient again later.

EPITHELIOMA OF THE PHARYNX.

Dr. WILLIAM HILL also showed a man, æt. 44, who consulted him at St. Mary's Hospital a week previously complaining of pain in the throat rendering swallowing difficult, and a shooting pain in the ear. On laryngoscopic examination an ulcer was seen in the right glosso-

epiglottic fossa, extending into the pyriform fossa; the right posterior pillar and the right side of the epiglottis were œdematous, the edges of the ulcer were hard and prominent to the touch; there were some tender and slightly enlarged glands on the right side of the neck at the level of the hyoid bone. There was no history or indication of syphilis. The patient had the day before been digitally examined by students at the College examinations, and the pharynx was much swollen and œdematous in consequence, and less typical in appearance. It was proposed to perform pharyngotomy, and endeavour to remove the growth and the enlarged glands. Mr. Pepper has recommended and offered to carry out this treatment.

Microscopical Specimens illustrating Case of Multiple Papillomata of Larynx.

Shown by Dr. Hunt. C. W—, æt. 12, was operated on by Mr. Paul at the Liverpool Royal Infirmary on September 28th, 1893, when a large growth, which had so completely obstructed the larynx as to demand tracheotomy two months previously, was removed by thyrotomy (see Liverpool 'Med.-Chir. Journal,' January, 1894). This growth was described by Mr. Paul as having "all the microscopic characters which point to the least malignant form of spindle-celled sarcoma, without allowing any question that it is a genuine sarcoma, and not a simple benign growth."

Six months afterwards I made a laryngoscopic examination of the patient, as his breathing was again becoming difficult, and recurrence was feared. I then found the cavity of the larynx filled by two pale warty-looking growths, springing from the left ventricular band, evidently pedunculated, and freely moveable with the breath current. A third growth of a similar character was situated on the posterior surface of the left arytænoid. These growths were easily removed by means of Schroetter's forceps, and on microscopic examination were found to present the characters of simple papilloma.

During the past year I have on many occasions removed similar growths from this patient's larynx, originating from the vocal cords, the ventricular bands, and the aryepiglottic folds, but so far there has been no recurrence of the original growth which sprung from the under surface of the left cord.

The PRESIDENT asked if anyone had seen a similar case in which the usual order of events had been transposed, and papillomata had followed sarcoma.

Mr. BUTLIN had never seen such a case.

Dr. HUNT, in reply, stated that there was no real recurrence, and that the papillomata were situated on a different site though close to the former scar.

LARYNGEAL STENOSIS; POLYPOID GROWTH FROM LEFT VOCAL CORD.

Case shown at the January meeting, 1895, by Dr. PERCY KIDD. After tracheotomy had been performed, the growth on the left side and portions of the fleshy swollen vocal cords were removed with Mackenzie's cutting forceps. Much increase of the glottic space was obtained, the tracheotomy wound was allowed to close, and, for a time, the patient experienced considerable relief.

Microscopical examination of the tumour revealed a well-marked papillomatous structure, with slight, small-celled infiltration of the submucosa, but no appearances of tuberculosis.

Early in March the patient's general condition began to deteriorate, the chief symptoms being progressive weakness, loss of flesh, moderate remittent pyrexia, and pain on swallowing.

The laryngoscope now showed swelling over both arytænoid cartilages, with some ulceration over the right. Examination of the chest gave no constant results. The sputum was examined seven times with a negative result, but a week ago tubercle bacilli were detected on two occasions. The physical signs now indicate infiltration of the apices of both lungs.

Present condition of the larynx:—Epiglottis swollen on right side. Much pale tumefaction over both arytænoid cartilages, with sloughy ulceration of the superior and laryngeal surface of the right. Both vocal cords of pale pink colour, and irregularly thickened. At the posterior end of the right cord is a small sessile reddish outgrowth Vocal cords motionless, lying close together and causing considerable stenosis of the glottis.

Case of Empyema of the Antrum of Highmore.

Dr. Scanes Spicer showed this case.

The President congratulated Dr. Spicer on the improved condition of the patient, he having since the operation fourteen days previously gained 11 lbs. The result of treatment in these cases by the members of the Society was most gratifying.

A Case in which a very Large and Hard Fibro-papilloma of the Larynx has caused Indentation of the Opposite Vocal Cord.

Shown by The President. The patient is a man aged about 40, who two years ago began to suffer from hoarseness, soon followed by dyspnœa and complete loss of voice. The difficulty of breathing became so great that tracheotomy had to be performed. Laryngoscopic examination showed an enormous tumour growing from the left side of the larynx, the exact origin of which could at that time not be made out, and completely filling the vocal organ. A fear was expressed that this might be malignant, and external operation had already been contemplated, when Dr. Johnson Smith, of Greenwich, sent the patient to Dr. Semon. The intra-laryngeal removal and subsequent microscopic examination (Mr. Shattock) of some fragments, however, showed that the tumour was of benign character, and it has in the course of several sittings been reduced to its present size, which is about that of a large bean. The interesting feature of the case is the fact that the right vocal cord is deeply eroded, corresponding to the pressure which the growth in its original size exercised upon it.

Mr. Symonds asked whether the opposing vocal cord in this case was absorbed or eroded.

The President stated that he could not say at present, as the time since the growth was removed was too short. It was quite possible, however, that absorption had taken place.

Suppuration of Frontal Sinus.

Mr. Symonds showed this case. Rev. J. E— consulted me on November 1st, 1892, for a foul discharge from the left nostril of seven years' duration. The left upper first molar had been removed just

after the discharge began. For six years he had been under treatment for what was described to him as "necrosing ethmoiditis," and had been cauterised regularly, but without relief. Three years ago a little discharge appeared on the right side, and this was also cauterised. The case was obviously one of empyema of the antrum, probably bilateral. Through the alveolus the left antrum was perforated, and much thick, foul pus forced through the nose. The nasal opening of the antrum was evidently small, and, on examining the nose, the middle turbinated was adherent to the outer wall, and the whole middle meatus blocked with adhesions, the result of the cautery. After removing the anterior end of the middle turbinated the stream came freely. Granulations still remained in the nose, and some pus escaped. In February, 1893, the right antrum was drained through the incisor fossa; much foul pus was found. In May this side was well, and the tube removed. Though little if any pus came through the nose when the antrum was syringed, pus, sometimes blood-stained, was always visible high up. In December, 1894, bare bone could be felt amongst easily bleeding granulations. These were curetted. The diagnosis now was suppuration in the ethmoidal or frontal sinuses, or both.

January 21st, 1895, he called with swelling in the centre of the forehead, evidently suppuration. A week later (January 28th) I incised in the median line over the centre of the fluctuating area, and let out a good deal of foul pus. A large opening in the frontal bone to the left of the median line led into the frontal sinus. All nasal discharge had ceased while the pus was collecting; a curved probe was easily passed into the nose. A piece of gum-elastic bougie was passed into the nose and retained. Later, a small silver cannula of a length to just enter the sinus was inserted, and through this the bougie was passed. The sinus was daily irrigated with boric acid, and later sanitas.

When shown to the Society rather less than three months from the opening of the abscess the discharge was mucus only, no pus escaped from the nose, no granulations were visible, and the bare bone felt by a probe passed through the nose into the sinus no longer existed. The left antrum for a long time gave no pus, the tube being retained as a precaution only.

Remarks.—The site at which the spontaneous opening formed seems the best at which to open the sinus, *i. e.* just to the left of the median line, and half an inch above the level of the eyebrow. From here a

drain can easily be passed into the nose, and retained by means of a projecting lip. This, covered with a piece of plaster, is by no means disfiguring. I think it much superior to the opening at the inner corner of the eye, through which it is difficult to pass a probe or drain into the nose, and I would suggest this site as the appropriate one for making the external opening. When both sides are involved, a median opening, either a long one or with a flap, will be best. The long period covered by treatment in this case was partly due to the neglect of the irrigation of the left antrum. The rigid tube at first employed gave much pain when introduced, but so soon as the wire one was substituted this inconvenience disappeared, and the antrum rapidly became healthy.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *May 8th*, 1895.

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

SCANES SPICER, M.D.,
W. R. H. STEWART, F.R.C.S., } Secretaries.

Present—31 members and 3 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentleman was elected a member of the Society:

Mr. David Moore Lindsay, L.R.C.P. and L.R.C.S.I., Salt Lake City, U.S.A.

The following candidate was proposed for election:

Mr. George Vincent Fourquemin, London.

Dr. C. Couper Cripps, Dr. G. Caldwell Stephen, and Mr. Bruce Hamilton were called to the table, and having signed the Register, were admitted members of the Society by the President.

OCCLUSION OF RIGHT POSTERIOR NARIS.

Shown by Dr. J. B. BALL. F. H—, æt. 21, has had obstruction of the right nasal passage as long as she can remember. She has always been troubled with frequent discharge of mucus from right nostril. A probe passed through the right nostril is arrested at the region of the posterior cavity by a hard, resisting structure apparently bony. There is no passage whatever for air through the right nostril, either with inspiratory or expiratory effort. By anterior rhinoscopy the right nasal passage is seen to contain a quantity of clear, viscid mucus. There is a slight deviation to the left of the anterior part of the septum near the floor. By posterior rhinoscopy the left choana

appears larger than normal, the distance of the posterior margin of the septum from the left Eustachian tube being greater than from the right tube. The right choana is completely occluded by a smooth reddish structure which joins the septum, not at its posterior margin but a little anterior to this, there being a distinct depression along the line of junction. To the finger the occluding structure feels firm and resisting. This patient was seen by me some six and a half years ago, when the condition and appearances were the same as now. The occlusion is no doubt congenital. Operative treatment was declined on the former occasion, but the patient is now inclined to have something done.

Mr. CRESSWELL BABER thought this was a case of congenital occlusion like a case he had shown to the Society. He had pushed through the obstruction and dilated under an anæsthetic; no tube was worn afterwards.

Dr. DUNDAS GRANT had a case he had treated by perforating with a trocar and introducing a vulcanite tube, which, in answer to Mr. C. Symonds, he stated the patient had to wear from time to time.

Mr. C. SYMONDS had a case in which the edge of the septum touched the outer wall. He had sawn out a portion with a Bosworth's saw.

PARALYSIS OF RIGHT VOCAL CORD.

Shown by Dr. J. B. BALL. M. A—, æt 18, came under observation at the West London Hospital in October, 1894. He complained of some weakness of the voice which had existed for about three months. On laryngoscopic examination the right vocal cord was found to be fixed in the position of complete paralysis, although there was some slight movement of the right arytænoid on phonation. He had no cough, and repeated examination of the chest at this time failed to discover any definite physical signs, and there was nothing in the case to point to the cause of the paralysis. He was next seen towards the end of December, when he had some cough, and then there was found to be some impairment in the percussion note at the right apex, front and back, and some crackling râles in the same region. His cough has left him for the last two months and he has gained in weight, but the breath-sounds are weak at the right apex and there is some dulness on the right supraspinous fossa together with some crepitant râles in deep inspiration. The diseased process at

the right apex, which is probably tubercular, gives a clue to the cause of the paralysis of the right recurrent laryngeal nerve, but the paralysis of the right vocal cord was in this case the first sign of disease to be discovered.

Dr. CLIFFORD BEALE had some doubt whether the paralysis could fairly be put down to the presence of apical disease. Cases of unilateral paralysis of one cord were by no means uncommon where no pleural or pulmonary disease existed, and as no pathological cause could be found for them they were generally classed as "functional." Cases of adhesion of the pleura at the right apex were, on the other hand, exceedingly common, but seldom produced paralysis.

CASE OF LARGE MASS OF MALIGNANT GLANDS IN THE NECK, WITH PARALYSIS OF THE CORRESPONDING SYMPATHETIC NERVE, AND IMMOBILITY OF THE SAME SIDE OF THE LARYNX.

Shown by Mr. BUTLIN. An engine driver, 56 years old, who four months ago had noticed a lump on the left side of the neck. About the same time he had begun to experience slight difficulty in swallowing.

At the present time he had a large mass of apparently malignant glands in the neck, extending from the clavicle up to the level of the hyoid bone. His voice was very hoarse, and he could only swallow solids with difficulty. The left side of the larynx was completely fixed, but healthy in appearance.

There were typical signs of paralysis of the cervical sympathetic, narrowing of the palpebral fissure, contraction of the pupil, absence of sweating on the corresponding side of the head and face. There was no reddening of the left side of the face and ear, which were a little paler generally than the corresponding parts on the right side.

Mr. BUTLIN believed the primary affection to be malignant disease of the left side of the œsophagus very high up, and not producing so much stricture as it does when the disease is lower down. He had reported an almost precisely similar case in the 'St. Bartholomew's Hospital Reports,' vol. xxix, p. 103, 1893. In that case there was scarcely any suspicion of malignant disease of the œsophagus until it was found after death. Yet there was a very large mass of glands in the neck, which had produced paralysis of the cervical sympathetic nerve, and immobility of the same side of the larynx.

Mr. C. SYMONDS stated that he had asked Mr. Butlin whether it was not a case of malignant disease of the thyroid, as there was a large nodule on the right side, and Mr. Butlin had replied that he had a

similar case previously, which he thought had been disease of the thyroid, but that, post-mortem, carcinoma of the œsophagus was found.

Case of Paralysis of the Right Vocal Cord of Uncertain Origin.

Shown by Mr. Butlin. A woman, 28 years of age, a cook, who was suffering from chronic enlargement of the tonsils, and complete paralysis of the right vocal cord, which was in a position midway between adduction and abduction.

In the middle of January of the present year she had been attacked suddenly by a very severe cough. In March the cough ceased, and she lost her voice quite suddenly.

The exhibitor had expected, from the history of the case, to find 'functional aphonia,' and was surprised to discover immobility of the vocal cord. The cause of the condition had been diligently sought for, but thus far without success. There was no history or appearance of catarrh (the larynx was perfectly healthy in appearance). No symptoms of disease of the brain or spinal cord. No tubercular or specific history. No history of injury.

No improvement took place during her stay in the hospital, except that her voice improved, and became almost of normal strength.

Dr. S. Spicer considered that as the paralysis was unilateral, functional paresis was excluded.

Case of Laryngeal Stenosis.

Shown by Dr. Dundas Grant. F. P—, æt. 28, was admitted on the 31st January, 1895, complaining of inability to breathe, except through the tracheotomy tube he was wearing in September, 1894.

He had been sitting up ten days convalescent from typhoid fever, when he complained of a sore throat. Difficulty of breathing set in three or four days later, and tracheotomy was performed.

Condition of the larynx on admission.—Vocal cords considerably obscured by the swelling existing around each *arytænoid* were swollen and red. The *cartilages* were more or less fixed and immobile, the right one completely so. There was a rounded inflammatory swelling at the posterior part of the right vocal cord, merging into the inter-

arytænoid fold, which was much swollen. Perichondritis was provisionally diagnosed. A later examination showed granulations at the posterior extremities of the vocal cords, and evidence of web formation in the anterior commissure.

On the 4th February, after removing some valve-like portions of tissue projecting into the tracheotomy wound, dilatation of the stenosed glottis was attempted by introducing an india-rubber conical dilator through a special tube introduced upwards into the wound.

On February 7th a laminaria tent was introduced from the tracheotomy wound, and left for some hours in the glottis.

By these means the breathing aperture was enlarged, so that by the 11th February some amount of breathing could be performed through it.

On the 11th March, after recovery from an attack of influenza, complicated with pneumonia, the web formation was divided with a Whistler's knife, and the smallest intubation tube passed in. The next day a larger one was used; the breathing was distinctly improved, but the effect was not sufficient to justify the postponement of operation. On the 17th the larynx was opened. The tracheotomy wound was enlarged three inches upwards in the middle line. All the soft parts over the thyroid cartilage were found to be matted together, and the latter was with difficulty exposed. Some granulation tissue was scraped away from the posterior wall of the larynx and bare cartilage was felt, but whether cricoid or left arytænoid was uncertain. The original opening in the trachea was also enlarged, granulations were scraped away, and the finger introduced in both directions found plenty of room. The breathing was much improved. The parts were then transfixed with silver wire and brought together.

A tracheotomy tube with an upward limb was introduced, but the patient could not tolerate it.

On April 8th, the glottic chink was so much more patent that the tube was taken out during the daytime, and the hole plastered over.

May 6th, introduced a dilator. Patient has passed a whole night with wound closed, but still wears tube during a portion of the day.

Case of Syphilitic Perichondritis of the Larynx.

Shown by Dr. William Hill. A female, æt. 34, who had applied at St. Mary's Hospital a week before, suffering from sore throat and loss of voice. There was a clear history of syphilis, and on examination the swollen and congested ventricular bands were seen to meet on the middle line, except for a short distance posteriorly, where a little of the right cord could be observed fixed and ulcerated; the right arytænoid region was swollen, and pus could be seen issuing from an ulcerated surface on the pharyngeal aspect of this region; the larynx was distinctly tender on pressure. Under iodide of potassium the local condition had slightly improved.

Specimen of Pachydermia Syphilitica Diffusa.

Shown by Drs. A. A. Kanthack and W. Jobson Horne. The larynx with portions of tongue and trachea attached was sent by Dr. Engelbach to the Pathological Department at St. Bartholomew's Hospital, with a note that it had been removed from a woman, aged 20 (married—one child—no miscarriage), who kept a brothel, and who for two years and a half had suffered from a very bad throat. In December of 1894 she had extreme dyspnœa, and died suddenly before tracheotomy could be performed.

The glottis was much narrowed. The epiglottis was entirely destroyed. The surface of the root of the tongue and of the interior of the larynx and trachea was studded with closely-set papillomatous-like excrescences.

Vertical sections were made through the anterior end of the right ventricular band, through the posterior parts of the aryepiglottic folds, and horizontal sections were made through the trachea.

Under the microscope there was found no loss of substance, nor destruction of epithelium, but the sections showed a thickening and heaping up of the epithelium together with a metaplasia of the cells from the cylindrical to the squamous variety, even in the trachea. Immediately beneath the epithelium there was an abundant small round cell proliferation, which extended into the deeper parts, and cells were found scattered between the muscle fibres. In places where

the cells were more closely packed, retrogressive changes had commenced.

Dr. CLIFFORD BEALE observed that confusion was likely to arise if such cases were to be indiscriminately classed as "pachydermia," as the lesions both in form and situation differed absolutely from that which was usually described under that name.

Mr. C. SYMONDS thought the case looked more like diffuse syphilitic ulceration rather than pachydermia.

CASE OF TUBERCULAR ULCERATION OF NOSE AND PHARYNX.

Shown by Mr. C. A. PARKER. F. McC— came to the hospital about February 7th, 1894, complaining of stoppage in nose of two to three years' duration, and was found to have hypertrophy of his inferior turbinate bone, which was removed on the right side with the cold snare.

Two or three days afterwards there was some epistaxis. About two weeks after the operation, ulceration was found to be present over the turbinate bone. This was at first treated by simple means, but it spread steadily and made its appearance on the pharynx.

Some little time later it was curetted, and painted with lactic acid frequently, and was improving rapidly towards the end of the year, at which time—in October—he went into the country. After his return, he attended at the Brompton Hospital for Diseases of the Chest.

In March, 1895, his *weight* was 8 st. 8½ lbs.; on May 7th, 8 st. 3 lbs.

Examination of Chest.—In April, 1894, marked flattening of left apex anteriorly with diminished movement and impaired percussion note. Vocal resonance and fremitus were both +. Bronchial breathing with numerous moist crepitations.

Night sweats occurred, but not much expectoration.

May 4th, 1895, examined again. But slight impairment of note. Respiration jerky; expiration prolonged, with tendency to hollowness. No crepitations could be heard. Vocal resonance and fremitus slightly +.

Dr. CLIFFORD BEALE commented on the comparative rarity of tubercular lesions in the nose and the importance of their early recognition and treatment by lactic acid. The corresponding lesions on the tongue and soft palate were more often recognised in their early stages, and were quite amenable to such treatment.

Microscopical Sections Illustrating the Histology of Turbinal Hyperplasias.

Shown by Dr. Pegler. The sections largely corroborated the views put forth by Wingrave, in a paper read before the last meeting of the British Medical Association at Bristol. Dr. Pegler had, however, been led to take a somewhat simpler view of the morbid changes, so far as his observation had gone, since, in every specimen examined, he had found mucoid degeneration in greater or less degree, and in no instance a true hypertrophic condition of the sinus walls. This applied to growths taken from any point along the free border of the inferior turbinate, from the middle turbinate, and from the septum. Special attention was directed in section (1)—(normal inferior turbinate)—to the walls of the sinuses, constituted by strands of visceral muscle-fibre crossing in all directions, and interlaced with bands of the wavy areolar tissue of the part. No. 2 was taken from a typical "anterior hypertrophy" of the inferior turbinate, the external contour of which was deeply convoluted, showing long finger-like processes in the section. This character was probably answerable for the fact of "papilloma" being commonly applied to such growths, but instead of a dense coating of stratified epithelium (altered by irritation?) with a thin line of vessels included, we had here a primary vascular outgrowth in a mucoid matrix, put forth apparently from the main body, and bordered by delicate ciliated epithelium. Attention was next called to the mucoid degeneration of areolar tissue, conspicuous in the lymphoid and general submucous area of the growth. Comparing carefully with the normal, it would be seen that this change had conspicuously attacked the walls of the venous sinuses, the mucoid thinning out of the areolar element throwing into prominence the muscular constituent, and creating an appearance of actual muscular hypertrophy. Sections 3 and 4 showed what were probably later stages of the pathological process (apparently progressive in character), the muscular trabeculæ themselves disappearing, till a mere rim surrounding some of the spaces remained. Wingrave believed that dilatation followed this atrophic stage, and proposed the term *turbinal varix* to designate it, but he also recognised a hypertrophic condition of the sinus walls in other cases. The remaining sections were from polypoid hypertrophies of the middle

turbinate, and wall of the septum. The septal growths were mucoid, and œdematous in the dependent portions, but contained numerous glands and sinuses towards the pedicle. This was evidently the structure of most septal proliferations, true papillomata being quite rare.

Mr. Charters Symonds had not sufficient experience in these cases to criticise.

Dr. Bronner considered them most interesting.

Dr. S. Spicer thought we ought to get rid of the name hypertrophic rhinitis, and call the condition by some more suitable one.

Dr. Pegler in reply stated that his observations were strictly limited to the sections he had shown, and though he had not as yet met with what appeared to him to constitute true tissue proliferation or hypertrophy of the sinus walls, he did not deny the existence of those conditions. He might have to alter his views; there were many sources of fallacy, and much still remained to be worked out.

Case of Fistula in the Neck.

Shown by Mr. W. R. H. Stewart. C. G—, æt. 19, was shown at the January meeting of the Society. He had been operated on several times, and when shown the sinus was nearly healed. It was quite healed a few days afterwards. Owing to adverse criticism as to whether an operation in this case was justifiable, Mr. Stewart brought the case again forward to show that it was possible to cure these cases by operation. In answer to Dr. Hill, Mr. Stewart stated that the dissection was carried back to the foramen cæcum.

Specimens of Polypi from the Antrum.

Mr. Symonds showed several polypoid masses, some of them three-quarters and half inch long, which he had removed from the right maxillary sinus. The patient, a woman æt. 25, had the right second bicuspid extracted for pain. There was no discharge from the nose. Soon after this a swelling projected through the socket, and was removed; a second soon followed. When first seen by Mr. Symonds, two pear-shaped gelatinous masses projected from the socket formerly occupied by the tooth. That these were not connected with the gum was shown by the fact that a probe could be passed all round them, and entered the antrum. The anterior wall of the

antrum was removed, and the polypi which were attached to the inner and posterior wall were removed by a sharp spoon. The largest measured about seven eighths of an inch in length. They were all attached about the same site and projected downwards. The aperture in the alveolus was much enlarged, and the polypi which projected through the opening were paler in colour and had a denser covering.

Large Nasal Polypus from a patient aged eighty-seven.

Shown by Mr. C. Symonds. This was a large mass with a portion of the middle turbinated, that had been removed by the cold snare. It is composed of many pendulous masses, and when removed was in outline as large as the palm of the hand. The walls of the nasal cavity had been much absorbed.

A Post-nasal Sarcoma.

Shown by Mr. C. Symonds.

Case of Pachydermia Laryngis.

Shown by Mr. C. Symonds. This case was that of Mr. H—, exhibited on several previous occasions.

The mass had nearly disappeared, so that the original view of the case has been confirmed. For three weeks the patient has resumed his duties as a schoolmaster, and during this time the greatest change has taken place for the better.

Case of Laryngeal Disease.

Shown by Dr. Herbert Tilley. S. E—, male æt. 49. "Complains of hoarseness and sore throat." Patient had syphilis about ten years ago, and was treated for it. About eighteen months after contracting the disease, he began to complain of his throat. It has been getting worse and worse, and he applied to the hospital early in February last, when he was at once put on anti-syphilitic treatment.

At first he improved, complained of less pain and easier breathing, but recently he has remained *in statu quo*.

There is no history of phthisis in family. There is a history of hæmoptysis when he was eighteen years of age. Recently he has been getting weaker. Altogether the history of phthisis is very indefinite, and the only physical signs in the lungs are those pointing to slight consolidation in the left apex.

There is a prominent granulation in the arytænoid space on left side. Left processus vocalis swollen. Over position of right vocal cord is a swollen mass of tissue which looks something like a large granulation. There is no fixation of the vocal processes beyond that due to inflammatory thickening. There is considerable laryngeal stenosis.

Dr. TILLEY was inclined to consider it a case of syphilis.

Dr. SPICER and Mr. STEWART considered it a case of tubercle.

Dr. BRUNNER thought it was syphilitic, and recommended mercurial inunctions.

Dr. TILLEY stated that Mr. Butlin had suggested that it might possibly be malignant.

INDEX.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY

OF

LONDON.

VOL. III.

1895–96.

WITH

LISTS OF OFFICERS, MEMBERS ETC.

LONDON
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1897.

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OF THE

Laryngological Society of London

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JANUARY 8TH, 1896.

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LARYNGOLOGICAL SOCIETY

OF

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Laryngological Society of London.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *October 9th*, 1895.

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

SCANES SPICER, M.D.,
W. R. H. STEWART, F.R.C.S., } Secretaries.

Present—22 members and 5 visitors.

The minutes of the previous meeting were read and confirmed.

The President, before the ordinary business of the meeting commenced, alluded in feeling terms to the loss the Society had sustained by the deaths of Mr. Arthur Durham and Herr Hans Wilhelm Meyer.

The following gentleman was elected a member of the Society:

Mr. George Vincent Fourquemin, London.

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

Mr. John Back, F.R.C.S.Ed., M.R.C.P.Irel., 54, Rodney Street, Liverpool.
Dr. John Walton Browne, M.D.Irel., M.R.C.S.Eng., 10, College Street North, Belfast.
Mr. Andrew John Brady, L.R.C.P. & R.C.S.Irel., Sydney, New South Wales.
Mr. Arthur H. Cheatle, F.R.C.S., 117, Harley Street, W.
Mr. John Macintyre, M.B., C.M.Glas., 179, Bath Street, Glasgow.
Dr. Arthur R. Reynolds, M.D.New York, 36, Washington Street, Chicago.
Mr. Walter Ridley, F.R.C.S., Ellison Place, Newcastle.
Mr. Edwin C. Stabb, F.R.C.S., St. Thomas's Hospital.

Dr. Cathcart and Mr. Fourquemin having signed the Register were admitted members of the Society by the President.

Case of Congenital Syphilis of Palate and Larynx.

Shown by Dr. Leonard Roper. E. W—, a girl æt. 21, came to Guy's with the following history.

Six months ago she gradually lost her voice, which has been getting worse. Has been liable to sore throat, but never lost her voice before. At sixteen her upper front teeth loosened and dropped out. Three years ago sores appeared on the upper lip and right side of nose. She was treated at Gray's Inn Road for lupus. While in the hospital she contracted erysipelas of face, after which the lupus (?) cleared up. The ulceration of face lasted twelve months. At the end of this time two swellings appeared on right arm, and now the lower end of right radius is much thickened. She never had any eye trouble.

The soft palate and pharynx are greatly hypertrophied. The epiglottis is thickened and "truncated." The false cords are thickened, and there is some infraglottic swelling.

Dr. William Hill said that the case much more closely resembled lupus than anything else, and he should require very strong evidence to convince him that the condition was due to syphilis.

Dr. Dundas Grant had seen the case before, and had considered it lupus.

The President, Mr. Butlin, and Mr. Stewart also considered it a case of lupus, and the President suggested that it should be microscopically examined, and the results submitted to the Society.

Dr. Roper, in reply, said no reference had been made to the swellings on the arm. There had been some slight improvement under Pot. Iod. He would remove and examine microscopically a piece of the hypertrophic tissue.

A Case of Tertiary Syphilis of Larynx and Nose.

Shown by Dr. Furniss Potter, with Dr. Law's permission. Henry G—, æt. 28, a carman, with a history of venereal disease three or four years, and sore throat about eighteen months.

He came to the London Throat Hospital on July 23rd, complaining of hoarseness, cough, and difficulty of swallowing solids. Slight dyspnœa. On examining him a large scar was found on the hard palate. Uvula was almost detached from velum, and had contracted an adhesion to the left posterior pillar of the fauces. The epiglottis had been almost entirely destroyed, a mere stump remaining. There was much

infiltration and œdema of the aryepiglottic folds and larynx generally; and this, together with much viscid secretion, rendered it impossible to obtain accurate details, but the rima glottidis appeared as a very small chink.

On the 25th inst. a much clearer view was obtained, the left cord being visible with some difficulty, owing to the view being obstructed by a large polypoid-looking mass which appeared to be attached to the stump of the epiglottis. There was also a smaller mobile hyperplasm in the arytænoid region. Pot. Iodid. grs. x and daily mercurial inunctions were administered till the gums became affected, then Pot. Iodid. grs. xx thrice daily, with the result that the man has steadily improved, and he has now a fair-sized glottic opening.

Case of Cicatricial Obstruction of Anterior Nares.

Shown by Dr. Scanes Spicer.

Mr. Butlin suggested a plastic operation by turning down a flap at the side of the nose. He had a case in hospital in which both nostrils were affected. He would bring his case and show it at the next meeting.

Dr. Dundas Grant would suggest that if this operation failed, then the columna should be cut through, and a silver saddle inserted to raise the tip.

A Case of Tubercular Ulceration of Septum of Nose.

Shown by Mr. C. Symonds. W. H. C—, æt. 48, came to Guy's for "stoppage of nose and pain." Fifteen months ago had influenza. Soon after pain commenced, and a small pimple appeared in left nostril. This got better, but appeared again and got worse; he had at this time an offensive smell in his nose,—he noticed it himself. One day on rising in the morning found his nose completely blocked. The smell now has ceased, and no odour can be detected. Has blown "casts" from his nostrils. Has been in Army, and when at Malta was invalided for consumption. Passed into Navy and invalided out for chronic bronchitis. Declares he has never had syphilis.

Family history.—Father died of phthisis; mother has phthisis now. There are no definite signs of phthisis in patient's chest.

A Case of Tubercular Disease of Septum.

Shown by Mr. C. Symonds. A. H—, æt. 16, sought advice for blocked nostril, right side. Has had it blocked for eight months. Came on gradually; bleeds at times, especially after blowing his nose. Has no history of any injury. No pain at any time. No history of phthisis. Lungs healthy.

On examination there is a mass projecting from anterior part of cartilaginous portion of septum; pale, firm. Does not bleed readily. Left nostril has some ulceration on septum quite anteriorly. Larynx and naso-pharynx normal.

Mr. Cresswell Baber considered that the case of the boy was one of tubercular disease of the septum nasi, and should be treated by removal with snare, scraping, and subsequent cauterisation with lactic acid or galvano-cautery.

Dr. C. Beale mentioned a case of a tubercular patient in whom the nodular thickening in the nose dried up of itself without any treatment.

Dr. Dundas Grant considered the case to be either tubercle or new growth, but thought the boy's general condition pointed rather to tubercle.

A Case in which the Left Vocal Cord was removed for Cicatricial Stenosis.

Shown by Mr. C. Symonds. H—, æt. 50. First seen some six years ago, when he was suffering from urgent dyspnœa. Immediate tracheotomy was performed in the scar of an old operation. He had been tracheotomised once before for the same trouble.

On examination the cords were red and swollen. Later several tags were seen on each cord and removed. The tracheal wound was closed, and patient resumed work. Again, four years ago, dyspnœa occurred, tracheotomy was performed, and later Mr. Durham divided the thyroid with a view of removing a supposed obstruction. After this latter operation he again came under Mr. Symonds' care, wearing a tube, and with great stenosis resulting from the irregular cicatrisation, so that it was impossible to remove the tube.

In February, 1895, the thyroid was again divided, and the left cord with its muscles removed, leaving the arytænoid.

In September last, finding the laryngeal aperture sufficiently wide for respiration, the tracheal fistula was closed.

Now, October 9th, the man breathes well, and his voice is improving in power.

Dr. C. Beale wished to know if the voice was now produced by the ventricular bands.

The President thought the voice was produced by the cicatricial bands.

Case of Frontal Sinus Disease.

Shown by Dr. Wm. Hill. Miss K— had previously been shown at this Society. She had then exhibited the classical signs of frontal sinus disease, but the chief symptom for which the patient sought relief was the profuse thick discharge of pus which flowed from the region of the nasal opening of the infundibulum. With the assistance of his colleague, Mr. Ernest Lane, the frontal sinus was opened by a vertical incision, exuberant granulomatous growths were removed, and the infundibulum dilated. The frontal wound was allowed to heal in the hope that the sinus would efficiently drain through the dilated and curetted infundibulum. In three weeks, however, there was pain, puffiness, and swelling, showing that the secretions of the sinus did not drain efficiently through the artificially dilated infundibulum. The wound was reopened, an Ellis drainage-tube inserted, and the patent was taught to pass a curved probe (as recommended by Luc) from the forehead through the sinus into the nose daily before using the syringe. Under this treatment there was no smell or excessive discharge, but directly the use of the probe was omitted, retention occurred. Dr. Hill proposed to enlarge the wound in the forehead and inspect the sinus again, and by some means so enlarge the opening into the nose as to insure efficient drainage; it might be found necessary to remove a little more of the middle turbinal.

Dr. Tilley and Mr. C. Baber suggested that Grünwald's method of removing the front wall of the sinus, packing the wound, and allowing the sinus to granulate up should be tried.

Mr. W. Hill, in reply, said that he would first try and carry out his idea of establishing good drainage into the nose. If this failed he would consider the suggestion Dr. Tilley and Mr. C. Baber recommended. The idea was, however, absolutely opposed to the general surgical principles which had hitherto guided us in the treatment of accessory sinuses, for we had regarded efficient drainage as indispensable. The disfigurement, too, must be taken into account.

Specimen of Carcinoma of the Larynx.

Shown by Dr. Kanthack. Patient complained of stiffness and hoarseness in February, 1889, but did not seek medical advice till September, 1892. November 14th, 1892, tracheotomy was performed on account of severe dyspnœa, which greatly relieved him. Laryngoscopic examination showed a growth on right side of larynx, involving both false and true cords. December 24th, thyrotomy was performed, and a sessile growth removed from right half of larynx. January 23rd, 1893, much swelling of neck, edges of tracheotomy wound everted and ulcerated. March 19th, 1893, patient died.

The specimen shows that the whole larynx is completely filled up with the malignant growth, which also invades the whole peri-laryngeal and peri-pharyngeal region. The rapidity with which the growth has extended is striking, so that the question is, how and in what manner paths are opened up for the dissemination of the growth by wounds?

Mr. Butlin did not think the splitting the thyroid had anything to do with the increased rapidity of the growth. It was not an uncommon thing for malignant growths to suddenly take on increased action in the way of rapidity of growth.

Mr. Bowlby had a case in which the thyroid was split for the removal of growth and was well united; but a few weeks after the cartilages were burst open, and a fungating tumour appeared in the neck.

Dr. S. Spicer asked whether the increased blood-supply and the more free anastomosis of the lymphatics had anything to do with the rapid increase of the growth.

Specimen of Carcinoma of Pharynx from a Woman.

Shown by Dr. Kanthack. It shows extensive necrosis of the posterior plate of the cricoid cartilage with ulceration of the pharynx, œdematous swelling and infiltration of the arytænoid area.

Specimen of Diffuse Papillomatous Hyperplasia of Laryngeal Mucous Membrane in a Child.

Shown by Dr. Kanthack. The whole surface is covered by numerous small warty growths, so that we have a verrucose condition

of the mucosa, which must not be confounded with the condition described by Virchow as pachydermia diffusa. Tracheotomy had been performed during life, and papillomatous growths have sprouted from the laryngeal mucosa through and along the track of the tracheotomy wound, and appear outside at the skin opening.

Mr. BOWLBY said the patient had been under treatment for growth in the larynx. Tracheotomy had been performed, but there was no material stenosis. The child suddenly had a choking fit in the ward and died. Nothing was discovered post mortem to account for the fit, which must be put down to spasm or some inspissated mucus.

The PRESIDENT had a case of papilloma. The growth was removed, but returned two years after, during pregnancy. Tracheotomy was performed; an abscess formed. The nature of the growth was changed. Post mortem specimen showed carcinoma, and the whole of the walls of the abscess cavity were lined by the growth.

SPECIMEN OF NECROSIS AND ULCERATION OF TIP OF EPIGLOTTIS, WHICH OCCURRED IN THE COURSE OF TYPHOID FEVER.

Shown by Dr. KANTHACK.

Dr. BEALE said it was an important point that these ulcers did not occur at the active stage, but occurred at the end of the disease. If due to the poison, why do they not occur at an earlier stage?

Mr. BUTLIN thought the ulceration was a perichondritis—a sequel to typhoid, same as periostitis in other parts.

Mr. BOWLBY had seen a case when the ulceration had occurred at an earlier stage—third week. There was great swelling of the larynx, tracheotomy was performed, and the patient still had to wear his tube on account of the stenosis.

The PRESIDENT said that evidently in some epidemics ulcerative throat symptoms occurred more frequently than in others. Greisinger found ulceration of the larynx in one in every five cases.

SPECIMENS SHOWN BY DR. FELIX SEMON.

1. LARGE NASAL POLYPI REMOVED FROM THE RIGHT NOSTRIL OF A LAD AGED NINETEEN.

The two polypi are remarkable for their enormous size, and also for the fact that they both were removed within three weeks from the right nostril of so comparatively young a patient, whilst the left nostril was quite free. The polypi did not show much in the nose itself, but were visible with the naked eye behind the soft palate, the naso-pharyngeal

cavity being almost completely filled with the growths. The patient stated that when a boy of twelve he had some polypi removed from the right nostril, but had been free until about one and a half years previous to the present removal, which was effected in October of last year at St. Thomas's Hospital. The aggregate size of the two polypi shown would seem to equal if not to surpass the largest mucous polypi put on record.

2. Tubercular Ulceration of the Soft Palate, Uvula, Right Tonsil, and Larynx.

The patient was a young man æt. 26, who died with general phthisis in St. Thomas's Hospital. The larynx was diseased previous to the palate, and the disease did not spread by continuity. The development of the tuberculosis of the palate could be followed from its very beginning, and it was not possible to check the disease by curetting and applications of lactic acid. In the specimen it is seen that the upper part of the epiglottis and the edges of the arytæno-epiglottic folds have been destroyed by tubercular ulceration, whilst the rest of the laryngeal cavity is ulcerated in different degrees from the same disease. In the cavity below the glottis, extensive areas of the mucous membrane are destroyed, the posterior border of the soft palate and the tonsil of the right side are similarly ulcerated, the uvula is thickened and nodular from the formation apparently of tubercles in its substance.

3. Large Laryngeal Papilloma.

The specimen dates from the pre-laryngoscopic era, and has been preserved for a long time in the museum of St. Thomas's Hospital. The brief clinical history appended to it simply states that the patient, an adult, had suffered for several months from increasing dyspnœa, and finally died from suffocation. The papilloma springs from the anterior part of the right vocal cord and fills the whole glottic cavity.

4. Myxoma of the Larynx.

The specimen is shown on account of the great rarity of laryngeal myxoma. The growth was situated in the anterior commissure of a girl æt. 26, who came in October, 1893, to the Throat Department

of St. Thomas's Hospital with the statement that she had been hoarse ever since she could remember. The growth, which looked like a bunch of granulation tissue, and was of the size of a cherry-stone, filled the anterior commissure of the vocal cords. It was removed without difficulty, and on microscopic examination proved to be a true myxoma. No recurrence so far as is known has taken place.

The microscopic section will be shown at the next meeting.

5. Syphilitic Endotracheitis.

This specimen has already been shown by Mr. R. W. Parker before the Pathological Society of London ('Pathological Society's Transactions,' vol. xxxvii, p. 119), but is again demonstrated on account of the great rarity of the affection.

The specimen represents two transverse sections of the trachea of a boy fifteen years of age, affected with inherited syphilis. There is a large amount of dense fibrous tissue produced in connection with the mucous membrane and submucous tissue, the lumen of the tube being at one part not more than a quarter of an inch in extreme diameter. The patient had been subjected to tracheotomy in consequence of a nearly fatal attack of asphyxia in 1877. In March, 1882, the tracheal fistula resulting was closed by operation by Mr. R. W. Parker. Some time later, the fistula having closed, an attack of catarrhal pneumonia set in, but did not prove fatal; death occurred, however, from a similar attack in February, 1885. After death the effects of the endotracheal inflammation were found to commence somewhat abruptly about an inch and a half above the bifurcation, and to increase in amount below. The lungs presented the appearances of extreme interstitial inflammation, and showed large tracts of dense fibrous tissue, in which lay groups of compressed alveoli; the smaller bronchial tubes and alveoli in the more peripheral parts of the lungs were filled with fœtid pus.

Dr. C. Beale stated he had a similar case of obstruction a few years ago, and on looking through the records, found it always occurred at the lower end of trachea.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *November 13th*, 1895.

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

SCANES SPICER, M.D.,
W. R. H. STEWART, F.R.C.S., } Secretaries.

Present—29 Members and 8 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were elected members of the Society:

Mr. John Back, 54, Rodney Street, Liverpool.
Dr. John Walton Browne, 10, College Street North, Belfast.
Mr. Andrew John Brady, Sydney, New South Wales.
Mr. Arthur H. Cheatle, 117, Harley Street, W.
Mr. John Macintyre, 179, Bath Street, Glasgow.
Dr. Arthur R. Reynolds, 36, Washington Street, Chicago, U.S.A.
Mr. Walter Ridley, Ellison Place, Newcastle.
Mr. Edwin C. Stabb, St. Thomas's Hospital.

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

Mr. J. J. Perkins, M.B.Cantab., Hospital for Consumption and Diseases of the Chest, Brompton.
Mr. W. G. Armstrong, M.B.Sydney, Sydney, New South Wales.
Mr. H. Lambert Lack, M.B.Lond., F.R.C.S., 55, Welbeck Street, W.

Dr. Arthur R. Reynolds, having signed the Register, was admitted a member of the Society by the President.

A Microscopical Section of Myxoma of Larynx.

Shown by the President. The section, which includes the entire tumour, consists throughout of an open meshwork of delicate fibrillæ, in which lie moderate numbers of multiform cells, furnished with delicate processes which construct the reticulum mentioned.

The growth is moderately vascular, and is covered with normal stratified squamous epithelium.

Case of Paralysis of Left Vocal Cord.

Shown by Dr. J. B. Ball. A. N—, æt. 36, a clerk, came to the West London Hospital on the 7th September last, complaining of weakness of voice and hoarseness, which had lasted for six weeks. He attributed his symptoms to having over-exerted his voice during the Hammersmith election, a few days after which the voice trouble began. The left vocal cord was found fixed in the position of complete paralysis, and has so remained. He had syphilis eight years ago. No other illness of importance. No cause, intra-thoracic or otherwise, can be found for the laryngeal condition. He took ten-grain doses of iodide of potassium for the four weeks following his first attendance at the hospital.

Dr. de Havilland Hall mentioned a case of complete paralysis of the left vocal cord, in which the paralysis preceded the signs of aneurism by about twelve months; at the post-mortem some eighteen months later an aneurism of the transverse part of the arch of the aorta was found. He also mentioned a case he had seen with the President in which physical signs of aneurism were very imperfectly marked for some months, but they afterwards became distinct. He suggested that the case in question was possibly due to aneurismal pressure.

Dr. Bronner suggested that the paralysis might be of central origin. It was frequently so in the case of the eye, why should it not be so in these cases?

The President said it was possible the paralysis was of central origin. It was impossible to find out the cause of these cases in five minutes. The more they were seen, the more inexplicable they were. It was very desirable to keep them under observation, and not to neglect the post-mortem. Tabes should be borne in mind, and the reflexes always examined.

Dr. Ball, in reply, stated that the reflexes in this case were normal.

A Case of Neurosis of the Larynx due to Laryngitis complicating Typhoid Fever.

Shown by Mr. Bowlby. The patient, a lad æt. 18, was admitted to St. Bartholomew's Hospital under the care of Dr. Hensley on August 27th, 1894. He suffered from typhoid fever without complication until September 1st, when he began to be deaf, and by September 11th had completely lost his hearing. On September 30th, when the fever had nearly subsided, he began to be hoarse, and on October 2nd had symptoms of laryngitis. On October 3rd, as he was suffering from severe dyspnœa, Mr. Bowlby was asked to see him. There was great swelling of the whole larynx, especially of the arytænoid cartilages and the ventricular bands, and slight ulceration of the posterior attachment of the left cord. Neither cord moved at all freely, the left being almost fixed. The opening of the glottis was very narrow. There was much stridor, the patient was cyanosed, and recession was marked. Tracheotomy was at once performed, with immediate relief.

On October 9th there was great swelling of the arytænoid region, simulating that of tubercle.

November 5th.—Left arytænoid flattened, but general swelling less and no ulceration. Cords very fixed, especially left.

18th.—Tube removed for a few hours, but had to be replaced.

December 11th.—Can breathe through larynx for some time with tube plugged.

January 4th.—No further improvement. Left cord fixed. No sign of present inflammation. A good deal of subglottic thickening.

In February and March, 1895, repeated attempts were made to dilate the larynx. After it the patient could do without the tube for a few hours; he could not, however, continue to breathe without it. His voice was nearly restored, being only a little hoarse. From February to the present time there has been no material change. There is now general thickening of the whole larynx at the subglottic region; the left cord is practically fixed, and the right moves imperfectly. The patient is very anxious for any operation that will enable him to dispense with his tracheotomy tube, and it is suggested that the left cord and adjacent mucous membrane and scar tissue might be excised with advantage.

Dr. Scanes Spicer stated that he had brought a similar case before the Society a year ago. It was then suggested that dilatation should be tried with Whistler's dilator and Schrotter's tubes. It was found impossible to use the latter. The larynx was opened and some mucous membrane removed. An intubation tube was inserted, but as soon as it was removed dyspnœa occurred, and the patient had to go back to the tracheotomy tube again.

Dr. Dundas Grant had a similar case, in which intubation did no good.

Mr. C. Symonds referred to the case he showed at the last meeting of the Society, in which the results of removal of the cord and soft tissues adjacent were shown.

The President remarked that in a case in which he had been consulted, thyrotomy had been performed against his wish, as he felt sure the voice would become worse; the results, however, had been very good. He stated that it was astonishing the amount of voice retained in these cases where the cord and adjacent soft tissues were removed.

Mr. Bowlby, in reply, stated that he would put the risks with regard to the loss of voice before the boy, and leave it to him to say whether he would have the operation performed or not.

Case for Diagnosis.

Shown by Mr. Bowlby. This patient had a swelling externally on the left side of the middle line, and there was a blackish-looking mass in the larynx.

Mr. Butlin thought the external swelling was either a high thyroid cyst or a low hyoid one. The internal mass looked suspicious, but he should be inclined to try the effects of mopping well with a brush, as it might be hardened mucus.

The President thought it was most likely mucus, and related a case that he had seen at Golden Square many years ago, which he had thought was an angioma, but which had turned out to be hardened mucus.

Microscopic Specimen of Hæmorrhagic Myxoma of Lingual Tonsil (in Albuminuric Patient).

Shown by Dr. A. Bronner. The specimen was from a woman æt. 35. For eight days had difficulty in swallowing, with expectoration of blood. There was a large tumour about the size of a walnut on the right side of the lingual tonsil, which came away spontaneously in three days. There was a thick capsule with concentric layers of red tissue. There is now the stump with small branches to be seen on the right side of the lingual tonsil.

Dr. PEGLER said he thought the growth consisted of adenoid, lymphoid, and fibrous tissue; could not distinguish any myxomatous tissue.

A CASE SHOWING REGENERATION OF TISSUE ALONG INFERIOR CREST AFTER TURBINECTOMY.

Shown by Dr. WILLIAM HILL. This was the case of a female, æt. 21, whose left inferior turbinal he had completely removed six months previously for the relief of marked obstruction in association with a narrow choana. After the operation granulations sprang up along the inferior turbinal crest; these organised, and the left nostril now presented a regeneration of tissue which in appearance simulated a fair-sized, soft, inferior turbinal body. The result was at present excellent, and did not bear out the fears that had been expressed in some quarters that turbinectomy would lead to atrophic changes in the nose.

Dr. PEGLER said the regrowth appeared to him to consist of a moveable body, which on being pushed back with a probe nearly touched the septum, and constituted a source of obstruction to free nasal respiration on that side. He did not distinguish any regeneration of turbinal erectile tissue in front of or behind it. The portion of growth he referred to was, he thought, distinctly œdematous, and if Dr. Hill decided to snare it off, he should be glad to know the result of the microscopic examination.

In reply to Dr. Pegler, Dr. HILL did not think the appearance of the regenerated tissue in any way suggested a localised œdema. He was inclined to expect that the granulation tissue had become organised into gland tissue covered by mucous membrane, and it was just possible that vascular tissue might also have been regenerated.

The following pathological specimens were shown by Dr. A. A. KANTHACK:

1. TYPHOID ULCER OF LARYNX.

There is a large ulcer just below the left processus vocalis. There was also perichondritis; a probe passes easily down as far as the upper margin of the cricoid cartilage.

Dr. WILLIAM HILL said that the ulceration seemed to be just where the cartilages of Elsberg are in the vocal cords. It was possible that this was the cause of the ulceration here.

2. Diffuse Papillomatous Hypertrophy of the Laryngeal Mucosa.

This specimen somewhat resembles the one exhibited at the last meeting. The child from whom it has been removed died suddenly of asphyxia. Looking into the aditus laryngis from above, we see that it is completely blocked by a dense papillomatous growth which filled up the whole of the larynx. The posterior wall of the trachea and a portion of the cricoid plate have been removed, so as to allow of a glance into the larynx from below. We find that the growth extends not only below the cords as far as the lower border of the cricoid, but even lower down, just below the tracheotomy wound (tracheotomy being done too late to save the child), a few small warty growths can be seen.

On microscopic examination the tracheal growths are distinctly papillomatous, and lined by a thick layer of a squamous epithelium. The epithelium at either side of the warts is of the stratified columnar type, heaped up in many layers, and in fact in the transition or metaplastic condition from the single columnar layer through the stratified columnar type to the squamous or epidermal type. In the sinuses which we find between the papillary outgrowths of the tracheal mucosa the epithelium, though several layers deep, is typically columnar.

A microscopical specimen of the tracheal wart is shown under the microscope.

3. Empyema of the Maxillary Antrum.

The specimen was removed from the body in the condition in which it is now. The bicuspids have disappeared (through caries and removal probably); the anterior plate of the alveolar process is thinned and in part destroyed. A glass rod is passed up through the opening in the alveolus into the antrum, there being therefore a direct communication between the antrum and the cavity of the mouth.

The lining of the antrum is much thickened, especially below and posteriorly, where a thick polypoid mass projects into the dilated cavity of the antrum. Through the deficiency in the anterior alveolar plate, the inflammatory material must have found a ready exit into the subcutaneous tissue of the cheek.

Dr. Scanes Spicer remarked that a very large opening would have been necessary in this case to remove thoroughly the growths.

Case of Pachydermia of the Interarytænoid Fold.

Shown by Dr. Percy Kidd. The patient, Elvina P—, æt. 33, has suffered from hoarseness for seven or eight years.

On examination the interarytænoid fold shows marked swelling of a greyish pink colour. The prominence is irregularly divided into two parts, that on the left side being the larger. The vocal cords are both somewhat thickened, and the movements of the right are distinctly impaired. When the patient was first seen, five or six months ago, the interarytænoid fold presented two symmetrical plate-like prominences separated by an indistinct furrow, but this appearance is now less marked. There is no evidence of syphilis or any other disease.

The treatment has consisted in the exhibition of iodide of potassium, the local application of Mandl's solution of iodine, and the use of lactic acid, 1 to 2 per cent. solution, in a Siegle's steam spray apparatus. The spray was suggested by Prof. Moritz Schmidt, who saw the patient at Brompton last July.

On the whole the swelling has slightly diminished, but the voice remains unaltered.

Mr. Butlin thought the case might be one of tubercle, from the situation and œdema. He should take a portion off for microscopical examination; suggested the application of the galvano-cautery.

Dr. Bronner had a case he treated with the galvano-cautery; this had made the patient worse. He then removed a portion with forceps. There was, after this, some slight improvement.

Mr. C. Symonds thought it was tubercle, as there was so much hoarseness; he would suggest treatment by the curette and lactic acid.

Dr. Tilley remarked that he had shown a case about six months previously with exactly the same appearance. The pain caused was, he thought, due to the fissure. His case had lactic acid applied twice a week, which made no difference. He removed a portion with the curette, and the voice at once improved. He thought the throat had got better since the patient had given up alcohol,

The President remarked that these cases were first noticed to occur exclusively in drinkers, when Hünnermann wrote an inaugural thesis on the disease at Virchow's request.

Dr. Scanes Spicer looked upon them as cases of ordinary inflammatory thickening; the tonsils and upper part of throat were also thickened.

Dr. Dundas Grant inquired whether the electrolytic treatment had been tried.

Dr. Kidd, in reply, said that he did not think the case was one of tubercle. He would try and remove a portion with the curette.

Although there was no distinct history of alcoholism the patient had been a tarmaid. He thought these cases were localised overgrowth of tissue.

Pathological Specimen of Syphilitic Ulceration of the Trachea with Cicatricial Stenosis of both Main Bronchi.

Shown by Dr. Percy Kidd. The specimen shows diffuse ulceration and thickening of the mucous membrane of the trachea, the ulceration being more recent in the upper third, with some whitish cicatrices toward the lower end. No definite stricture of trachea.

Ulceration extends into both main bronchi, which are slightly stenosed from cicatricial contraction.

In the left lung there are circumscribed areas of fibrosis, one small gummatous nodule, and two small cavities, probably due to softened gummata.

The soft palate and pharynx were also scarred, and a cicatrix was found on the penis.

No trace of tuberculosis could be discovered in any organ.

Case of Lupus of the Pharynx and Larynx.

Shown by Dr. Ed. Law. Patient, G. E—, æt. 10, came to the London Throat Hospital in September on account of "something in the throat." Twice had chicken-pox, once measles; scarlet fever two years ago, and has never been well since. Seven months ago the mother first noticed the frequent efforts of the child to clear the throat. Breathing was occasionally troublesome at night. At no time was there pain or difficulty in swallowing. Patient is the seventh of eight children; the eighth died of "consumption of the bowels." One sister has been to Ventnor with a bad cough, and has suffered from lupus on the back of the hand for five years. There was much infiltration of the soft palate and pillars of the fauces, with cicatricial patches on the velum and right posterior pillar. Epiglottis was greatly thickened and nodular, the tip destroyed by ulceration. Ary-epiglottic folds and ventricular bands were œdematous and swollen. The cervical glands are enlarged, and granulations are present in the left ear. Dr. Law saw the patient for the first time ten days ago, and was informed that she had gained in weight and the local trouble had improved, whilst taking powders of Hyd. cum Cret. and syrup of the

iodide of iron. No local treatment has as yet been employed, but he should scrape and apply lactic acid with the internal administration of arsenic.

Case of Nasal Obstruction from Septal Deflection and other Causes.

Shown by Dr. E. Law. Patient æt. 17. Consulted Dr. E. Law on August 14th for a stoppage in the nose, a discharge from the left nostril, a desire to hawk in the morning, slight deformity, headache, sickness, liability to colds with loss of smell and taste. Examination showed extensive deflection of septum to left, with a ridge-like projection at the base; bony enlargement of right middle turbinate pressing against concave surface of the septum. Large clusters of adenoid growths, polypoid hypertrophies of the posterior extremities of the turbinate bodies blocking up the choana; a large accumulation of mucus; very anæmic. Iron and arsenic were given and the adenoids removed. The secretions diminished, and for a time patient was slightly relieved. At the present time there is great discomfort and inconvenience from nasal obstruction. The opinion of the members is requested as to the most suitable operative procedure.

Dr. Tilley recommended that the anterior nasal spur on the left side should be removed, then the posterior end of the turbinate on that side. He suggested the use of Jones's turbinotome, a modification of which he had had made by Hawksley.

Dr. Dundas Grant also suggested the use of the turbinotome.

Dr. Hill said that when it was desired to remove only the posterior extremity of the inferior turbinal, but not the whole body, he had found it useful to detach the posterior extremity of the turbinal from the turbinal crest for half an inch or more with Carmalt Jones's turbinectome, and then remove the portion desired by a snare, which was readily inserted and retained in the groove thus made.

Dr. Law, in reply, stated that he should feel inclined to try and remove the hypertrophied tissue from the choana and the anterior extremity of the right turbinate before interfering with the septum. If such treatment did not relieve the obstruction, he would then remove the spur.

A Warty Growth of Suspicious Nature on Left Vocal Cord in a Man aged Fifty-four.

Dr. Scanes Spicer showed this case. Patient has had hoarseness for two years.

On examination the left vocal cord is injected, projects slightly, and lags a little in movements; at centre of ligamentous portion is a dusky, purplish, well-defined, spherical, sessile nodule; no ulceration to be seen. There is no difficulty of swallowing or breathing; no pain, no loss of weight, no history of syphilis, no enlarged glands externally. The age of the patient, the lagging of the cord, and the injection surrounding the growth suggest the possibility of malignancy, against which the long duration of hoarseness *in statu quo* militates. The patient had been taking Pot. Iod. gr. xv t. d. s. for a fortnight. Opinions were invited.

Dr. Percy Kidd thought the case one of angioma, and would attempt removal.

The President and Mr. Butlin both recommended an attempt at endolaryngeal and microscopical examination before splitting larynx. They regarded growth as suspicious, but more probably it was recurrent.

The President also said that some time ago he had a patient aged sixty-three, on whom he performed thyrotomy; the right vocal cord was removed, recurrence occurred as a red round growth without infiltration at the anterior commissure. Examination after removal showed this to be a granuloma.

Case of Malignant Disease of the Œsophagus in a Girl aged Twenty-three.

Shown by Mr. W. R. H. Stewart. E. H—, æt. 23, female servant, came to the London Throat Hospital on September 11th, complaining of difficulty in swallowing solids. Three months previously she began to feel soreness in the throat, especially on swallowing. This increased so that deglutition became quite painful, chiefly in respect to solids, though at times she could not get down liquids. Father died of "consumption;" one brother and two sisters died young, cause unknown. Has two brothers and two sisters alive and in good health. No history of syphilis obtainable.

Examination.—On the wall of œsophagus is an ulcerating swelling. On digital examination a firm mass can be felt, which bleeds readily. Both arytænoids are swollen and reddened. Had hæmorrhage from throat during the night of October 21st. Secretions removed from growth, and examined by Mr. Waggett, showed no tubercle bacilli. Patient has been on Pot. Iodid. gr. xv three times a day without improvement. She has also had arsenic. Mr. Stewart had no doubt about the diagnosis, notwithstanding the age of the patient, more especially as it is

exactly like a case he had about a year ago in a young woman aged twenty-nine, the specimen from which case he showed to the Society.

Mr. Butlin said there was no doubt about the diagnosis; he had recently a case in a girl aged twenty-four.

Case of Enlargement of Thyroid Gland in a Boy which almost blocked the Lumen of the Pharynx.

Shown by Mr. Stabb.

A Case for Diagnosis—Tubercle or Cancer.

Shown by Dr. Clifford Beale. The patient, a sailor æt. 47, had suffered for about two years from chronic tubercular infiltration of the apex of one lung, and for about four months from a steadily increasing loss of voice. The disease in the lung had never been very active, nor had there been any marked emaciation. The voice was not entirely lost, but was generally reduced to a hoarse whisper if the patient attempted to use the voice much. On examination the left side of the larynx was seen to be affected. The left ventricular band was swelled, and just below it was an angry-looking fleshy prominence which seemed to project from the ventricle, partly concealing the cord below, which appeared to be irregularly thickened. When first seen the left side of the larynx hardly moved at all on attempted phonation, and by palpation externally a small enlarged gland could be felt. Under observation, but with no local treatment, these conditions improved considerably in the course of three weeks. The movement of the left side became free, although not so good as that of the opposite side. The enlarged gland could no longer be felt, and the internal swelling, although not much altered in size, was much less angry in appearance. This improvement, which took place *pari passu* with a similar improvement in the lung, suggested that the infiltration in both organs was probably tubercular.

Mr. Butlin was not sure of the diagnosis; would suggest closely watching the case.

The President said the movements of the cord were not quite free. He suggested malignant disease, but would try the effect of iodide of potassium.

Dr. Hall had a similar case, which was undoubtedly tubercular.

A Case of Swelling of the Submaxillary Gland (due to a Salivary Calculus).

Shown by Dr. Dundas Grant. A. S. P—, æt. 15, complained of a lump in the throat, namely, in the right submaxillary region. A small swelling had been present for about twelve months, but within the last two weeks it had got much larger. When first seen there was a considerable swelling, slightly lobulated, corresponding in shape and position to the submaxillary salivary gland, and it was found that it increased considerably in size during eating, and subsided afterwards. There was considerable redness and swelling in the neighbourhood of the orifice of Wharton's duct, which was covered with a whitish exudation, and was extremely tender. The duct felt harder than normal to the touch. It appeared that for about three months there had been a swelling under the tongue, from which there occasionally issued a little matter having a saltish taste. No calculus was detected. Small doses of calomel and a mouth-wash of chlorate of potash were prescribed.

On the 13th November the glandular swelling was much less, the duct less swollen; there was a fistular orifice of the size of an ordinary pin-head opening into the duct in the hollow between it and the tongue, about three eighths of an inch to the right of the frænum. On closer inquiry it was elicited that a few days previously, while the patient was gargling, two small "stones" emerged, which were thrown away.

Mr. Spencer had a similar case under him, in which he could find no calculi when the duct was slit up; he then scraped out the gland, but this did not improve. So he had to excise the gland, which on examination showed calculoid disease.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *December 11th*, 1895.

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

SCANES SPICER, M.D.,
W. R. H. STEWART, F.R.C.S., } Secretaries.

Present—29 Members and 2 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were elected members of the Society:

Mr. W. G. Armstrong, M.B., C.M.Syd., Sydney.
Mr. H. Lambert Lack, M.B.Lond., F.R.C.S., 55, Welbeck Street, W.
Mr. J. J. Perkins, M.B.Cantab., Consumption Hospital, Brompton.

Mr. Ewen Stabb, having signed the Register, was admitted a member of the Society by the President.

Dr. de Havilland Hall and Mr. Spencer were nominated as Auditors.

The President announced that the Annual Dinner would take place in January at the Café Royal.

PAPILLOMA OF NOSE.

Mr. CRESSWELL BABER gave a further account of the case (Rev. —, æt. 36) which was shown before the Society on April 10th, 1895.

On April 22nd the growth, which was attached to the floor of the nasal cavity and lower part of the septum, was removed (under gas and ether) with knife and curette, bringing away in addition to the soft tissue a small piece of cartilage apparently from the floor of the nose. The wound, which extended down to the bone, was then freely

touched with the galvanic cautery. It healed satisfactorily. There was a slight growth of soft tissue on the septum, further back behind the original growth, which appeared on removal to be mostly granulation tissue. When the patient was last seen (November 29th) there was no sign of any recurrence of the growth, and the healed surface was quite smooth. Microscopic examination showed the growth to be papilloma; the detailed report (for which I am indebted to Mr. H. H. Taylor) is to the effect that the growth consists of a number of branched processes. Each process is made up of:—(1) A central fibro-nucleated tissue which is sharply defined from and supports (2) a thick layer of epithelium, the deepest cells of which are from eight to ten in thickness, placed longitudinally to the surface, with oval nuclei. The cells above these are larger, irregular in outline, and contain large nuclei. The most superficial cells are flattened, and all, right up to the surface, contain flattened nuclei.

Mr. DE SANTI referred to a case shown by him at this Society a year ago. It was that of a man who had a growth from the septum, which on removal proved to be a true papilloma. It had not recurred.

Dr. HILL stated that Dr. Scanes Spicer had shown a case of true papilloma a little while ago. We had now had three cases of true papilloma shown to the Society, and they all had grown from a point near the entrance to the nose.

CASE OF GROWTH ON LEFT VOCAL CORD.

Shown by Dr. J. B. BALL. T. D—, æt. 48, a mechanic, has suffered from hoarseness for three years, which appears to slowly get worse. On laryngoscopic examination a small tumour is seen, pedunculated and freely moveable, attached by a broadish base to the inner edge of the left vocal cord, about the junction of the anterior third with posterior two thirds of the cord. It is about the size of a small pea, smooth, and of a pale red colour. On phonation it lies between the cords, preventing complete approximation. It has the appearance of a soft fibroma.

Dr. DE HAVILLAND HALL considered it a soft fibroma of the vocal cord.

Dr. W. HILL and Mr. W. R. H. STEWART thought the growth came rather from the under surface of the cord than the outer edge.

Pathological Specimens of Tubercular Infiltration of Pharynx and Tongue.

Shown by Dr. Clifford Beale. The two specimens were taken from cases of long-standing tuberculosis of the lung. The ulceration had only appeared within a few weeks of the end, and seemed clinically to be only of a superficial character. The microscopic examination, however, very carefully carried out by Dr. Hugh Walsham, proved that the infiltration of the tissues beneath the ulcers had extended deeply into the muscular layers, both in the pharynx and on the tongue. There had been remarkable enlargement of the papillæ of the dorsum of the tongue, but there did not appear to be any connection between this and the tubercular infiltration. In one case the tonsil was found to be free of any tubercular affection, although during life it was constantly bathed in tuberculous débris from the ulcer. The infiltration of the affected tissues had evidently begun at a much earlier period than the ulceration.

Microscopical Section of Round-cell Sarcoma of the Thyroid.

Shown by Dr. Bennett.

Case of Naso-Pharyngeal and Nasal Polypi.

Shown by Mr. L. Lawrence. E. L—, æt. 20, a strong healthy-looking girl, first noticed a stoppage in her nose about a year ago. Since that time it has gradually been growing worse.

Both nostrils are practically completely blocked with nasal polypi of the mucous variety. There is a large mass in the naso-pharynx, chiefly on the right side. This presses on the soft palate. The naso-pharynx is not completely blocked. The mass is red and fairly firm to palpation; no spontaneous bleeding has ever occurred. The patient is not losing flesh, and there are no enlarged glands.

Mr. de Santi suggested it was a case in which the soft palate should be split, and the growth removed that way.

Mr. Cresswell Baber considered this a case of simple mucous polypi in the nasal cavities and hanging down into the naso-pharynx,

which might be removed by means of a snare. It was important to use rather stiff wire.

Mr. SPENCER suggested that if it was not possible to get the growth away with the snare, Lowenberg's forceps should be tried.

Dr. DUNDAS GRANT would remove with polypus forceps.

Dr. PERMEWAN thought the case simply one of mucous polypi, and he would hesitate to recommend splitting the palate. He would use the snare simply, and had lately removed an exactly similar one.

Mr. WAGGETT had generally found these growths were cystic on examination.

Dr. SCANES SPICER thought this case was undoubtedly cystic, and would recommend the use of polypus forceps if the snare failed.

Mr. LAWRENCE, in reply, thought he would be able to remove the growth with a snare.

PATHOLOGICAL SPECIMENS OF TUBERCULAR ULCERATION OF TRACHEA, LARYNX, AND PHARYNX.

Shown by Mr. DE SANTI.

1. Male, æt. 28, began to be ill October, 1894; signs of phthisis soon manifested themselves, and he gradually got worse. Throat became painful and he lost his voice beginning of October, 1895. Laryngoscopic examination showed well-marked tubercular disease of larynx. At the beginning of November an ulcer about the size of a sixpenny piece was found in posterior wall of the pharynx. Patient died November 20th.

Post-mortem.—Well-marked extensive phthisis and empyema; well-marked tubercular ulceration of trachea and larynx. Tubercular ulcer size of a sixpenny piece in posterior wall of pharynx.

2. This man was operated on for tubercular disease of right metatarso-phalangeal joint in October; he was suffering from phthisis at the time. The disease rapidly increased. In the beginning of November miliary tubercles were found on the soft palate, fauces, and pharynx.

Post-mortem.—The pharynx and fauces are the seat of tuberculous deposit and ulceration. There is a small ulcer at base of the left vocal cord.

Dr. DE HAVILLAND HALL said he had another similar case under him; it was extremely rare to have three cases of tubercular disease of the pharynx in the ward at the same time.

A Case for Diagnosis.

Shown by Dr. F. Semon. The patient, a gentleman æt. 35, was sent from Western Australia by Dr. H. J. Lotz, an old St. Thomas's man, with the following history.

He caught cold twenty years ago, and has been hoarse ever since. Four years ago he had what was called a sarcoma removed from the testis, but subsequent attendants had thrown doubts on the correctness of this diagnosis. Fifteen months ago he caught fresh cold, after this he suffered from dryness of the throat and cough in the morning. For two or three months at that time he occasionally brought up some blood. He consulted a specialist in Adelaide, who found thickening of the vocal cords. After this the throat gradually got weaker, and ultimately the voice was almost lost. He saw another specialist in August of this year in Adelaide, who found a growth in the larynx, and removed a portion for diagnostic purposes. The piece removed, however, was too small to make microscopic sections. Till this he had never complained of any pain or feeling of discomfort in the throat. In October of this year he caught a fresh cold, his throat began to feel raw and dry, and the cough in the morning increased.

On laryngoscopic examination Dr. Lotz found congestion of the mucous membrane of the larynx. The left ventricular band was swollen, particularly anteriorly, and presented here a small excrescence, which was of the same colour as the surrounding mucous membrane. The right vocal cord was very much ulcerated. There was no ulceration on the left vocal cord, which moved fairly well. On the left side of the laryngeal surface of the epiglottis there was a narrow streak of superficial ulceration. Externally the thyroid glands were felt enlarged. The patient was ordered to take 15 and 20-grain doses of iodide three times a day for about a month, and during that time he put on flesh and felt much better; his voice had also improved, but this, in Dr. Lotz's opinion, may have been due to the improvement in the acute laryngitis produced by instrumental interference. Nothing abnormal could be detected in the lungs. The sputum was repeatedly examined for bacilli without results. There was no history of syphilis.

Dr. Lotz, who was unable to decide as to whether the affection was tubercular or syphilitic, sent the patient for diagnosis.

On examination the remnants only of the condition described by

Dr. Lotz were found, with exception of the condition of the left ventricular band, which even now shows the remains of the excrescence described by him. The right vocal cord, which at the time of the patient leaving Australia was described as "very much ulcerated," shows only very superficial ulceration in the neighbourhood of the vocal process, and moves well. On the epiglottis the ulceration on the left side has been replaced by two spots of white discolouration. The left vocal cord is still somewhat swollen, but the voice is much better. Patient has been taking iodide of potassium all through. The questions arising are:

1. Is the affection tubercular or syphilitic?
2. Has it anything to do with the "sarcoma" removed four years ago?
3. What is the nature of the excrescence of the left ventricular band?

Dr. Scanes Spicer thought that the bright redness of the parts pointed to syphilis.

Dr. Poore noticed that the left vocal cord did not move properly.

Dr. Hill did not think it was tubercular. He stated that in some parts of Europe there was a kind of ulcerative laryngitis, but in this case there were no crusts found. The patient had evidently improved since he left Australia.

Dr. Semon, in reply, said he had not yet made up his mind what the case was; the epiglottis looked like syphilis, the vocal cord like tubercle, and the ventricular band—he did not know what it looked like.

A Case of Laryngeal Stenosis.

Shown by Mr. W. G. Spencer. A woman, æt. 53, was at first under the care of Dr. de Havilland Hall, who then found a chronic laryngitis secondary to hypertrophic rhinitis. The latter was cured, but the larynx did not improve. There is now extreme laryngeal stenosis, so that with the deepest inspiration the larynx does not dilate to more than 2 mm. at the widest part. There is a hard mass between the arytænoids and in front of the cricoid.

On several occasions she has had attacks of dyspnœa, which have been relieved by lactic acid in increasing strength up to the full B.P. acid.

Should operative measures become imperative, excision of the vocal cords will be tried; but there have not yet been indications sufficient

for an operation not only dangerous but of doubtful efficacy. In all probability the framework of the larynx would sink in. Small operations such as the cautery or curette would only tend, it would seem, to further narrowing.

The disease is now stationary, a fibrous contracture has involved the inter-arytænoid fold, the perichondrium, and probably the nerve-fibres of the abductor muscles.

Dr. DE HAVILLAND HALL stated that the patient had been under his care, at intervals, for upwards of twelve years. At first the patient suffered from chronic laryngitis with subacute exacerbations. At this time there was marked nasal stenosis due to hypertrophic rhinitis. Dr. Hall suggested that the chronic hypertrophic laryngitis or fibrosis of the larynx was due to interference with nasal respiration.

The PRESIDENT said that if such a case as this was due to nasal obstruction, why was it not more often seen? He would like to know on what grounds such a suggestion was made.

Dr. SCANES SPICER agreed with Dr. Hall in maintaining, as a general truth, that an unfavourable influence was exercised by chronic nasal obstruction (and its resultant—mouth breathing) on the mucous membrane of the larynx, trachea, and lower respiratory tracts, in producing and maintaining congestive and inflammatory states. He thought that in this case the nasal obstruction which Dr. Hall found must have had a pernicious influence, and that it had rightly received attention. With reference to the present condition of the patient, he advised curettement (with Krause's double laryngeal curette) of the large hypertrophic or pachydermatous mass of the posterior wall, preferably at once, but at any rate on the slightest increase in laryngeal stenosis.

The PRESIDENT said he would like to know how many cases such as this, in which the nasal obstruction was supposed to have caused the condition of the larynx, had occurred. He did not believe it was thus brought about. Why should the larynx be deemed incapable of suffering from a chronic inflammation and thickening, independently of the nasal trouble? Of course if there was concurrent mischief in the nose it ought to receive treatment.

Mr. C. BABER did not think that obstruction of the nose could mechanically produce the condition of larynx seen in this case. He thought that the inflammatory trouble might be of the same character in the nose and larynx.

Dr. DUNDAS GRANT, while a great believer in the influence of nasal obstruction in producing laryngeal disease, could not consider the hypertrophic rhinitis described as sufficient to produce such extreme changes. He had seen similar conditions follow nasal disease, but only nasal disease of a purulent nature, presumably suppuration in the sphenoidal or other sinuses, the infective material inhaled from these infecting the interior of the larynx, and setting up severe inflammatory conditions.

Dr. PERMEWAN failed to see any real evidence that this laryngeal condition was secondary to nasal obstruction. He regretted the tendency to deny to the larynx a liability to primary disease. In this case he thought the infiltration was under the perichondrium as well as in the mucous membrane, and that there was ankylosis from arthritis of the crico-arytænoid joint.

Dr. ST. CLAIR THOMSON asked if chronic alcoholism as a cause had been excluded, and if the classical treatment by salt-water spray and paintings of solution of nitrate of silver had been used.

Dr. DE HAVILLAND HALL, in answer to Dr. W. Hill, said that there was no history of an acute attack of laryngitis.

Mr. SPENCER, in reply, said he did not see the case until three years ago. He thought a purulent catarrh, as suggested by Dr. Dundas Grant, had taken place, and a thickening of the perichondrium had been caused. The case had now been stationary for three years. There was no history of chronic alcoholism; nitrate of silver had been tried without effect. He thought curretting would do more harm than good. Lactic acid was now being tried.

A CASE OF THYROID DISEASE AFTER OPERATION.

Shown by Mr. EWEN STABB. This was the lad shown at the last meeting of the Society; the tumour had been removed and the wound was quite healed.

Mr. STABB, in answer to Dr. Poore, said there was a distinctly cretinous history in this case.

CASE OF LARGE FIBROMA OF THE NASAL SEPTUM.

Shown by Mr. W. R. H. STEWART. W. G—, æt. between 50 and 60, came to the Great Northern Central Hospital in May last for complete blockage of the nose and some hæmorrhage. He stated that he had a blow on the nose forty-four years ago. Twenty-five years ago the nose began to get blocked. He then saw a doctor, who told him that a serious operation would be necessary to thoroughly remove the growth. Nothing was done, and the case gradually became worse until complete blockage of both sides was established. The nose was considerably bulged on the left side. Examination revealed a large tumour projecting slightly from the anterior naris and filling up the naso-pharynx. A small portion removed for microscopical examination proved to be fibrous tissue. Under an anæsthetic an attempt was made at removal by the écraseur, but it was found

impossible to get the wire between the roof of the naso-pharynx and the tumour. Further digital examination seemed to indicate that its origin was the base of the skull. A week afterwards Mr. Macready, at Mr. Stewart's request, after a preliminary tracheotomy turned back the upper jaw on the left side, performing a slightly modified Mansell-Moullin operation. The tumour was pulled away with some difficulty, the posterior knob being firmly held by atmospheric pressure in a rounded hollow in the base of the skull. The growth measured when fresh $4 \times 2\frac{1}{8} \times 1\frac{5}{8}$ inches, and was found to have grown by a very small pedicle (which contained a piece of bone) from a ridge on the much distorted septum. Mr. Waggett reports that the microscopical examination of a section from the centre of the growth showed it to be composed of a very dense white fibrous tissue arranged as lobes growing from a less dense central hilum which contained spicules of bone near the pedicle. The patient made an uninterrupted recovery. This is, as far as published records go, an unique case. The only account of a pure fibroma growing from the nasal septum to be found is one recorded by Lefferts; this was the size of a hazel-nut, and growing low down near the anterior naris. Mr. Stewart expressed his indebtedness to Mr. Waggett, not only for his careful research amongst the literature on the subject, but also for some excellent drawings of the fresh tumour made a few hours after removal.

Mr. Waggett said that a very small number of firm fibrous septal tumours are recorded in literature, and in most of these there was a traumatic history. The largest was the one reported by Lefferts, and that was the size of a hazel-nut, so that the present case is quite unique in point of size.

The President suggested that as this was an unique case, a woodcut should be obtained for insertion in the Society's 'Proceedings.'*

Mr. Symonds communicated further notes of two cases of disease of the septum nasi shown in October. In the case of the man W. H. C—, æt. 48, the ulceration, and thickening of the septum, and the obstruction rapidly disappeared under iodide of potassium. In the boy, A. H—, æt. 16, the disease proved to be tubercle, both by the microscopical appearance of the section and by the presence of bacilli. The chief mass was removed, leaving a large aperture in the septum, and he was still under treatment by lactic acid and the curette.

* The woodcut will be issued as soon as possible.

Case for Diagnosis.

Shown by Mr. E. B. Waggett. A woman, æt. 54, gave a history of an impacted fish-bone with symptoms persisting for fourteen months. The pharynx, examined two months after the accident, was acutely inflamed. There was a small swelling on the lateral epiglottic fold, which remained unchanged, with persistence of discomfort and pain, for fourteen months. There is no localised inflammation, and no evidence of a wound or of a foreign body.

Dr. W. Hill thought it was a small keloid tumour.

Dr. Poore would like to hear if anyone had ever found a fish-bone in the throat; and what became of those not found.

The President stated that in nine cases out of ten no foreign body could be found, but it was necessary to continue the examination for some time. In one case he had, after half an hour's search, found a bone three-quarters of an inch long in the tonsil, only a very small portion of which was showing.

Mr. Spencer said that after a time ulceration sets up and the fish-bone comes out. Sometimes, of course, this becomes a very dangerous process, the large vessels becoming perforated.

Mr. Waggett, in reply, said that the swelling was freely moveable, and therefore probably not keloid as suggested. Dr. Whistler had removed a fish-bone an inch long which had remained undetected, after frequent examination extending over several weeks.

Case of Inspiratory Spasm of the Vocal Cords.

Shown by Dr. W. A. Willis. Mrs. M. D—, married, æt. 44, came to the out-patient room at the Westminster Hospital on November 7th suffering from dyspnœa and huskiness, which had come on the previous day.

Her respirations were 50 per minute and pulse 120, and there was some lividity. On examination of the larynx there was slight laryngeal catarrh, and with inspiration spasmodic approximation of the vocal cords leaving only a narrow chink at the posterior part of the glottis.

She said she had had similar attacks to the present during the last six or seven years, but not so severe.

She was ordered to keep in a warm room and to use pine oil inhalations, and in the course of the next ten days she improved; but

the spasm was still present on the slightest excitement or exertion, she was therefore sent into the ward under Dr. Hall, to whose kindness Dr. Willis is indebted for the opportunity of showing her to-day.

There she has steadily improved with the exception of one night about a week after admission, when there was so much spasm that she had to use chloroform inhalation.

Under ordinary circumstances there is now no spasm, but laryngoscopic examination is generally sufficient to reproduce the condition.

There is no evidence of marked hysteria in this patient though she may perhaps be somewhat emotional, but the laryngeal condition may, it is presumed, be looked upon as entirely functional; such cases, however, are not free from danger of asphyxia, notwithstanding the absence of organic disease.

Dr. SCANES SPICER thought this was a case of real abductor paralysis.

Dr. PERMEWAN drew attention to the spasm of the soft palate, and would be inclined to emphasise the connection.

The PRESIDENT thought it was a case of perverted action of the vocal cords. He remembered a similar case at Golden Square, in which a cold douche produced functional aphonia.

Dr. W. HILL had a similar case for some months under bromide; she got better, but she also had functional aphonia.

Dr. C. BEALE drew attention to the fact that the glottis did not completely close, and the patient could breathe during a spasm.

The PRESIDENT said that for making a differential diagnosis between such a case as this and one of bilateral paralysis it was necessary to make the patient phonate as long as possible, he then must take a breath; in these cases at this moment the vocal cords separate widely, in bilateral paralysis they become tightly closed.

ERRATA

IN NO. OF 'PROCEEDINGS,' NOVEMBER 13TH.

On page 11, *for* Mr. John Back *read* Mr. John Bark.
„ 11 „ Mr. Edwin C. Stabb *read* Mr. Ewen C. Stabb.
„ 13, line 1, *for* Neurosis *read* Stenosis.
„ 20 „ 12, *after* endolaryngeal *insert* removal.
„ 20 „ 13, *in place of the word* recurrent *read* a fibroma.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ANNUAL GENERAL MEETING, *January 8th*, 1896.

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

SCANES SPICER, M.D.,
W. R. H. STEWART, F.R.C.S., } Secretaries.

Present—33 Members and 2 visitors.

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

Dr. W. Hill and Dr. Pegler were appointed Scrutineers of the ballot for the election of Officers and Council for the ensuing year.

The Report of the Council was read as follows and adopted:

Your Council has much pleasure in reporting that the Society continues to increase in strength, and that there are now one hundred ordinary members and nine honorary members.

During the past year the Society has had to lament the loss of one of its most distinguished honorary members, in the person of Dr. Wilhelm Meyer of Copenhagen, and one of its original members, Mr. A. E. Durham. Dr. V. D. Harris, an original member, has had to resign, owing to a permanent engagement on the Society's meeting day.

As resolved at the last General Meeting, a Conversazione was given at the Salle Erard, during the Annual Meeting of the British Medical Association in London, to the foreign and provincial practitioners taking part in the work of the section of laryngology, and was well attended.

The Council have instituted a Morbid Growths Committee, to consist of Mr. Bowlby, Drs. Kanthack, Pegler, Mr. Waggett, and the Senior Secretary, with power to add to their number.

The Council recommend that in future the Session should commence in November and end in June, instead of as heretofore, so that

a meeting would be held on the second Wednesday in June, instead of in October.

The Treasurer's Annual Statement was then presented as follows:

BALANCE-SHEET, 1895.

INCOME.	£	s.	d.
Balance in hand from 1894 .	38	17	5
Subscriptions—			
63 members at £1 1s. . . £66 3 0			
21 members at £2 2s. . . 44 2 0			
2 members at £9 9s. . . 18 18 0			
	129	3	0
The two subscriptions of £9 9s. each are composition fees of Dr. Newman and Dr. Davison (country members).			
Total . .	£168	0	5

EXPENDITURE.	£	s.	d.
Rent (20, Hanover Square) and Electric Light for 1895 . . . . £31 10 0			
For last quarter of 1894, additional 2 17 6			
	34	7	6
Adlard for Printing and Postage	55	0	0
Miller and Woods, Electric Fitting	1	1	0
Petty Cash—			
Clarke (for indexing volume, 1895) £0 18 0			
Mayer & Meltzer (Spray) . . . 0 4 0			
Doughton, attendance, 1895 . 2 0 0			
Do. till May, 1896 1 5 0			
Dr. Scanes Spicer (includes indexing volume, 1894, 18s.) 1 19 3			
Mr. Stewart . . 0 10 0			
Bank charges . 0 0 10			
	6	17	1
Frank Rogers, Chemicals .	1	15	0
Balance in Teasurer's hands, Jan. 1, 1896	68	19	10
Total . .	£168	0	5

The income for the year, £129 3s., includes two composition fees amounting to £18 18s.

	£129	3	0
	18	18	0
Ordinary income	£110	5	0

The expenditure for the year, £99 7d., includes £3 15s. 6d. for rent and indexing, 1894, and £1 5s. paid in advance for attendance at meetings till May, 1896.

	£99	0	7
	5	0	6
Ordinary expenditure . . .	£94	0	1

Audited and found correct,
Jannary 6, 1896.

F. DE HAVILLAND HALL.
WALTER G. SPENCER.

The Treasurer's Report was then adopted.

The Librarian's Report was then taken. He stated that several additions had been made to the Society's Library during the past year, chiefly by foreign contributors, and that the principal foreign periodicals had been regularly supplied in exchange for the Society's 'Proceedings.'

The following works have been added to the Library since the last catalogue was issued.

Presented by Professor Ferdinand Massei.

L'Intubazione della Laringe (Massarotti).
Lezioni Cliniche, sulla Malattie della Prime Vie del Respiro (Massei).

Presented by the authors.

Gimnastica vocale e polmonare (Grazzi).
Corps Étrengers de l'Oreille (Natier).
Polypes des Fosses Nasales (Natier).
L'Eclairages des Cavitiés de la Face (Tucker).
L'Ulcère perforant de la Cloison du Nez (Moure).
Cas de Rhinolithe Spontanée (Moure).
Empyème du Sinus Sphénoidale (Moure).
Cas d'Angio-kératome de la Corde Vocale (Moure).
L'Oblitération Congenitale Osseuse des Choanes (Gouguenheim and Hélary).
Vasogene (Bayer).
Du Catarrhe Naso-pharyngien (Vittorio Grazzi).
Fistule Branchiale du Cou (Lichtwitz).
Angiome au Pharynx (Lichtwitz).
Laryngeal Paralysis in Chronic Nervous Disease (W. Permewan).
Diseases of the Upper Respiratory Tract (P. Watson Williams).

Presented by Dr. Edward Law.

Textbook of Diseases of the Ear (Gruber, translated by Edward Law and C. Jewell), 1st English edition, 1890; 2nd Eng. ed., 1893.

Reports.

Rendiconto dell'Anno Scolastico, 1892-3; della R. Universita di Napoli.
Proceedings of "Nederlandsche Keel—Neus en Vorheelkundige Vereenigung."
Med.-Chir. Soc. of Glasgow—Report of Discussion on Anæsthetics.
Proceedings of Brighton and Sussex Med.-Chir. Soc., 1893-4.
Verhandlungen der Laryngolischen Gesellschaft zu Berlin.
Corso Complimentaire di Oto-Rhino-Laringologia della R. Universita di Pisa (Vittorio Grazzi).

Periodicals.

Revue Internationale de Rhinologie, Laryngologie, et Otologie.
Revue de Laryngologie, d'Otologie, et de Rhinologie.
Archivi Italiani di Laringologia.
Bolletino delle Malattie dell'Orecchio, della Gola e del Naso.
Archiv für Laryngologie, Bd. ii, Heft. iii.
Journal of Laryngology, June, 1895.
Il Policlinico, Ann. 1, No. 8.

The Report was adopted.

It was proposed as a recommendation from the Council, that the Sessions of the Society should in future commence in November instead of October, and end in June instead of May. This was unanimously adopted, and the Rules were directed to be altered to this effect.

The Scrutineers reported the result of the ballot as follows:

President.—Felix Semon, M.D.
Vice-Presidents.—E. Cresswell Baber, M.B.; A. Hodgkinson, M.B.; Charters Symonds, F.R.C.S.
Treasurer.—W. Johnson Walsham, F.R.C.S.
Librarian.—E. Clifford Beale, M.B.
Secretaries.—W. R. H. Stewart, F.R.C.S.; St Clair Thomson, M.D.
Council.—J. B. Ball, M.D.; F. W. Bennett, M.D.; J. W. Bond, M.D.; Scanes Spicer, M.D.; P. Watson Williams, M.D.

The Ordinary Meeting of the Society was subsequently held, the President being in the Chair.

The President briefly returned thanks for his re-election for the third time.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were elected Members of the Society:

Mr. F. A. N. Bateman, L.R.C.P., M.R.C.S., 4, Charles Street, St. James's, S.W.
Mr. J. R. Whait, M.D., C.M.Edin., L.R.C.P., M.R.C.S., Charlton's Fair, Hazel Gardens, South Hampstead.

The following gentleman was proposed for election at the next Ordinary Meeting.

Dr. W. Bolton Tomson, M.D.Durh., M.R.C.S., L.R.C.P., Park Street, West Luton, Beds.
Proposed by Mr. W. R. H. Stewart, Mr. H. T. Butlin, Mr. R. Lake.

Before commencing the business of the day the President stated that he had received a letter from Professor Massei of Naples, an honorary member of the Society, in which the latter, with reference to a discussion which had taken place at a recent meeting of the Society concerning the explanation of obscure cases of laryngeal paralysis, again drew attention to his view first brought forward at the Paris Congress of Otology and Laryngology in September, 1889, viz. that in many of these cases the cause of the paralysis was to be sought for in a primary neuritis of the trunk of the recurrent laryngeal nerve; and in which he further contended that the more recent experiences of transitory paralysis of the recurrent laryngeal after influenza strongly pointed towards the conclusion that this statement corresponded to actual facts.

Case of Bulbar Paralysis, Progressive Muscular Atrophy, Complete Paralysis of Left Abductor, Paresis of Right Abductor.

Shown by Dr. F. Semon. J. S—, labourer, æt. 54. The patient is an inmate of the Queen Square Hospital for Epilepsy and Paralysis, under the care of Dr. Hughlings Jackson, F.R.S., who kindly allowed Dr. Semon to show him. Duration of illness about fifteen months. After influenza in October, 1894, a difficulty in swallowing and articulation was noticed; this was soon followed by progressive weakness of movements of right arm and leg. In September, 1895, the same process began in limbs of left side. Ever since gradual progress of affection. The muscles of the hands, particularly of the right, are much wasted. There is no power over the explosives in articulation, and he cannot pucker up his lips well. The right orbicularis oris et palpebræ is weaker than the left; the right pupil larger than the left. There is fibrillary twitching in the thigh and calf muscles. The pharyngeal reflex is diminished on the right side more than on the left. On phonation the palate is drawn up a little to the right. No affection of sterno-mastoids and trapezii muscles. The movements of the tongue are performed with some difficulty, the organ is considerably wasted, and there are tremors on movement. He loses breath when walking quickly, and has occasionally slight choking attacks.

On November 12th, 1895, Dr. Semon made the following note:— "During quiet respiration the vocal cords stand nearer one another than under normal circumstances, the distance being about 4 mm. On deep inspiration no further opening of the glottis takes place, but, on the other hand, the cords are not sucked together. The movements of the left vocal cord are distinctly more defective than those of the right. On phonation complete closure of the glottis occurs." On December 19th it was seen that the abductor paresis of the left side had advanced into total abductor paralysis, and that the free borders of both cords appeared slightly excavated. Since then no changes have occurred.

Mr. Spencer, basing his remarks on his experiments upon monkeys, as well as on the results of other observers, maintained that although the case was one of a wide-spread lesion, yet if any localisation could be made it would be one of the lesions, viz. that which produces difficulty of swallowing. The difficulty in swallowing, the paralysis

of the lower face, and the paralysis of the abductor fibres all agreed with a lesion some distance above the calamus scriptorius in the floor of the medulla. On the other hand, the freedom of the tongue, of the abductor fibres of the larynx, and of the muscles of the neck indicates that the lowest portion of the floor of the medulla and the upper end of the spinal cord is not involved.

The PRESIDENT, in reply to Mr. Spencer, stated that it was impossible to fully discuss the large question as to the ultimate supply of motor fibres to the larynx in the course of the present discussion, and that he hoped at no distant date to more fully enter upon this important subject. All he could say at present was that whilst fully admitting the force of the anatomical researches made by Mr. Spencer, Grabower, Grosmann, and others, he did not yet see his way to reconcile the resurrection of the view that the vagus supplied the motor innervation of the larynx with a large number of well-ascertained clinical facts, and that in view of the frequent changes of opinion concerning this question which had taken place from the beginning of this century to the present time, he thought it wiser to keep his mind quite open on this question. One thing, however, appeared clear to him, viz. that cases like the one brought forward by himself were not calculated to elucidate this question. A disseminated lesion or one extending over so large a tract as undoubtedly present in this case was open to so many interpretations, that from the clinical point of view alone it seemed to him impossible to argue from it for the correctness of either view. It was in cases rather like those brought forward by Hughlings Jackson, Stephen Mackenzie, and others, in which there was associated lesion of one half of the tongue, one half of the palate, the corresponding vocal cord, and the corresponding sterno-mastoid and trapezial muscles or in cases such as reported by Gerhardt, in which clonic spasm of the last named muscles was associated with twitching movements of the corresponding vocal cords that conclusions as to the innervation of the larynx seemed justified, and such cases did not seem to him to speak in favour of Mr. Spencer's view.

CASE OF EXCISION OF LARYNX; MYXO-CHONDROMA OF LARYNX.

Shown by Dr. BOND. This patient a man of 50, had the whole larynx removed in September, 1892, save the epiglottis and the posterior and superior borders of the thyroid cartilage. The cricoid cartilage, with the growth in lumen of it, weighed 11½ drachms, and was portrayed in 'Lancet,' June 3rd, 1893. Eight days after operation the patient was able to eat a chop. The patient has now worn his artificial larynx for thirty-nine months and is in robust health. He presents no signs of recurrence. His voice is good. The case was shown at Clinical Society in 1893.

Case of Complete Excision of Larynx for Epithelioma; numerous Glands Removed.

Shown by Dr. Bond for Mr. Harvey. Tracheotomy was performed on this patient in July, 1894, for laryngeal obstruction due to an epitheliomatous mass affecting right cord, &c. The patient at that time declined a radical operation. On August 14th, 1894, the whole larynx was removed, but epiglottis left. Numerous glands were removed from both sides, most of them through the operation wound, but separate incisions were made to remove others. After the operation the patient was for a time in a miserable condition owing to the large flow of saliva through the upper part of wound. Finally, two plastic operations were performed and the gap above site of artificial larynx opening closed up. The operation was performed seventeen months ago. The patient now wears an artificial larynx without reed, can speak well, swallows solids and liquids without difficulty, looks in robust health, and states that he can follow his employment as well as he could before the operation. The larynx, on removal, was found extensively affected on both sides. Patient is now fifty-one years of age. At present there is no recurrence.

Dr. Bond, in reply to Dr. Dundas Grant, said the sub perichondreal operation was performed.

Case of Clonic Spasm of Pharynx and Soft Palate.

Shown by Dr. Bond. This patient, a man of 33, came to the Throat Hospital, Golden Square, on account of deafness. Both mallei were found adherent to promontories.

On examining throat the back of pharynx was found to move in a rhythmical manner, horizontally to the left and back again, and at the same time the left side of soft palate was drawn up and then relaxed. The larynx was not affected. Patient could give no history of the malady, as he thought his throat was quite healthy. There was no clicking heard by patient himself, or by others. It is a case of so-called chorea of the pharynx, but the name is an inappropriate one.

Dr. Clifford Beale thought the case should not be described as one of chorea, as the movements were so very unlike those of chorea.

Dr. Bond, in reply, stated that he had seen a somewhat similar case in which a small tumour of the medulla was afterwards found.

A Large Nasal Polypus Removed from the Naso-pharynx of a Man aged 32.

Shown by Dr. A. Bronner. In this case there had been nasal obstruction for two or three years, and for some months the patient had seen a round tumour projecting below the soft palate. The tumour was removed through the mouth by forceps. It was four inches long. The mucous membrane of the nose was slightly thickened, but there were no other polypi or polypoid degeneration.

Mr. Cresswell Baber had several times seen these post-nasal polypi occurring singly, and found that they often did not recur after removal.

Case for Diagnosis.

Shown by Dr. Couper Cripps. William S—, æt. 50, presents a smooth elastic swelling about half the size of a large walnut on the left side of the thyroid cartilage extending over the middle line. The patient has been aware of its presence for several years, and it has noticeably increased during the last two. The larynx appears normal, but there is considerable enlargement of the lymphoid tissue at the base of the tongue and some chronic naso-pharyngeal catarrh.

Mr. Bowlby exhibited a similar case at the last November meeting, which was considered to be either a thyroid or hyoid cyst.

Mr. C. Symonds thought the swelling was either a thyroid or a hyoid cyst.

Microscopical Section of Regenerated Tissue after Turbinectomy in Patient Shown at Last Meeting.

Shown by Dr. W. Hill.

Mr. Cresswell Baber thought that the specimen consisted of a hypertrophy of the remaining tissue.

Mr. C. Symonds did not think that any regeneration had taken place, but rather an overgrowth of what was left.

Dr. Pegler thought the cylindrical epithelium was of an œdematous character, but also pointed out that the subepithelial connective tissue was in a similar condition, and probably also the ill-developed muscular walls of the sinuses. He ventured to think that the opinion he had given of the case when shown, was so far verified by this section.

Two Cases of Tubercular Laryngitis, in which Complete Recovery took place.

Shown by Dr. David Newman.

J. P—, æt. 29, came under Dr. Newman's care in January, 1889, for impairment of the voice, which commenced at the beginning of September of the previous year.

When first seen, the voice was soft, very weak, and aphonic; but occasionally it suddenly broke into a falsetto note, which was sometimes maintained for a few minutes. The patient had had three slight attacks of hæmoptysis. The quantity of blood lost was never more than a few drops at a time. The expectoration was composed of greyish-white semi-transparent muco-purulent material, which frequently contained large numbers of tubercular bacilli. It was at no time profuse.

On examination, the epiglottis and the mucous membrane covering the arytenoid cartilage on the left side presented the characteristic appearance of tubercular laryngitis. The vocal cords were normal in appearance, but the mucous membrane of the larynx was at one point studded over by numerous miliary tubercles. There were no objective or subjective evidences of tubercular disease elsewhere than in the larynx. The patient complained of considerable difficulty in swallowing, and on account of the pain had been prevented from taking a proper amount of nourishment. Emaciation and anæmia were marked. Temperature was practically normal. Appropriate treatment was adopted, and the patient carefully watched, frequent examinations being made of the sputa, larynx, and lungs. In May, 1889, physical signs developed indicative of pulmonary phthisis on the left side.

The second case in many respects resembled the one just described, it also being a case of primary tuberculosis of the larynx, in which the lungs became involved secondarily.

The patient, W. B—, æt. 19, a tall, slim lad, presenting the characteristic physiognomy of a tubercular patient, came for consultation in June,1887. The previous February he noticed that his voice was very easily fatigued, and that if he spoke much, even in a quiet way, he became slightly hoarse. When first seen, the hoarseness had developed into complete aphonia; dysphagia was very marked, the pain being so severe that he was unable to take solid food; but fluids could be taken without great difficulty; cough was short and dry, and

expectoration was small in quantity, but very viscid. Occasionally he suffered from sudden attacks of dyspnœa.

On examination the mucous membrane of the pharynx, palate, and larynx was very anæmic, while the margins of the pillars were of a bright red colour. The epiglottis was greatly indurated, and there was some thickening of the arytænoid mucous membrane, with ulceration of the right vocal cord. The sputa was sometimes free from tubercular bacilli, but the majority of specimens examined contained large numbers of these micro-organisms. The only indications of pulmonary tuberculosis were slight moist râles at the right apex in front, and a marked prolongation of expiration over the upper third of the right lung.

In both these cases the larynx was examined previous to any pulmonary signs presenting themselves, and in both a physical examination of the chest showed the lungs to be ultimately implicated.

The treatment adopted in both cases was a carefully regulated diet. The patients were kept in a warm, moist atmosphere, impregnated with menthol, terebine, and eucalyptus. The principal local treatment was spraying the larynx with cocaine, and when sufficient anæsthesia was so produced, the larynx and pharynx were freely sprayed with a concentrated solution of iodoform in equal parts of alcohol and ether. This was repeated at first twice daily, and subsequently three times a day. At first the patients complained a good deal of the irritation of the applications, but after a few days they experienced so much benefit from the spray that they were willing to have it used as frequently as was desired. Codeia combined with nepenthe was occasionally given to relieve cough, and the general treatment of tubercular laryngitis was carried out. In both instances the dysphagia became less pronounced, the voice improved in strength and tone, and the patient began to gain in weight.

Dr. Newman has employed the iodoform spray in a considerable number of cases of tubercular laryngitis, and in almost all, considerable relief has been experienced; but these are the only two in which a cure has been effected. The patients are now (1896) to appearance perfectly healthy. The laryngeal condition in both cases is so much improved that it was very difficult to discover the remnants of the old lesion when the larynx was last examined. In the first case the only distortion is a puckering of the epiglottis, and an undue paleness of the mucous membrane over the left arytænoid cartilage.

It may be remarked that when the larynx is sprayed with the iodoform solution, the odour of the iodoform can be detected in the breath for fully six hours after the application is made. To be efficient, the iodoform treatment must be adopted before ulceration of the mucous membrane has set in.

Case of Epithelioma of the Left Tonsil, Left Posterior Pillar, and Uvula.

Shown by Dr. David Newman. Mr. A—, æt. 55, a farmer, consulted Dr. Newman in June, 1890, for a swelling in his throat and pain in the left ear lasting four weeks. Dr. Newman had seen him two years before for a simple tonsillitis. On examination of the tumour in the throat, it was found to involve the upper third of the left tonsil, where it originated, as well as the posterior pillar and the left side of the uvula.

From the appearance of the growth it was at once considered to be an epithelioma; this was confirmed by a microscopic examination, and the tumour, with a good part of the surrounding healthy tissue, was excised within twenty-four hours.

The patient made a good recovery, and no recurrence has taken place till now January, 1896).

Case of Carcinoma of the Tonsil and Soft Palate.

Shown by Dr. David Newman. Mrs. L—, æt. 51, was admitted into the Glasgow Royal Infirmary on the 20th November, 1891, suffering from a carcinoma of the left tonsil and soft palate.

The history of the case showed that fifteen weeks previous to admission the patient for the first time noticed a difficulty in swallowing, which soon became very painful, especially on taking hot food. On admission the patient appeared fairly healthy, but stated that during the last three months she had been losing flesh and weight. She complained of little or no pain in the throat unless when swallowing, but great pain at times in the left ear. This pain never affected her till after the throat symptoms had developed.

On examination the left tonsil was found to be swollen and ulcerated. The ulcer extended from the tonsil to the anterior pillar,

and to the margin of the soft palate and uvula. There was not much enlargement of the tonsil, nor were the lymphatic glands involved. Carcinoma was suspected, and confirmed by an immediate microscopic examination. Within half an hour, tracheotomy having been previously performed, the tonsil was excised. A free incision was made with the electric cautery, and the tumour, together with a considerable portion of the surrounding healthy tissues was removed.

The wound healed in about three weeks. Now (January, 1896) the patient is well.

Mr. C. SYMONDS congratulated Dr. Newman on his success, as operating in these cases was not usually successful. He would like to ask Dr. Newman how he operated, and whether it was possible to do so through the mouth alone. In these cases recurrence so frequently occurred in the glands that he had determined to always dissect out the side of the neck whether there was any glandular enlargement or not.

Mr. DE SANTI thought that one case was sarcoma and the other epithelioma.

Dr. C. BEALE remarked that the recoveries from tubercular laryngitis were very few, and usually in those cases in which the lung tissue was also slightly improving.

Dr. NEWMAN, in reply, stated that the growth was small, that he removed it in one case under cocaine, together with a large amount of healthy tissue, through the mouth with the galvano-cautery; the other case was done under chloroform and with the cautery. He thought they were adeno-carcinomatous, and in answer to Dr. Pegler said that he called them adeno-carcinomatous as they resembled the type of carcinoma formed in the mamma. In reply to Mr. Spencer, he stated that he sprayed the iodoform solution three times a day; at first it was done by himself and afterwards by a nurse, who with a little trouble was taught to do so efficiently. In reply to Dr. Spicer, he stated that the solution was composed of equal parts of ether and alcohol, with as much iodoform as this would take up.

CASE OF ABDUCTOR PARALYSIS WITH LARYNGEAL CRISES.

Shown by Mr. C. A. PARKER. W. W—, æt. 32, a porter, was first seen on November 26th, 1895. He gave the following history;

Between three and four years ago he woke up during the night with difficulty of breathing, coming on quite suddenly and accompanied by a violent cough. Inspiration was very noisy, like whooping-cough. The dyspnœa became worse and worse, and his limbs began to twitch, when suddenly he fell back unconscious and motionless.

His wife states that he remained unconscious about two minutes, that he did not become cyanosed, but was perhaps rather paler than usual. When he recovered consciousness he could breathe quite well. He has had about five other exactly similar attack at intervals of about six months. The last one occurred during the day whilst at work, and was preceded by a tickling sensation in the throat; all the others were during the night.

On examination of the larynx the left vocal cord was seen to be fixed in the middle line, whilst the right was paretic, not abducting beyond the cadaveric position. Phonation was normal.

No knee-jerks could be elicited. Gait slightly unsteady. Tottering on standing with feet together and eyes closed. Some difficulty in walking along a line, and in walking backwards. Argyll Robertson's phenomenon not present. No loss of sensibility.

There is a distinct history of syphilis.

Whilst under observation the patient has had no further laryngeal crises, and the condition of the cords remains the same, but the tabetic symptoms are more marked. He now complains that he cannot walk steadily, that his feet are cold and numb, and he is suffering from lancinating pains in both legs.

In this case we may note:—The first symptom of tabes was evidently the laryngeal crises. The length of time between first attack and other tabetic symptoms. The vocal paralysis is only of left vocal cord. ? Will the right cord pass from paresis to true paralysis.

The PRESIDENT stated that Mr. Parker's observations deserved particular consideration, as showing that in tabes laryngeal symptoms may precede every other symptom, and therefore in these cases the reflexes should be always examined.

Dr. WATSON WILLIAMS asked if in this case the pulse-rate was regular. He considered that an irregular pulse-rate in association with laryngeal paresis pointed to tabes. He had recently had a case illustrating this.

MICROSCOPICAL SECTIONS OF WARTY GROWTH OF SUSPICIOUS NATURE ON LEFT VOCAL CORD.

Shown by Dr. SCANES SPICER. The patient, a man æt. 54, was shown at the November meeting of the Society. The growth was removed under cocaine, with Mackenzie's cutting forceps, at second sitting. After a fortnight the voice was strong, and showed a slight

roughness only, the cord moved well, though still reddened, and a slight white projecting point marked site of attachment.

The histological report by Dr. T. H. R. Crowle, Surgical Registrar at St. Mary's Hospital, is as follows:

"The tumour was round, measuring 1½ mm. in diameter, firm, and of a pinkish colour; to it was attached a small portion of mucous membrane.

"Microscopical examination shows it to consist of fibrous tissue in various stages of development, but for the most part fully formed; in it there are numerous capillaries, and around these are collected small cells. On the right of the section is an area consisting almost entirely of these small cells, which are evidently of inflammatory origin. The attached mucous membrane also shows collections of small cells beneath the epithelium.

"There is no trace of epithelial cells in the nodule, and the mucous membrane shows no irregular proliferation of the covering epithelium. The epithelium does not pass over the surface of the nodule, but ends abruptly on each side, and on the right it is folded back on itself. The nodule also appears to be more or less isolated from the mucous membrane. These appearances are probably due to the forceps used at the operation having squeezed the nodule out of its bed. Although the epithelium probably extended over the nodule for some distance, I do not think that the surface was entirely covered by it.

"The nodule is evidently of inflammatory origin, and the inflammation must have been very chronic and of long duration to produce fibrous tissue such as that found in the nodule."

Fibroma (? Fibro-Sarcoma) of the Cartilaginous Septum. Case and Microscopical Specimen.

Shown by Dr. St Clair Thomson. This case was brought forward as in some way a pendant to the one shown by Mr. Stewart at the last meeting ('Proceedings,' page 30), although in the present instance members might decide that the growth was distinctly malignant, and not a simple fibroma. M. N—, æt. 29, on 28th October last sought advice for nose bleeding. Two years previously he had had blood-spitting on and off for three months, and had been treated for chest disease. He had three attacks of epistaxis during the year

1895, and at odd times in previous years. Not noticed difficulty in nasal respiration. An irregularly ovoid, lobulated growth was removed from the right middle meatus with a snare. It grew by a fairly thick pedicle from the centre of the cartilaginous septum. The free hæmorrhage had to be controlled with the galvano-cautery. A week afterwards the base was touched with the cautery, and at his third visit two weeks later there was distinct proliferation of the root. The growth had by this time been cut, and although some skilled pathologists held it to be a simple growth, others took it to be distinctly sarcomatous. Taken in conjunction with the recrudescence, Dr. Thomson inclined to the latter view. Thinking that the cautery might have an irritating action, the stump had been touched with chromic acid. It still tended to sprout, so that a month ago it was, for the last time, freely seared level with the surface by means of the galvano-cautery. Members would now see that after four weeks' interval it was most distinctly recurring. As a stump does not contract under cocaine, it cannot be a growth of erectile tissue. The septum itself does not appear to be infiltrated, and the opposite side is healthy.

An interesting subjective symptom is that for the last twelve months the patient has constantly had a musca volitante, about the size of a halfpenny, floating in front of the right eye. With the removal of the nasal growth this entirely disappeared; but on reporting himself yesterday the patient remarked that he felt sure that the tumour was growing again, as a small spot as large as a pin's head was once more moving in front of the right eye.

Is the growth a sarcoma, and if so, how radical should the removal of it be?

Mr. SANTI thought it was a sarcoma.

Mr. SPENCER did not agree that it was distinctly sarcomatous; he would wait a month and see the results.

Mr. C. SYMONDS said that from the microscopical section he would not hesitate, but operate freely at once.

Dr. D. NEWMAN considered it undoubtedly sarcoma.

Mr. WAGGETT thought it was a sarcoma.

Mr. STEWART thought it was a sarcoma, and suggested that it should be sent to the Morbid Growths' Committee.

Case of Interarytænoid Pachydermia Laryngis.

Shown by Dr. H. Tilley. Patient is a woman æt. 53, and was shown at a meeting last year. All her symptoms are better now than they were then, when they consisted of feelings of suffocation and darting pains to each ear from the throat.

Examination shows a growth in the interarytænoid space, with a vertical fissure dividing the growth into what at first were two equal halves. A small portion, however, of that on the right side has been removed.

Treatment has been by application of lactic acid, from weaker solutions up to the Pharmacopœial strength of 50 per cent.; nitrate of silver grs. 30 ad ℥j every third day for two or three weeks. The condition has much improved as far as her personal comfort is concerned.

In answer to Dr. Scanes Spicer, Dr. Tilley stated that the anterior portion of one of the turbinate bones had been removed, but there was nothing wrong with the nose now.

Laryngeal Case for Diagnosis.

Shown by Dr. H. Tilley. Patient is a man æt. 51. Thirteen years ago he had syphilis, since which time he has had throat trouble. He came to the London Throat Hospital last January complaining of difficulty of breathing and hoarseness.

On examination granulation masses on the vocal processes—which are still present in less degree—were noted, the vocal cords were moveable, there was a swelling of the left arytænoid. The whole laryngeal surface secreted mucus freely, and was very red and congested.

He has been continually on iodides and mercury, and has improved to such an extent that he now has no difficulty in breathing, but the appearances as described are present in less degree, and he has been *in statu quo* for three months. The question is whether there is any other than a syphilitic disease present, *e.g.* tubercular or even malignant disease.

The President remarked that it was very difficult to give an absolute diagnosis. He thought it was either a syphilitic or an

ordinary inflammatory growth. He saw no harm in removing a portion for microscopical examination.

Case of Probable Intrinsic Carcinoma of the Larynx.

Shown by Dr. Dundas Grant. J. W—, æt. 45, consulted Dr. Grant on December 9th, 1895, for hoarseness of two years' duration and difficulty in breathing, with stridor on inspiration and to a lesser extent on expiration.

There was no spontaneous pain, but difficulty in swallowing liquids, which made him cough. He also had an aphonic cough, with the expectoration of a little mucus tinged with blood.

Had never had hæmoptysis nor night sweats, there was no family history of phthisis, and the condition of the chest was normal. No direct or indirect history of syphilis. No enlarged glands. No spreading of the thyroid cartilage.

On laryngoscopic examination there was found to be inward distortion of the left side of the epiglottis, swelling and immobility of the left aryepiglottic fold and arytænoid cartilage. The left ventricular band was red and infiltrated, and below it, covering the greater portion of the vocal cord, was a pale granular swelling, sessile and projecting beyond the median line.

The right side of the larynx was slightly congested, but free from ulceration or fixation.

Tracheotomy was performed, and the wound healed without the slightest delay.

The exhibitor thought there would be no difference of opinion as to the nature of the case.

The President suggested an immediate and radical operation in this case. He should at once perform thyrotomy and thoroughly remove contents of larynx.

ERRATA

In December No. of 'Proceedings.'

On pages 32 and 33, *for* Dr. W. A. Willis *read* Dr. W. A. Wills.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *February 12th*, 1896.

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

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

Present—24 Members and 4 visitors.

The minutes of the previous meeting were read and confirmed.

Dr. W. Bolton Tomson, Park Street West, Luton, Beds, was elected a Member of the Society.

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

Mr. M. R. P. Dorman, M.B., B.C.Cantab., M.R.C.S., L.R.C.P., 9, Norfolk Crescent, Hyde Park, W.

Dr. L. G. Glover, M.D., B.C.Cantab., M.R.C.S., L.R.C.P., 1 College Terrace, Fitzjohn's Avenue, N.W.

DISCUSSION ON THE NATURE OF THE LARYNGEAL COMPLICATIONS OF TYPHOID FEVER.

Dr. KANTHACK then read the following paper written by himself and Dr. J. A. DRYSDALE.

Opinions differ considerably with regard to the frequency of intra-laryngeal ulcerations during typhoid fever. After a short review of the literature relative to this point, the authors gave an account based on an examination of the post-mortem records of St. Bartholomew's Hospital during the years 1890 to 1894 and up to October, 1895. Of 61 cases, 14 showed loss of substance in the larynx; in 8 it was

stated in the post-mortem books that the larynx had not been examined, so that assuming that the larynx had been examined in all the remaining 53 cases, which is doubtful, ulceration was found in 26 per cent. of the fatal cases. These defects are situated generally over the tip and edges of the epiglottis and in the neighbourhood of the processus vocalis. In these 14 cases the epiglottis alone was affected four times, the larynx proper seven times, both larynx and epiglottis once; in 2 cases the soft palate or pharynx was ulcerated as well as the epiglottis.

The following associated conditions were noted: in 8 cases congestion or œdema of the lung, pleurisy in 4 cases, otitis media and pyæmia in 1 case, gangrene of the lung in 1 case. The intestinal ulceration was extensive in 8 cases, limited in 2, and healing or healed in 4. It is therefore not true that the laryngeal lesions invariably appear during the acute period of the fever before the healing commences.

The next question discussed was the pathological nature of the lesions—are they specifically typhogenetic? Dittrich's assumption that the ulcers are decubital was set aside as insufficient and erroneous. Rheiner's view is more commendable, viz. that the ulcers are produced by small repeated injuries acting on debilitated tissue. Rokitansky upheld the typhogenetic nature on anatomical reasons, the ulceration affecting the adenoid tissues of the larynx. This, they said, is incorrect, since along the tip and edges of the epiglottis and over the processus vocalis no such tissue ever develops. Others from analogy of other post- or intra-typhoidal lesions, such as periostitis and parotitis, have assumed that the typhoid bacillus produces these ulcers. The evidence on this point is weak and insufficient, more especially because until recently the *Bacillus coli* and the typhoid bacillus have been constantly confounded, and therefore none but recent observations by competent bacteriologists can be accepted. E. Fränkel and Brieger never obtained the typhoid bacillus in these laryngeal ulcers, and they themselves failed to do so in a recent case. As to other post-typhoidal suppurative lesions, typhoid bacilli have occasionally been found, and Janowski has shown experimentally that the typhoid bacillus is capable of producing suppuration either unaided or with the assistance of the pyococci. He gives, however, no observations regarding laryngeal ulcerations, and hence the bacteriological evidence is very incomplete and such as there is points against their specifically typhogenetic nature.

Further, the clinical evidence does not support the typhogenetic specificity; there seems to be no relationship between the symptoms of the fever and the laryngeal lesions. The condition of the mucous membrane of the mouth and pharynx is of importance; in nine out of twelve fully reported cases it was described as dry and brown over the tongue, and in four fissured as well, and in one even bleeding. In many if not in most cases the patient was in the so-called "typhoid state." This condition must act as a predisposing element, especially since it may be assumed that in many cases the laryngeal mucosa was in a similar condition. It is then readily injured and forms a portal for the pyogenetic cocci always present in the mouth and larynx. Naturally this would occur most commonly over and in the most insufficiently vascularised portions, *i.e.* the tip and edges of the epiglottis and the processus vocalis. This explanation, however, does not satisfy all cases, and difficulties still remain.

Undoubtedly the lesions are caused by micro-organisms; there is the strongest evidence that these are the pyococci, and not, except rarely, the typhoid bacilli. In some cases no doubt the latter may be the cause of the trouble, but it is only the soundest possible observations on this point which can be convincing. The best accounts (Brieger and Fränkel) certainly disprove the view that the ulcers are truly typhogenetic. Secondary or fresh infections by pyococci are common enough in other bacterial fevers, and there is no reason why this should not occur in typhoid fever, especially since it is well known that in this disease the streptococcus may produce endocarditis, and that in most suppurative lesions occurring during or after the fever pyococci are found. To speak of these ulcers as primarily typhoidal without the soundest and most objective evidence is mere theorising; the evidence in their possession convinces them that these laryngeal ulcers occurring during the course of typhoid fever are caused by fresh infections with pyogenic organisms which always abound in the larynx, and which gain a firm foothold on the debilitated tissues, although they cannot deny that in an individual case the typhoid bacillus may have escaped and caused the lesion.

Dr. Watson Williams (Bristol) was of opinion that while the acute and chronic laryngeal lesions arising in the course of or immediately after an attack of typhoid fever are sometimes undoubtedly secondary, and the result of septic infection, they are in the main specific and due to the typhoid toxin, and that they are more fre-

quently associated with the presence of the Eberth-Gaffky bacillus than Dr. Kanthack's observations had led him to believe. He submitted the following reasons for arriving at this conclusion.

1. As regards lymphoid tissue, Cornil and Ranvier had found that while in typhoid cases dying from pulmonary and bronchial complications, catarrhal laryngitis was generally present, in a smaller proportion and in a more acute form of laryngitis, a form characteristic of typhoid fever, the "lymph follicles" were tumefied and formed nodules in which the multiplication of the nuclei and infiltration of the retiform tissue were entirely similar to what is observed in the closed follicles of the small intestine. These tumefactions often give place to crateriform ulcers.

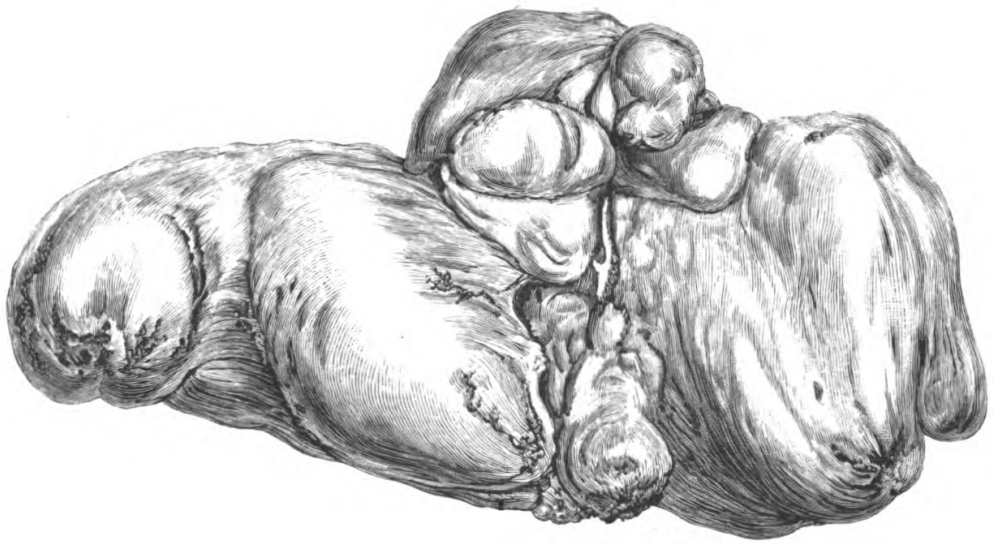
2. The remarkable frequency of initial lung symptoms in typhoid fever was suggestive of a specific origin, and in fact the typhoid bacillus had been found in the lungs in numerous instances (Councilman and others), especially when lung complications were marked. Similarly in renal typhoid complications, Neumann, who has demonstrated the typhoid bacillus in eleven out of forty-eight cases, concluded that the bacilli appear in the urine only when the kidney is directly involved. The renal lesions, like the pulmonary, formerly thought to be due to pyrexia, should be regarded as being generally due to the action of the typhoid bacilli or their toxins.

3. The remarkable frequency as well as the more or less characteristic aspect of laryngeal ulcers of typhoid fever, as distinguished from their rarity in the other exanthemata, pneumonia, and acute bronchitis, and furthermore the fact that they were especially prone to occur when the lung complications, probably specific, predominated, was strong *primâ facie* evidence in favour of their specific nature.

It might appear strange that if the laryngeal and lung lesions were alike due to specific infection, the latter alone should so frequently result in ulceration. But in congenital typhoid the intestines do not present ulceration, and this Dr. Watson Williams attributed to the absence of saprophytic micro-organisms, especially *Bacillus coli*, which abounding in the intestinal tracts in after life, increase the virulence of the typhoid bacilli, the symbiosis resulting in the characteristic disintegration and ulceration. So in the larynx the ulcerative process may be attributed to the fact that, unlike the lung, it is much exposed to the combined action of saprophytic and typhoid bacilli under *conditions which markedly favour the development of extreme pathogenic properties.*

4. It was hardly possible to account for the inoculation of certain cases except by aërial infection. He referred to cases occurring in the Bristol Royal Infirmary which he had already reported in detail,* in which a patient and a nurse apparently caught typhoid fever from the expectoration of a case with laryngeal ulceration. All three cases were virulent and fatal, and two at any rate had typical typhoid ulceration of the larynx. Moreover, *from these typhoid ulcers in the second case, the Eberth-Gaffky, differentiated from* Bacillus coli *bacilli, had been obtained* by culture. Lucatello had also obtained typhoid

* 'Brit. Med. Journ.,' Dec. 15th, 1894.



Woodcut illustrating Mr. W. R. H. Stewart's case of Fibroma of the Nasal Septum.
(Exact size of fresh specimen.) See page 30.

bacilli from the laryngeal lesions in a case dying on the twenty-first day. With all bacteriological precautions he found these bacilli both in the expectoration and in the tumefied but non-ulcerated mucous membrane.

5. Just as more general typhoid lesions fell into two groups, the acute and the chronic secondary focal abscesses, otorrhœa, and osteomyelitis, in which typhoid bacilli had been demonstrated, so likewise did the laryngeal complications of typhoid fever.

Mr. S. G. SHATTOCK exhibited some preparations showing the ulcers so typical in situation, viz. over the vocal process of the arytænoid. He could say from having examined especially into the point that there was no lymphoid tissue in this situation in the normal condition, and therefore the lesions in the larynx were not strictly comparable to the intestinal lesions.

Dr. JOBSON HORNE, observing that when ulceration of the larynx is noted in typhoid fever it is not necessarily typhoid in nature, said this point had been brought to his notice whilst investigating microscopically a number of larynges presenting all sorts and conditions of ulceration. The ulceration in some of the larynges obtained at autopsies of persons dead from typhoid fever had been found under the microscope to be of a tubercular nature. This he considered of interest, having regard to the fact referred to by Dr. Kanthack and Dr. Drysdale in their statistics, that not infrequently deep ulceration of the larynx in typhoid is associated with advanced pulmonary changes. In such cases it would be important to know the condition of the lungs and larynx before the onset of the fever. In one case the history suggested that the ulceration was a pre-existing condition. Bearing in mind that tuberculosis more commonly follows typhoid than any other fever, it may be that typhoid renders the laryngeal tissues more vulnerable to the attacks of the tubercle bacillus. He considered that typhoid may be a possible factor in the ætiology of tubercular ulceration, and the tubercular diathesis a factor in the ætiology of typhoid ulceration, of the larynx. This point might be considered in future statistics.

The PRESIDENT asked Dr. Kanthack why the cricoid cartilage was so frequently the seat of disease. There were several specimens showing this apart from ulceration at the vocal processes.

Dr. KANTHACK, replying to Dr. Watson Williams, did not accept the statement with which he credits Cornel and Ranvier with regard to the lymph follicles in the larynx. His own observations and those of others have shown the absence even in disease of any adenoid tissue over the processus vocalis and the tip of the epiglottis. This anatomical point was beyond discussion. Further, he desired to know what authority Dr. Williams had for stating that the typhoid bacillus had been found in the lungs in "numerous instances." He could not obtain any evidence on this point, in fact it was generally acknowledged that the presence of Eberth's bacillus in the blood during typhoid fever was extremely rare and unusual. The comparatively frequent occurrence of this bacillus in the urine was indisputable, but from that no one could argue that the tissues generally were infected; organisms may readily find their way through the kidneys

into the urine and bladder without there being a blood infection. The bacterium coli, for instance, escapes fairly easily into the kidney, and yet the tissues are free from it. To argue from congenital typhoid fever in his opinion was to argue from the unknown. Dr. Williams assumed that the typhoid bacillus in the lungs produces no ulcerative lesions because it does not exist there in symbiosis with the *B. coli.* Dr. Kanthack, on the other hand, had shown that it is always present there, so that following Dr. Williams' own argument, necrotic lesions in the lungs should be common, "since the typhoid bacillus exists there in numerous instances." He suspected that there must have been a confusion between the *B. coli* and the typhoid bacillus, if not perhaps in all cases, certainly in almost all cases. The case quoted by Dr. Williams was striking, and although he could not reject the observation he was by no means prepared to accept it, because he knew the errors generally committed in the diagnosis between the *B. coli* and Eberth's bacillus. In any case it had no more value than a single observation could have. Most authors, including Wassermann and himself, had failed to find typhoid bacilli in the suppurative or inflammatory complications of enteric fever. He would not say that the typhoid bacillus never caused such processes, chiefly because Janowski had found it and because he himself and also Dr. Klein had discovered it in the blood in ulcerative endocarditis. Savarelli no doubt was a brilliant writer, but as to the soundness of his discoveries he was less certain, and he would therefore recommend the use of more than a grain of salt with the conclusions of this versatile writer. Facts and not theories were wanted, and what Dr. Williams maintains had not been established as yet, viz. that the typhoid bacillus has been found over and over again in the typhoidal laryngeal ulcers. With regard to the President's question, he was not prepared to answer it without a little more thought and study, but he had always considered the cricoid perichondritis to be secondary to the ulceration over the processus vocalis.

Discussion on Foreign Bodies in the Upper Air- and Food-Passages.

Mr. Charters Symonds in opening the discussion said he proposed to limit his remarks to the questions of diagnosis and treatment. In the *nose* where no history was given he thought the most characteristic symptom was a unilateral purulent discharge, with more or less obstruction, the discharge being often blood-stained. In young children he suggested that in all such cases a careful examination under chloroform should be made. He asked for information as to other causes of a unilateral purulent discharge in children under six or seven. In his experience he had seen but two cases where no foreign body was found. He had found a probe and forceps the best instruments for removal. The plan of forcing a stream of water up the healthy side he had known to succeed, and asked as to the value of this method. He had no experience of sternatatones, and doubted

their value. In the pharynx, stress was laid upon the importance of examination with the mirror, and the close resemblance of a string of glairy mucus to a fish-bone. The site of puncture was to be recognised as an elevation having a grey centre and showing a ragged aperture. Where nothing could be seen the finger should be used, and if the body were felt, a forceps could be guided down. In young children this was the only method available. The danger of further driving in sharp bodies was referred to. Attention was next directed to the persistence of irritation after the removal of the foreign body, and of the nervous apprehension that frequently ensued. In the larynx the foreign bodies were divided into those which are small, and after the first paroxysm do not impede the respiration, but give rise to local pain, cough, and some dysphagia but no danger; and those which are large, or being small are so placed as to impede respiration. In the first class, removal by intra-laryngeal methods could be safely undertaken, and a case was given of a small bone successfully dislodged. In the second group he laid stress on the importance of having everything ready for tracheotomy in the event of a spasm being set up.

Where death or expulsion had not occurred, tracheotomy should be performed, and then the body removed through the wound if possible. If impacted in the glottis, he thought it better, after recovery from the operation, to attempt removal through the mouth before dividing the thyroid cartilage. The necessity of submitting such cases to a skilled operator before resorting to thyrotomy was insisted upon. In children after tracheotomy a foreign body might be felt by the finger and removed from the larynx. A case was mentioned of this kind. With regard to the wound he thought that if all extraneous substances were removed there was no necessity to retain the tube. He preferred to put in one suture above and cover with gauze, rather than to suture the trachea and skin. In young children the danger of a tube itself was pointed out as a reason for not delaying extraction after tracheotomy; for if the body could not be reached and removed by the forceps guided by the finger, division of the larynx must be carried out. The confusion liable to arise from the resemblance of the symptoms to those of acute laryngitis was pointed out, and cases given in illustration.

In the trachea and bronchi the value of the paroxysmal cough was referred to, also the importance of a knowledge of the nature of the foreign body. The danger of mistaking the quiet period for complete recovery was pointed out. A case of impaction of a pebble in the left bronchus was described, where removal was effected in the sixth week. Though much emaciated from hectic fever the child rapidly recovered. The danger of inversion and succussion without previous tracheotomy was thought to be sufficient to exclude the method. That tracheotomy should always be performed when a foreign body is in the trachea or bronchus was held to be a rule of surgery.

Cases of death from the entrance of food during the administration of anæsthetics were given, and others in which tracheotomy was successful.

In the œsophagus the main points dwelt upon were: the danger of over-manipulation causing fatal laceration; of driving a penetrating body into the aorta; the wisdom of forcibly pushing down impacted food rather than waiting a few hours for solution to take place. With regard to *coins*, importance was attached to sounding with a bullet probang or the money-catcher, and the inadvisability of using an ordinary bougie. In this connection the speaker asked if the gullet should necessarily be explored in all cases. If so, and the child proved refractory, ought we to give an anæsthetic? He asked for experience as to the value of emetics.

The removal of tooth-plates by œsophagotomy was next discussed, and a case under the speaker's care was described. The operation gave rise to no difficulty in performance, and the tooth-plate was easily removed. In making suggestions for the management of the wound, preference was given to packing with gauze, after suture of the gullet.

Finally the speaker asked for information regarding the utility of illumination of the œsophagus.

The discussion was adjourned to the next meeting of the Society.

The following regulations have been made by the Council to facilitate the use of the Society's Library by the members.

> Any member who may wish to borrow a work in the Library (other than single numbers of current periodicals) should apply to the Librarian by letter at least three days before any meeting of the Society, at which meeting the work will be handed to him. Works thus borrowed may be kept for one month, but if applied for by the Librarian shall be returned at the next ensuing meeting of the Society. Any works lost or damaged must be replaced or made good by the borrower.

A list of the works at present in the Library will be found in the 'Proceedings' for January, 1894, and January, 1896.

Members wishing to obtain odd numbers of the 'Proceedings' to complete imperfect set, &c., can do so on application to the Librarian. The price of such numbers has been fixed at 6*d.*, and the price of full sets (unbound) at 2*s.* A few copies of Volumes I and II bound together will shortly be obtainable, price 2*s.* 6*d.*

The Council have confirmed the following regulations of the Morbid Growths Committee.

> That reports be presented to the Society at the January, March, and June meetings.

That the Committee shall receive specimens to report upon from the Society only, and not from individual members.

That the reports presented by the Committee shall not be open to discussion.

That if the Society has carried a resolution that a specimen be sent to the Morbid Growths Committee for examination, the member shall give the section or specimen to the Senior Secretary before leaving the meeting if possible, or forward it on the earliest possible occasion, together with a short epitome of the case.

That no section or specimen be received for immediate diagnosis.

That a cabinet of sections be formed to be placed under the care of the Senior Secretary for the use of the members of the Society only, at the Society's rooms; no section to be taken away from the room.

That members be requested to contribute to the formation of such a collection. The sections so given to be submitted to the Morbid Growths Committee.

W. R. H. Stewart,
StClair Thomson, } Hon. Secs.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *March 11th*, 1896.

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

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

Present—25 Members and 3 visitors.

The minutes of the previous meeting were read and confirmed.

Mr. M. R. P. Dorman, 9, Norfolk Crescent, Hyde Park, W.; Dr. L. G. Glover, 1, College Terrace, Fitzjohn's Avenue, N.W., were elected Members of the Society.

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

Mr. Gustave Schorstein, M.B.Oxon., M.R.C.P.Lond., 11, Portland Place, W.

Dr. A. Logan Turner, M.D.Edin., F.R.C.S.E., 2, Coates Crescent, Edinburgh.

The following report of the Morbid Growths Committee on the microscopical specimen of a growth removed from the nose by Dr. StClair Thomson, and shown at the January Meeting, was then read.

The Morbid Growths Committee report that they received from Dr. StClair Thomson specimens consisting of three sections of a growth, and the following notes of the case:

Microscopic specimen, labelled "StC. T. &c., No. 126.—Removed on October 25th, 1895, from the right middle meatus of a man aged 29. Growth was the size of a hazel nut, irregularly ovoid and lobu-

lated, with marked and fairly thick pedicle growing from centre of right cartilaginous septum. Removed with cold snare; free hæmorrhage, checked with cautery. Base freely treated at intervals with the galvano-cautery, and also (thinking that the cautery might produce too much reaction) with chromic acid. Recurrence took place, and after leaving the stump entirely alone for a whole month the recurrence was the size of a nut without its shell. This portion has just been removed and will also be microscoped. The tumour had had no treatment whatsoever before being removed. The septum was in no way infiltrated; the growth was quite localised, and the opposite nasal fossa was perfectly normal. Since removal three months ago the growth has not tended to attack neighbouring parts. The growth was hardened in corrosive sublimate, embedded in paraffin and stained with logwood and eosin."—Signed, StClair Thomson.

The report of the examination is as follows :—"The specimens submitted to us comprise three sections, each about the size of the transverse section of a pea. Each of them is almost completely surrounded by normal columnar epithelium, beneath which is some loose connective and myxomatous tissue in some parts, whilst in others the epithelium is placed directly on a new growth. This new growth is composed almost entirely of blood-vessels of very different sizes, whose walls are formed of cells and do not contain either elastic or muscular tissue. The stroma between the vessels consists of loose fibrous tissue with oval and spindle cells which are of uniform character throughout and arranged concentrically around the vessels, amongst which there is a good deal of extravasated blood. We consider the tumour to be an angeioma."—Signed on behalf of the Committee, W. R. H. Stewart.

Case of Cyst of Glosso-Epiglottic Fold.

Shown by Dr. Clifford Beale. The patient, a man æt. 38, was admitted to Victoria Park Hospital suffering from bronchitis. He stated that for some months past he had been aware of something at the back of his tongue which had slightly affected his voice, but had caused him no other inconvenience. On examination, a swelling the size of a cherry was seen at the back of the tongue, and in contact with the epiglottis but not attached to it. The walls of the tumour

were vascular, and on palpation with a probe the swelling was found to be soft and yielding to the touch, and to be attached to the tongue by a broad base. No local treatment was applied, but the patient was treated by ordinary remedies for his attack of bronchitis, which subsided in about ten days. During this period the swelling had got much smaller according to the patient's own statement, and on further examination this was found to be the case. The question then arose for decision as to the best means of treatment for its complete destruction, and an expression of opinion was asked as to the respective merits of free incision—excision of a part of the cyst wall, or destruction by galvano-cautery.

Dr. Bond asked if Dr. Beale was sure of the cystic nature of the growth; if such, he would suggest the use of the galvano-cautery and curette.

The President stated that he had usually found a free incision or the use of cutting forceps under cocaine sufficient.

Mr. Symonds usually cut off the top of the cyst.

Dr. McBride had found them most obstinate to cure.

Dr. Beale, in reply, stated that he had examined most carefully with a probe, and was certain that the tumour was cystic.

Case of Tubercle or Cancer?

Shown by Dr. Clifford Beale. The patient, who had been previously shown to the Society ('Proceedings,' vol. iii, p. 21), had been kept under observation for three months, and had been treated with iodide of potassium and good diet, and latterly, by the advice of Mr. Stewart, with local applications of zinc chloride. The swelling springing from the left ventricle of the larynx had become much less prominent and less angry in appearance. A small amount of thickening of the whole cord remained, but the movements had not been in any way impaired, and no further change had taken place in the small gland in the neck. The patient himself had maintained his weight and general nutrition, but his voice was as weak as before.

Dr. Beale was of opinion that the case was one of chronic tubercular infiltration, and that the disease in the larynx was in all probability following the course of the disease in the lung, which was gradually undergoing the usual fibroid shrinking.

Case of Larvæ in the Nose.

Shown by Dr. J. W. Bond. Case was brought forward owing to the great rarity of the condition in this country.

The patient, a woman æt. 49, had attended the Throat Hospital for some eighteen months for chronic pharyngitis, &c. In May, 1895, she noticed a profuse watery discharge from nose for three weeks, and sharp shooting pains in left frontal region. The discharge was never purulent. On examination of nose the passages were found patent, and indeed the mucous membrane over turbinate a little atrophic. For about six weeks various nose lotions were used without good result. Then, after using a dilute Mandl solution (mxv in ʒj) twice, four grubs came from the nose, and she was relieved. She remained quite well for another two weeks, during which she attended the hospital.

The grubs were segmented, somewhat stained by the iodine; some of them developed into flies, which on examination by Mr. Charles O. Waterhouse, of the Natural History Museum, were pronounced to be *Piophila casei*, Linnæus, the larvæ of which are said to feed on cheese, bacon fat, and animal matter generally.

There was no particular smell noticed likely to attract the fly. The case seems to have been very readily cured, no doubt because the accessory sinuses were not invaded.

Mr. Spencer would like to know if there had been any dogs about the patient, and whether this form occurred in dogs.

Dr. Bond had no information as to dogs. Had never come across any record of a case of this description before.

Specimen of Myxoma of Larynx.

Shown by Dr. Bond. The patient, a man æt. 50, gave a history of attacks of huskiness and loss of voice for twenty years.

Twelve months ago voice almost went, and on examining the larynx on January 15th last, a growth about the size of a pea was seen to occupy the upper surface and edge of the middle of the right vocal cord. It was transparent in the centre, and had a cyst-like appearance. On February 15th it was removed by the endo-laryngeal method, since when the voice has wonderfully improved, and patient states that it is better than for the past ten years.

The growth removed was jelly-like. Microscopically it seems to be a pure myxoma.

Dr. Bond directed attention to the long history in the case. No doubt the man may have had chronic laryngitis for some years. It was common to find some myxoma in a laryngeal tumour, but a pure myxoma was very rare. He thought it possible there may have been some growth for a long time, and that a pure myxoma was here, owing to the time which such growth has had to undergo change.

The PRESIDENT said that with Dr. StClair Thomson's case, and one they had a few meetings ago, there had been shown at the Society in a comparatively short space of time three cases, whilst up till quite recently only six cases had been recorded. He thought, too, it was remarkable that in each case there was a history of trouble of nearly twenty years' standing.

Dr. LAMBERT LACK said he had one such case this year, and one mixed with slight amount of fibrous tissue last year.

Dr. KANTHACK stated that he began examining these cases some years ago. He thought that most of them were more myxomatous degeneration, which was comparatively common, than pure myxomata, which were extremely rare. He suggested that the growths should be sent to the Morbid Growths Committee. [This it was resolved should be done.]

CASE OF MYXOMA OF VOCAL CORD.

Shown by Dr. STCLAIR THOMSON. Marion J—, æt. 38, had taught since the age of seventeen, but always in private schools, the number in her class never at any time exceeding twelve. She used to sing, but her voice had been "thick" for a year past, and for the last twelve months she had given up attempting to sing. For three months she had suffered from hoarseness and partial loss of voice, especially after using it much. A spherical growth, about the size of a small pin's head, smooth, red, and pedunculated, was found projecting into the glottic space at the junction of the middle and anterior thirds of the right vocal cord. There was some injection and thickening of the adjoining upper surface of the cord, and impaired approximation of the cords in phonation. The growth was removed with Mackenzie's antero-posterior forceps, and sections showed that it was a myxoma,—unless, indeed, it should be regarded as simply œdematous mucous membrane. In 1880 Morell Mackenzie spoke of myxoma of the vocal cords as "very rare," and said that he had only met with a single case ('Diseases of the Throat and Nose,' vol. i,

page 306). It was therefore noteworthy that this growth was removed on the same afternoon as the one already referred to by Dr. Bond. Both cases occurred at the Throat Hospital, Golden Square, in the clinic of Dr. Bond, to whom he was indebted for kind permission to show this one.

Case of a Growth on the Hard Palate of a Girl.

Shown by Mr. L. Lawrence. A girl, æt. 11, showed a flat, warty-looking growth growing from the mucous membrane of the hard palate, attached by a thin pedicle in the centre; patient is unaware of the length of time she has had it.

Mr. Symonds stated that he had a case of small tumour of the soft palate which had turned out to be a dermoid.

Dr. Pegler said that Dr. Whistler had told him of a poodle that he had seen that had three small tumours on the hard palate.

Specimen of Growth Removed from the Naso-pharynx.

Shown by Mr. L. Lawrence. This was removed from a case shown before the Society at the end of last year. The growth was an ordinary mucous polypus without cysts. It had been removed by forceps from behind.

Case of Elongated Cervical Sinus resembling a Branchial Fistula.

Shown by Dr. Dundas Grant. The patient is a girl æt. 19, first seen in October, 1895, complaining of an inflamed swelling in the neck. This was a fluctuating, thinly-covered swelling at the lower end of the anterior margin of the right sterno-mastoid muscle, of about the size of half an ordinary child's marble. To its inner side was another smaller though similar swelling with which it communicated. There was an enlarged gland near the angle of the jaw, and a firm cord could be felt running from the lower swelling close up to this gland. The lower swellings were both incised, pus evacuated, and the lining scraped. A drainage-tube was passed through both openings. In a few days this was removed and the patient went home.

At present the inner of the two openings is represented by a firmly

healed dimple, the outer one by an orifice leading into the cord before observed. A fine celluloid bougie can be passed up the interior of this for a distance of nearly two inches, where it abruptly stops.

The sinus is probably the result of a gland abscess, but its position and character somewhat suggest a branchiogenic origin.

After-history of the Case of Carcinoma Laryngis previously shown at the January Meeting.

Shown by Dr. Dundas Grant. Death took place twenty days after the operation of thyrotomy. The patient was never able to swallow, and nutrition was kept up with apparent good result by means of enemata for a week. The patient then got into a condition of mental wandering and drowsiness. The iodoform was given up, and bismuth and boracic acid employed, but no difference took place. Free stimulation and stomach feeding were then practised, but the mental condition became gradually worse, coughing ceased entirely, and after death the lungs were found congested and œdematous, but free from pneumonic consolidation. Laryngoscopic examination, about a week after the operation, showed that the left half of the larynx was quite inactive, and it will be seen from the notes of the case previously given that one of his primary symptoms was a difficulty in swallowing liquids. There was no fistula to account for this, and it would be interesting to know whether this symptom may in general be regarded as unfavourable. There was ample evidence of regrowth round the site of operation.

Case of Chronic Hoarseness in a Patient with Chronic Rhinitis and Pharyngitis.

Shown by Mr. Spencer. A maidservant, æt. 19, has been hoarse as long as she can remember. Formerly she had suffered from nasal obstruction, but did not now complain of the nose. She has never been aphonic except once or twice when she had a cold. On examination, there is chronic dry rhinitis and pharyngitis, with crusts. The larynx can be well seen, as well as the trachea. The vocal cords come together, but fail to become tense. At the moment of adduction there is irregular bulgings. The patient was exhibited as a contribution of the relation between chronic nasal obstruction and the larynx.

Dr. CLIFFORD BEALE thought there was enough in the larynx to account for hoarseness without going to the nose for an explanation. He thought local stimulation might bring the voice back.

Dr. MCBRIDE noticed that there was a certain amount of abductor paresis of the left vocal cord, which was also much congested. He did not think the case was functional, but would look upon it with great suspicion.

Dr. TILLEY had also noticed that there was less movement of the left vocal cord than the right.

Mr. SYMONDS thought the chief complaint was in the nose. He would treat the nose and leave the larynx alone.

Dr. SCANES SPICER thoroughly supported Mr. Symonds' views.

Mr. LAKE considered that if the laryngeal congestion had been of recent origin it would get well if the nose was treated alone, but in this case the congestion was chronic.

The PRESIDENT said that the history of this case showed hoarseness from birth, with dryness of pharynx and larynx. There was some abductor paralysis of the left cord. He hoped Mr. Spencer would give a further history of the case, and would adopt one of two methods in the treatment of the case, either treat the larynx and leave the nose alone, or *vice versâ*.

Mr. SPENCER said he would treat the larynx first, and leave the nose alone for a time.

CASE OF PHARYNGEAL TUMOUR, PROBABLY SYPHILITIC.

Shown by Dr. H. TILLEY. A woman, æt. 33, came to the hospital on February 25th, 1896, complaining of a "stifling sensation in the throat," which was worse at night. She noticed the trouble first early in January.

She has had syphilis. Had two miscarriages; has two children, the youngest having been treated for congenital syphilis.

On examination, February 25th, 1896, there is a large ovoid swelling on the posterior wall of the pharynx, rather low down and about opposite the epiglottis. The larynx could not be seen. On examining her again March 10th, after she had been on anti-syphilitic treatment for a fortnight, the swelling was considerably smaller, and the larynx could then be seen.

CASE OF TUBERCULOSIS OF THE NOSE.

Shown by Dr. W. HILL. The specimen was referred to the Morbid Growths Committee.

Case of Lupus of Palate and Larynx.

Shown by Mr. E. C. Stabb.

Dr. McBride asked what the prognosis was in these cases. He had a number of cases in which the prognosis was most favorable. He used the galvano-cautery and chromic acid.

The President stated that where the parts were easily accessible, he preferred scraping and the application of strong lactic acid. When the disease was situated in the larynx he would not use the scraping from fear of stenosis following. He had treated some of his cases with simply giving arsenic and cod-liver oil, no local remedy being used.

Mr. W. R. H. Stewart mentioned that he had a case now under his care that was getting well under the administration of arsenic alone.

Case of Tumour of the Soft Palate.

Shown by Mr. E. C. Stabb.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *April 15th*, 1896.

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

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

Present—23 Members and 4 visitors.

The minutes of the previous meeting were read and confirmed.

Dr. A. Logan Turner, M.D., F.R.C.S.E., 2, Coates Crescent, Edinburgh, and Mr. Gustave Shorstein, M B.Oxon., M.R.C.P.Lond., 11, Portland Place, W., were elected Members of the Society.

Mr. M. R. P. Dorman, having signed the Register, was admitted a Member of the Society.

ADJOURNED DISCUSSION ON FOREIGN BODIES IN THE UPPER AIR AND FOOD PASSAGES.

Dr. SCANES SPICER remarked that in children for removing foreign bodies impacted in these passages a general anæsthetic should be given at once unless asphyxiation is imminent, in which case tracheotomy should be done, and then anæsthetisation. The distress and terror of the little patient is thus allayed, calm and gentle procedure on part of the surgeon is facilitated, the risk of increasing impaction is lessened, and chances of removal improved. Foreign bodies in the nose in children, from the smallness of the channels and from the swelling—usually secondary to previous attempts at removal or to consecutive rhinitis,—are not usually to be detected even by skilled rhinoscopy, and the diagnosis must depend on the probe. This must be used with caution in the right direction, and the finger inserted in the naso-pharynx to guard against backward dislodgment of the intruder into the larynx or œsophagus. *Forcible* injection of water

with Higginson's or any other syringe is undoubtedly attended with risk to the ears, especially if practised through the pervious nostril with the other one blocked. *Gentle* injection of a stream of water, insufflation of air up the open nostril (Dodd's method), and sternutatories he had seen tried without avail. When a suitable case presented itself, however, he intended trying these methods again while holding open the anterior naris of the blocked side with a speculum tilting up the tip of the nose, so as to enlarge and straighten the passage, and flexing head well on to sternum. A case was referred to in which a short vulcanite cylinder got impacted in the anterior recess of the nose; one in which a lead drainage spigot was accidentally pushed by a patient into his maxillary antrum, which had been opened for empyema through the canine fossa some months before: and one in which a young woman who was having her larynx brushed out for hysterical aphonia bit on the metal mop holder with such force that it was divided, and disappeared through her fauces; careful examination gave no trace of its position then or afterwards, and for some months she has not suffered any abnormal symptoms or from aphonia. It is not improbable in the case of certain metallic foreign bodies, *e. g.* needles and pins which had perforated the wall of the œsophagus and were lying more or less parallel to its axis (such bodies as it is most important to remove forthwith), that assistance would be given by a strongly magnetised bougie of flexible steel shaped like an ordinary gum œsophageal bougie but fluted longitudinally. He had not had a case suggesting the need of such an attempt since this idea had presented itself. With reference to the use of emetics for dislodging impacted bodies, he would fear to initiate the action of a powerful *vis-a-tergo* which could not be regulated or controlled. Emesis appeared just as likely to increase impaction and damage surrounding structures as the *vis-a-fronte* of the surgeon acting with undue violence at the end of an œsophageal ramrod—a method now so generally deprecated. He would be glad to hear what were considered the best methods of treating (1) the gullet; (2) the external wound after œsophagotomy for impacted foreign bodies.

Mr. Laurence related the case of a lady who had a whiting bone in the epiglottis low down close to the left pyriform sinus. The bone caused no symptoms, except an occasional prick. She localised the position as in the posterior faucial fold. Mr. Laurence drew attention to the difficulty of localising throat impressions generally. Another case, that of a very large rhinolith, was mentioned. The stone had no nucleus, and the removal piecemeal caused unusual hæmorrhage, not to be accounted for by the operation.

Dr. A. A. Kanthack gave the following account of a specimen of impacted piece of meat in the larynx, which he showed. A piece of meat, during hasty swallowing, had become lodged in the aditus laryngis, and has there been firmly impacted. A sagittal section had been made, which shows the relation of the parts to the foreign body. The epiglottis has been pushed forwards against the tongue, and the piece of meat has been firmly moulded into the upper part of the larynx. The specimen affords a good example of what happens when

the epiglottis does not act and becomes pushed forward, and refutes the view expressed by Prof. Anderson Stuart that the epiglottis during deglutition becomes applied against the basis linguæ, and acts as an inclined plane for the bolus to slide along into the œsophagus beyond the larynx. Experimentally this view had already been disproved by the speaker in conjunction with Mr. H. K. Anderson of Cambridge ('Journal of Physiology,' 1893).

Dr. Lambert Lack entirely disagreed with Mr. Symonds with regard to the absence of odour with a unilateral purulent discharge from the nose in children as diagnostic of the presence of a foreign body. In a large number of cases he had, the fœtor of the discharge was expressly noted. In one case an intensely horrible smell pervading a whole ward was traced to a foreign body (a piece of string) in the nostril. Dr. Lack had always considered that a unilateral *fœtid* and purulent, and often irritating discharge from the nose of a child indicated a foreign body, had usually administered an anæsthetic, and only once failed to find the foreign body. With regard to fish-bones in the pharynx, he thought that they were sometimes present when we did not find them, and that the persistence of symptoms so well known is really due to their presence. These symptoms usually last one or more months, and possibly their disappearance at the end of this time is due to absorption of the bone. If it is a needle or similar unabsorbable body which is complained of, it will probably be found or heard of later. Thus in one case which had come under his notice a needle was complained of. A month later it was found in the tricuspid valve. The places in which these foreign bodies most often lodge and escape observation are the tonsils, faucial and lingual; these should always be examined by palpation as well as illumination. A most useful and delicate method of palpation was first suggested by Dr. Sutherland. Having localised the position of the foreign body as far as possible by the patient's sensation, the part is well illumined and palpated carefully all over with a probe. The patient complains of pain and pricking, the more acutely the nearer we approach the affected spot, the greatest pain being caused when we touch the foreign body itself and in this way we may localise accurately, and remove a foreign body which we can hardly see at all. The following cases of interest were quoted.

Case 1.—The patient, a middle-aged woman, gave the history that one night, three weeks before, she woke suddenly with a violent choking attack. She coughed violently, could neither speak nor swallow, but says her breathing was not obstructed; she vomited copiously, and the attack subsided. In the morning her throat was very painful, and a doctor who was called in treated her for tonsillitis. The patient now missed her tooth-plate for the first time. This plate she had worn constantly day and night for many years, but had latterly noticed it was becoming loose. As, however, symptoms had subsided, it was presumed that the plate had been thrown away with the vomit. At the end of a week the soreness of the throat had nearly vanished, and she went to the seaside to complete her cure. Three weeks later she complained of a pricking in the throat, which she could not localise definitely. This was increased by swallowing

or turning the head suddenly. She could swallow without difficulty, and could speak easily, although with a perceptible hoarseness. She had a slight irritable cough, a little mucous expectoration, a fear that the plate was still in her throat, but no other symptoms. On examination the tooth was seen resting on the right arytænoid, and the plate extended obliquely across the larynx to the anterior parts of the left ventricle, the left ventricular bone, and the arytæno-epiglottic fold. The plate was removed with an ordinary Mackenzie forceps. The parts with which the plate had been in contact were superficially ulcerated, and soon healed. The chief point of interest in this case is the slight subjective symptoms caused by such a formidable looking object—an indefinite pricking sensation, a scarcely perceptible hoarseness, a slight cough with some scanty expectoration, were all that were complained of. Case 2.—A male, æt. 17 years, was intubated at a general hospital, in the summer of 1891, for laryngeal obstruction, probably of traumatic origin. During a violent fit of coughing the string broke, and the tube was sucked down into the trachea. Inversion and exploration by a probe and finger through a laryngotomy wound failed to detect the tube. Eventually it was assumed that the patient had swallowed it, and he was discharged from the hospital. During August, 1891, he gained flesh, and was fairly well, although suffering from much cough and purulent expectoration. In September, during a severe fit of coughing, something was felt to slip in his chest, and signs of occlusion of the left bronchus came on. This was followed by increased cough and purulent expectoration (a pint or so a day), rapid wasting, and soon by evidence of a bronchiectatic cavity at the left base. Dr. Lack then resected three inches of the sixth rib, and nine days later opened a large abscess-cavity deep in the lung. The tube could not be found. The boy was much relieved by this operation, but died a month later from hæmorrhage. Post-mortem a No. 3 O'Dwyer's tube was found in the left bronchus, separated only by a thin membrane from the pulmonary artery. The left lung was very small and collapsed, and contained a large abscess-cavity, which had been opened. One point of interest here is that the tube had remained three months in the trachea, and yet exploration by a laryngotomy wound by probe and finger, by inversion, &c., had failed to remove or even detect it. It is doubtful if the tube could have been safely removed, considering its anatomical relations, even if it had been reached. Dr. Lack entirely agreed with Mr. Symonds's remarks about the real danger of foreign bodies entering the windpipe during chloroformisation. A case of post-nasal adenoids under his care owes her life entirely to the fact that tracheotomy instruments were at hand during the operation. He would also point out that in some cases of foreign bodies in the larynx breathing may not be restored, even after tracheotomy, until the foreign body is removed, apparently because of the spasm its presence excites.

Mr. Cresswell Baber showed three rhinoliths to illustrate the subject under discussion. The first came from the left nasal cavity of a medical man. He applied with a history of discharge from that nostril for two or three months, having had no inconvenience at all

before that. On inquiry he remembered when three or four years old putting a boot-button into his nose. Examination showed the rhinolith to contain so much iron (over 30 per cent.), that it was evidently the boot-button, which must have been there for twenty-five years. The case was interesting as showing that a foreign body may lodge in the nose for over twenty years without attracting even an intelligent patient's attention. Case 2.—A child, æt. 12. History of discharge from left nostril with bleeding six years. No history of introduction of foreign body. After removal of the foreign body under anæsthetic, it was found to consist of a concretion having for its nucleus a plug of tightly folded rag. The rhinolith in this case had produced considerable distortion of the bones, the left side of the nose and left cheek were bulged out, the septum deflected to the right, and there was a deep depression in the centre of the inferior turbinated body. Case 3.—A man, æt. 33, with an intermittent purulent discharge mixed with blood from the left nostril for about nine months. A rhinolith, having a glass bead for nucleus, was found deep in the inferior meatus. It weighed sixteen grains. There was no history of its introduction. (These cases are published in full in the speaker's article on "Foreign Bodies in the Nose, and Epistaxis," in Burnett's 'System of Diseases of the Ear, Nose, and Throat'). In addition to forceps, Mr. Baber found a steel hook, of which the hook itself measured a quarter of an inch in length and one eighth of an inch in breadth, very useful for removing foreign bodies in the nose and rhinoliths. It must be strong, as in the case of rhinoliths it is often necessary to use *considerable* force. Mr. Baber remarked on the necessity of examining the naso-pharynx in cases in which a foreign body is felt by the patient in the larynx, as sensations in the naso-pharynx are often referred to that region.

Dr. Clifford Beale referred to the possibility of sudden obstruction of the larynx during meals, by means of scraps of meat, and related a case in which by instant inversion of the body and a deep inspiration, followed by a forcible expiration, the foreign body was ejected. The necessity for a very deep expansion of the lungs under such circumstances was insisted upon.

Dr. Herbert Tilley mentioned a case in which a child, æt. 4, swallowed an intubation tube, which was removed from rectum two days later by means of a nasal polypus forceps. He also mentioned a case of almost fatal asphyxia during operation for adenoid overgrowths; the portion of growth which had slipped into the glottis, however, was loosened by forcible pushing upwards of the larynx. He pointed out the advantage of having the patient's head well hanging over in this operation, and obviating the accident mentioned.

Dr. W. Hill remarked that one of the commonest forms of foreign body which he had been called upon to deal with had been pledgets of wool and lint which had been inserted into the nose after operative measures for the suppression of hæmorrhage; from the fact that several pledgets or pieces of lint are often inserted, one such body is liable to be overlooked, and great discomfort and stench results from its retention for more than two or three days. Such an accident had unfortunately happened in a case under his care in conjunction with

a general practitioner, and undoubtedly one or other of them was responsible for leaving a piece of blue gauze in the nose; no discomfort was felt for a week, and the patient was sent to Bournemouth, where he became very ill with fever, violent headache, noseache and marked fœtor; it was removed by Dr. Davison, to the immediate relief of the patient. Dr. Hill had recently removed a stinking pledget of cotton wool from the posterior naris, which had been inserted for epistaxis two weeks previously at a general hospital. In reference to Dr. Spicer's remark that one-sided nasal suppurations in children under six years of age did not necessarily point to foreign bodies, but were frequently associated with deflections and deviations of the septum, Dr. Hill said the fact that septal deformities were so comparatively rare in young children, and unilateral suppurative rhinitis being not so very uncommon, would point to this explanation being far-fetched and inadequate. The speaker had once removed a fair-sized turnip from a cow, which had apparently lodged in a pouch of the œsophagus, and he asked Mr. Symonds whether he had seen in his practice foreign bodies lodged in a pouch of the pharynx or gullet.

Dr. GRANT recommended the use of the air-bag by the opposite nostril instead of fluid syringing. Cocain should first be applied, then an oily spray should be used, and Dr. Spicer's advice to dilate the orifice should be carried out. During the use of the bag, both ears should be plugged by means of pushing in the tragus, and the patient directed to blow out the cheeks forcibly. Dr. Grant had found an instrument like a sharp recurved crochet-hook of considerable value. He, on one occasion, used the pan-endoscope for the œsophagus, and found no difficulty in introducing the instrument, but the amount of light was small, although sufficient to make it certain that no foreign body was present. He had seen the coin-catcher used with the greatest success for the removal of a tooth-plate from the œsophagus in a case in which he had endeavoured to remove it by means of forceps, and in which he was deterred from using the coin-catcher from fear of the points tearing the mucous membrane during the extraction. He narrated a case of impaction of a fine herring-bone in the lingual tonsil, which was invisible when the laryngoscope mirror was held in the left hand, but easily seen when it was held in the right one. It could only be extruded sufficiently for extraction by means of forceps when forcible pressure was made in the submaxillary region, and the patient phonated. He had in his experience come across a case of a second fish-bone after the removal of the first. With the umbrella probang he had only once withdrawn a fish-bone, although he had used it very many times.

Dr. ADOLPH BRONNER had seen numerous cases of foreign bodies in the nose. These had in nearly every case been easily removed by the use of Poitzer's bag or by a stream of water applied to the opposite nostril (not the douche). In cases of foreign bodies in the trachea it was always best to perform tracheotomy, as the body might at any time become loose and get impacted in the glottis, with fatal results. Kirstein's antoscope was often of great use in nervous patients or in children, who would not allow the laryngoscopic mirror to be introduced. Dr. Bronner would like to ask Mr. Symonds

why cases of œsophagotomy for removal of foreign bodies were so fatal. Dr. Bronner was of opinion that the use of the continuous nasal douche was very dangerous, but that the use of Higginson's syringe was not attended by any bad after-effects.

Mr. W. R. H. Stewart wished to draw attention to the difference between forcible syringing up the healthy side of the nose to remove a foreign body, and the ordinary use of the Higginson douche. Speaking as an otologist he strongly objected to the *forcing* of a stream of water up one nostril if the other was blocked, owing to the damage that might be done to the ears. The ordinary use of the Higginson's douche was one of the best ways of employing nasal irrigation, but he doubted its efficacy in removing a foreign body unless force was applied. He disagreed with Mr. Symonds with regard to the absence of fœtor when foreign bodies were in the nose. He had frequently met with cases in which a very fœtid smell was present. He had a very uncomfortable personal experience with regard to the sudden entrance of food into the glottis, some syrupy matter having suddenly entered and blocked the lumen of the glottis, causing the greatest distress for some seconds. With regard to rare foreign bodies, he had that day on removing a pair of tonsils lost one, and after a long hunt had found it squeezed into the posterior nares.

Mr. Charsley promised to exhibit a specimen showing one vertebra of a haddock which had passed through the larynx of a child aged six, and had become impacted immediately below the glottis. The dyspnœa produced was not excessively urgent. There was no history of anything having been swallowed. Although the writer saw some whitish body between the vocal cords when the child was first brought to the hospital, the house surgeon thought nothing need be done.

Dr. Sherman asked if stiffness of the neck had been noticed as a symptom of a foreign body in the œsophagus. In Mr. Harvey's absence he saw a child at the Throat Hospital, that had swallowed a halfpenny three weeks before admission. The only symptom was stiffness of the neck, the child would not put its head either towards one shoulder or the other, almost as if disease of cervical spine were present. Nothing could be seen with the laryngoscope. Use of the coin-catcher immediately brought up the halfpenny.

Mr. Jessop inquired from Mr. Symonds as to any practical method of getting rid of very viscid mucus occurring after repeated examination of the throat for foreign bodies. The umbrella probang was useful in satisfying the feeling of patients after assuring them that there is really no foreign body present. Patients frequently confess to feeling much relieved after this operation.

Mr. Waggett said that he had been working with Mr. Sydney Rowland to prove the use which could be made of the Röntgen rays in the diagnosis and treatment of foreign bodies in and about the larynx. Employing a "focus" Crooke's tube transmitting X rays transversely through the neck, they had been able to obtain, with an exposure of five minutes, clear shadow pictures of coins and fish-bones attached to the surface. As the cartilages of the larynx were transparent, and gave no land-marks on the picture, projection charts representing the distorted image of the structures of the neck had been

made, reference to which permitted of localisation of any given point. Further help in this direction was to be obtained by taking more than one position, and no difficulty was to be expected in obtaining a stereoscopic effect. In order to make exclusion possible, the relative opacities of a variety of bodies likely to obtain accidental entrance had been determined. The cryptoscope, essentially a screen of cardboard coated with potassio-barium cyanide, proved somewhat less sensitive than the photographic plate, but has the advantage of permitting of contemporaneous observation. In a darkened room the front portion of the neck appeared in half shadow, bounded above and behind by the black shadow of the jaw and spinal column. A defined shadow was cast by the hyoid bone, and on introduction of a probe into the larynx or œsophagus, the movements of the instrument could be followed without difficulty on the luminous screen. The cryptoscope should afford a valuable aid in the guidance of the forceps in the removal of foreign bodies.

[Owing to the kindness of Mr. Rowland, who had brought his apparatus, photographs were shown, and the cryptoscope demonstrated to the members.]

The PRESIDENT, before calling upon Mr. Charters Symonds to reply, thanked Mr. Waggett and Mr. Rowland for their most interesting demonstration, which in connection with the subject under discussion opened new and most important possibilities for the diagnosis and removal of foreign bodies from the upper air passages. He then briefly summarised the more important points touched upon in the discussion, and instanced as such (1) the question of danger to the ear by forcible injection of water into the nose for the removal of foreign bodies from the nasal cavity. This danger he thought was greater when a continuous than when an interrupted current, such as produced by Higginson's syringe, was used; (2) the danger of pieces of adenoid vegetations penetrating into the lower air-passages when the operation was performed with the patient sitting up; he warmly advocated the position with pending head; (3) the deficient power of localisation in the upper air-passages; sensations, even when originating in the naso-pharyngeal cavity, frequently being referred to the laryngo-tracheal region; (4) the desirability of any digital exploration being preceded by careful inspection of the parts; (5) the persistence of sensations long after the removal of the foreign body. In conclusion, he thanked Mr. Symonds in the name of the Society for having by his careful introduction given rise to so interesting and important a discussion.

Mr. SYMONDS, in reply to Dr. Spicer, said he recognised the unilateral discharge from the nose in young children with adenoids, where the other side was obstructed, but he had referred to a purulent discharge without any such cause. The different opinions expressed by the speakers as to the danger of syringing the nose, showed that the method might be employed with little risk of injury to the ear. The fatalities after œsophagostomy were due to septic cellulitis. He suggested that this might be avoided with certainty by operating in two stages, or again by plugging the wound with gauze after suturing the gullet.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *May 13th*, 1896.

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

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

Present—32 members and 10 visitors.

The minutes of the previous meeting were read and confirmed.

Douglas D. Macrae, M.B., C.M.Montreal, was proposed for election at the next Ordinary Meeting of the Society.

The following report of the Morbid Growths Committee on the microscopical sections from cases by Dr. Bond, Dr. StClair Thomson, and Dr. W. Hill was read.

The Morbid Growths Committee report that they received from Dr. BOND a microscopical specimen and the following notes of the case.

The patient, a man aged 50, gave a history of attacks of huskiness and loss of voice for twenty years.

Twelve months ago voice almost went, and on examining the larynx on January 15th last, a growth about the size of a pea was seen to occupy the upper surface and edge of the middle of the right vocal cord. It was transparent in centre, and had a cyst-like appearance. On February 15th it was removed by the endo-laryngeal method, since when the voice has wonderfully improved, and patient states that it is better than for the past ten years.

The growth removed was jelly-like. Microscopically it seems to be a pure myxoma.

Dr. Bond would direct attention to the long history in the case.

No doubt the man may have had chronic laryngitis for some years. It was common to find some myxoma in a laryngeal tumour, but a pure myxoma was very rare. He thought it possible there may have been some growth for a long time, and that a pure myxoma was here, owing to the time which such growth had to undergo change.

The report of the examination is as follows:

Specimen consists of microscopical preparation of three minute portions of tissue, stained with eosin and hæmatoxylin.

Examined under low and high powers it shows a covering of stratified squamous epithelium.

Immediately beneath this there is a definite layer of fibrous tissue which is somewhat dense and firm.

Deeper down, in what was probably the centre of the growth, the tissue is much looser, more cellular; many of the cells are branched, and in this part the growth has the structure of a myxoma.

In our opinion, the appearances above described point to the conclusion that the growth is a fibroma undergoing myxomatous degeneration.

The following notes are of Dr. StClair Thomson's case.

Marion J—, æt. 38, had taught since the age of 17, but always in private schools, the number of her class never at any time exceeding twelve. She used to sing, but her voice had been "thick" for a year past, and for the last nine months she had given up any attempt at singing. For three months she had suffered from hoarseness and partial loss of voice, especially after using it much. A spherical growth about the size of a small pin's head, smooth, red, and pedunculated, was found projecting into the glottic space at the junction of the middle and anterior thirds of the right vocal cord. There was some injection and thickening of the adjoining surface of the cord, and impaired approximation of the cords in phonation. The growth was removed with Mackenzie's antero-posterior forceps, and sections showed that it was a myxoma, unless, indeed it should be regarded as simply œdematous mucous membrane. In 1880 Morell Mackenzie spoke of myxoma of the vocal cords as "very rare," and said that he had only met with a single case ('Diseases of the Throat and Nose,' vol. i, page 306). It was therefore noteworthy that this growth was removed on the same afternoon as the one already referred to by Dr. Bond. Both cases occurred at the Throat Hospital, Golden Square, in the clinic of

Dr. Bond, to whom Dr. Thomson was indebted for kind permission to publish this one.

The following is the report of the examination.

Specimen consists of a single slide with six small sections, stained with eosin and hæmatoxylin. The growth is covered by stratified squamous epithelium, and consists of fibrous tissue. There are no branched cells and no appearance of true myxomatous tissue. We consider the growth to be an œdematous fibroma.

The following is the report of Dr. W. HILL's case.

The section presented for examination is about one square centimètre in area, and stained with hæmatoxylin, rubin, and orange.

It is of irregular outline, the surface of the tissues being represented by a narrow condensed layer on three of its four sides, but no covering epithelium is present. The central portion is composed of delicate open fibrous tissue somewhat distorted during preparation, and other elements of the turbinate body. Roughly speaking, the peripheral zone of the section, from 1 to 3 millimètres in breadth, is of a denser structure than the centre, and has failed to take the hæmatoxylin stain fully. This zone is formed of detached and coalesced patches of diseased tissue, the larger patches presenting a sinuous outline, and sending offshoots towards the centre of the specimen. In certain spots a very definite line of demarcation, constituted by a narrow zone rich in inflammatory corpuscles which take the hæmatoxylin stain freely, separates the healthy from the diseased tissue. The latter is found to consist of the fibrous tissue of the turbinate, the elements of which have lost definition of outline and the faculty of staining with hæmatoxylin. This tissue is densely infiltrated with inflammatory corpuscles, the larger number of which are in a state of degeneration. The centre of many of the larger patches are occupied by areas staining yellow, and of granular appearance. In the neighbourhood of these caseous centres the lumen of the vessels is obliterated by infiltration and degeneration of their walls, and the diseased areas are anæmic throughout. The inflammatory process appears to result in caseation and not fibrosis. No typical tubercles are present, but here and there a concentric arrangement can be made out, and at least two well-defined giant cells are to be seen. These contain numerous nuclei placed peripherally. No tubercle bacilli have been detected in other preparations. We consider the specimen to be tubercular.

Case of Obstruction of Larynx due to a Web.

Shown by Dr. Barclay Baron (Bristol). A man, aged 39 years, who had not had syphilis nor other constitutional dyscrasia. In October, 1894, he had hoarseness and loss of voice with gradually increasing difficulty of breathing, which induced his own doctor to perform laryngotomy.

On being admitted into the Bristol General Hospital under Mr. Baron, there was found to be intense inflammation of the whole of the larynx, the vocal cords, which were in apposition, were especially affected, being intensely red, swollen, and motionless.

In spite of all that was done he continued in this condition for three months. Tracheotomy was then performed, and the laryngotomy tube removed. The effect of this was soon beneficial,—first one vocal cord and then the other leaving the middle line, and then the anterior two thirds of the vocal cords was found to be united by a web.

This has been cut by Whistler's cutting dilator, and dilated by Schrotter's and other bougies, and now only a small amount of web tissue uniting the under surface of the vocal cords in front persists. The tracheotomy tube has been removed, and the man is able to do his work as a farm labourer. The points of interest in the case are—

1. There is no history of syphilis, and it is believed to be an instance of a web forming after a common cold.

2. The laryngotomy tube kept up the inflammation in the larynx, and tracheotomy is therefore to be preferred to laryngotomy.

Dr. Baron asked members of the Society to express an opinion as to the advisability of doing anything further.

Dr. Hall mentioned a case in which agglutination of the vocal cords occurred as the result of syphilis. When first seen the cords were united by only a narrow band; unfortunately the patient declined admission into the hospital. When he applied a week later the cords were adherent nearly along the whole length, and tracheotomy had to be performed at once. Whilst under treatment for removal of the laryngeal obstruction, stenosis of the trachea occurred. The patient left the Westminster Hospital after attempts had been made to check the growth in the trachea by scraping and astringents. Some weeks later the patient is reported to have died in Paris while being operated on.

Dr. Cresswell Baber thought the case might be syphilitic.

Dr. Bond would not go any further with the treatment.

The President had a case of suicide in which a web formed where

the cut was. A second web had formed above by the agglutination of the cords. Webbing might occur from inflammation. He thought laryngotomy ought not to be performed as it caused inflammation and prevented healing.

Case of Thyrotomy for Epithelioma of the Larynx.

Shown by Dr. Felix Semon. The patient, a gentleman aged 65, was first seen on February 18th of this year. The only symptom was hoarseness dating back nearly a year and a half, and supposed to have commenced after an attack of influenza, which had also caused purulent discharge from the right nostril; this, however, troubled the patient very little. The whole of the left vocal cord, particularly in its middle part, was considerably tumefied, and showed a granular appearance. At the same time its mobility was surprisingly free, and the hoarseness comparatively speaking very slight. Malignant disease had already been diagnosed by Dr. Madden and Mr. Dudley Wright. The diagnosis was further corroborated by Mr. Butlin.

The operation was performed on February 27th, and offered no incidents of importance. On opening the larynx the growth was seen to extend all over the left vocal cord, and the ventricular band also appeared somewhat swollen. In front the growth just extended to the median line. The whole affected portion was delineated by two semicircular cuts at a distance of about three-quarters of an inch from the growth, meeting in front and behind and cut out with curved scissors. Posteriorly the extirpation extended to the front part of the arytænoid cartilage, which was also removed.

The patient made an excellent recovery, except that on the third day some ominous black spots appeared in the wound, supposed to be due to infection from the purulent nasal discharge. These were scraped out, and nothing further occurred. The voice is now tolerably good, a cicatricial ridge having formed in the situation of the left vocal cord, and it will probably be better when a bunch of granulation tissue, which is at present situated just in the anterior commissure, will have been removed. This removal, however, has been purposely postponed until after the demonstration to the Society, in order to show that not every tumefaction which appears in the neighbourhood, or in the situation itself of the scar after an operation of this kind, ought to be at once considered to represent a recurrence of

the disease. The present case (which is, moreover, remarkable by its complication with purulent nasal discharge, probably due to empyema of the right frontal sinus) is particularly suitable for illustrating this fact, which has been observed by the author in three or four previous cases. The formation of granulation tissue is not limited to the interior of the wound, but also extends to the external scar, and is no doubt due to necrosis and sequestration of small portions of the completely ossified projecting angle of the thyroid cartilage. Granulations such as present now in the upper part of the wound also luxuriantly grew up from the lower parts. This, however, healed spontaneously and rapidly after elimination of two or three minute particles of necrosed cartilage, which were eliminated through the external wound, and there is hardly any doubt that the same will take place with regard to the parts in which granulations are still at present seen.

Case of Uncontrollable, Intermittent, Laryngeal Cry.

Shown by Dr. Bond. A boy, 11 years of age, began in March, 1895, one night when in bed to utter at irregular intervals a loud cry. This he continued to do until August, 1895, when he went to stay for about ten days in the country, and towards the end of the visit the cry "gradually" ceased. At Christmas, 1895, a second attack came on at 3 a.m., and has continued since. The boy has lately had measles, during which the cry was emitted as usual. Until recently the mother states that the cry persisted during sleep.

The boy seems dull and stupid, hands and arms are continually working, almost like those of a child with chorea. At intervals, varying from about 12 seconds to 1½ minutes, he utters an explosive, sudden cry of considerable volume, very like part of a milkman's cry, but not resembling any word. The cry is associated with somewhat violent action of the diaphragm, and with a lifting of the soft palate. It is never emitted during a laryngoscopical examination, but directly after such an examination has been made the cry is emitted. The boy has double proptosis, also he has adenoids of the naso-pharynx.

The child's mother has had rheumatic fever, a brother has died from "irritation of the brain." The child has never had convulsions, nor worms. There is no history of chorea in the family.

The PRESIDENT did not think the mischief organic, and asked whether malingering might be excluded.

Mr. STEWART thought the trouble might be caused by the presence of the adenoid growths.

Mr. SPENCER said they had a case in Westminster Hospital a little while ago of spasmodic cough. Patient was hypnotised, when the cough changed to attacks of sneezing. She ultimately got well.

Dr. SCANES SPICER thought, from the condition of the eyes, that it was not functional.

Dr. DE HAVILLAND HALL suggested a sea voyage. He had a case in which this had excellent results.

Dr. BOND, in reply, stated that the lowered mental condition, the almost choreiform restlessness of limbs, the action of the diaphragm, and the explosive cry taken together, seemed to negative the idea of malingering. The case was very unlike the cases of nervous laryngeal cough, and seemed to be a case of "tic convulsif." After the removal of adenoids (which would end a source of irritation, and ensure sounder sleep), in conjunction with the administration of arsenic and a prolonged change of air in the country, Dr. Bond thought the patient likely to improve. He disapproved of the employment of faradism, thinking such treatment very likely to make the boy worse. On the other hand, he had seen a cure of nervous laryngeal cough, with stiffness of one knee of two years' standing, cured in a few minutes by faradism.

CASE OF TUBERCULAR LARYNGITIS ON WHICH THYROTOMY HAS BEEN PERFORMED.

Shown by Dr. BOND. This patient, a man of 45, in June, 1895, had a sore throat which persisted until October last. He was then having night sweats, had been losing flesh, and had attacks of severe suffocating cough. He had pain shooting up to left ear. He had lost three children from phthisis. He was much emaciated, and his face pinched and sallow. We could find no trace of syphilis, and there was no history of it. He seemed to have had slight consolidation at right apex, having slight dulness, bronchial breathing, &c., but no râles could be heard.

The left side of the larynx was fixed. There was great swelling of the left ventricular band, which was red and coarsely granular, and at the back was superficially ulcerated. The front of left cord could be seen with difficulty. There were no enlarged glands; voice very husky.

The case seemed a doubtful one, and one on which an exploratory thyrotomy should be performed, and this was done on November 15th. The whole left ventricular band was found affected and was removed, and

also the inner edge of the brim on left and the left cord. On the posterior commissure were several papillary excrescences, and the mucous membrane here was also removed. The left thyroid plate was scraped, and also the anterior commissure.

The patient left hospital a month after the operation with a narrow sinus unhealed, and with some cough. Since he has considerably improved, his temperature is normal and his weight has increased to 12 stone. The larynx is somewhat deformed and congested, but there is no definite infiltration to be seen, and no ulceration. His voice is feeble, owing in part to the escape of air through the sinus.

The specimen removed was pronounced to be tubercular, and tubercle bacilli have been found in the sputum.

Case of Sarcoma Recurring in Nose.

Shown by Dr. Bond. The patient, a man of 62 years of age, began to have severe attacks of epistaxis from left nose in November, 1892. When seen at the Throat Hospital, in October, 1893, the left side of nose was congested, greatly swollen, and completely plugged in front by a fungating, slightly movable mass, which bled freely on examination with a probe; enlarged glands could be felt below the angle of left jaw. The mass was removed piecemeal by a snare, and its base thoroughly curetted, and the nose firmly plugged. Afterwards the site of growth was cauterized with the galvano-cautery. The growth sprang in the front of the nose from the lower part of the septum, from the floor, and from the front of the lower turbinated bone. The enlarged glands were also removed. Recurrence occurred after two and a half years, and in March, 1896, a mass was removed from lower part of septum and floor of nose. Recurrence has, however, already occurred in nose, and there is an enlarged gland in neck.

The fact that sarcoma of the nose is so amenable to intra-nasal operative treatment is noticeable. Dr. Bond had seen several cases of extensive sarcoma of the nose live for years, where it was impossible to perform a radical operation, and where occasional extensive curetting, &c., gave considerable relief. He would like to ask whether

others have found cases of sarcoma of nose less malignant than is commonly supposed.

Mr. C. Baber said these cases bleed very much. He had a case in which there was great difficulty in stopping the bleeding after removal. There was no recurrence.

Dr. Bennett would merely keep the passage clear, and do nothing else.

Mr. Lambert Lack thought the tumours were not so malignant in the nose. Extensive operations through the nose did good.

Case of Healed Tubercular Disease of the Larynx.

Shown by Mr. Lambert Lack. Patient, a girl aged 28, was quite well until 1893, when symptoms of phthisis developed, and she lost her voice. In October, 1893, the patient was losing flesh, had much cough, and a hectic look. She was nearly aphonic.

Examination of lungs showed dulness over the upper half of the chest on both sides, back and front, with abundant moist sounds and bronchial breathing at the right apex.

Examination of larynx showed irregular fleshy thickening of both vocal cords, with very deficient movement on the right side. There was a prominent ulcerating growth on the anterior surface of the right arytænoid, and some œdema of both arytænoids. Treatment: cod-liver oil and iron internally, and pure lactic acid well rubbed in locally once a week. After some months' rather irregular attendance, she was much improved, but the tumour remained much the same. This was then entirely scraped away with the curette, and pure chromic acid applied to the resulting ulcer. This slowly healed, and in the spring of 1895 the ulcer of the larynx was quite healed. In November the larynx appeared almost normal, the movements being quite free, and there was no trace of swelling or ulceration.

Dr. Hall thought that the only thing to be done was to congratulate Dr. Lack on the success of his treatment. The cords were practically normal, and there was hardly any trace of a scar.

Case of Lupus Pharyngis.

Shown by Mr. Lambert Lack. The patient, aged 34, says for several years he has suffered from occasional dry throat, but for seven

weeks the condition has been much worse. He consulted a doctor, who noticed a small spot in the centre of the pharynx, which he cauterised, but other spots appearing he sent the patient to me.

The patient has always had good health, has had no special illnesses, there is no history of syphilis, and no tubercular history in his family.

The posterior wall of the pharynx is irregularly nodular, in places red and inflamed, in places abraded, and in others cicatrising. Caseous scattered nodules can be seen, but no large ulcers.

The condition extends from the level of epiglottis up to the vault of the pharynx. There is no lupus on the skin, in the nose, palate, or larynx. A piece removed for examination shows numerous tubercles with much inflammatory tissue. The treatment has been arsenic internally and the cautery locally, but no sufficient time has elapsed to note the effect.

The case is apparently a very acute one, and in its limited distribution probably a rare one.

Dr. Scanes Spicer could not call the case one of lupus.

Dr. Bond thought it was lupus, and did not consider isolated lupus of the pharynx rare.

The President was of the same opinion.

Dr. Pegler would like a portion removed, and a section made.

Case of Healed Antrum and Frontal Sinus Suppuration.

Shown by Mr. Lambert Lack. Patient, F—, æt. 32, for about sixteen years has suffered from nasal obstruction, with occasional thick yellowish discharge, and pains over left side of head. The pain she describes as almost constant, and at times "maddening." Eleven years ago some polypi were removed from the left nostril. Patient first seen by Mr. Lack in 1893. She complained then of intense continuous pains above both eyes and in the left cheek, with a yellowish discharge from left nostril. The left nostril showed polypi and pus, the right polypi but no pus. The polypi were removed, and the left antrum drilled. The antrum contained pus, but was cured by a few weeks' syringing. The patient was very slightly improved. In 1894 the left frontal sinus was opened through an incision in the line of the eyebrow, the field of operation being bounded by the supraorbital notch and the pulley of the

superior oblique. A large piece of bone was removed by the chisel, and much pus was evacuated. A long rubber tube was passed through the infundibulum into the nose, and retained for about ten days, when it was replaced by a short silver tube. After six weeks all symptoms had disappeared, the tube was left out, and the wound soon healed, leaving an inconspicuous scar under the eyebrow. The patient, nearly two years later, remains well.

Case and Specimen of cured Polypi of Frontal Sinus.

Shown by Dr. H. Tilley. Patient was a man aged 45, who came to the London Throat Hospital complaining of slight discharge from both nostrils, and occasional frontal headache. Some polypi were seen under the middle turbinate on the left side, which were removed from time to time. A discharge of pus was also constantly seen in this situation.

On further examination a probe could be passed easily into the frontal sinus. The patient was therefore anæsthetised, and a vertical incision about two inches long made from the nasion upwards—the soft parts and periosteum were drawn aside and the anterior surface of the left sinus removed by means of gouge and mallet, when the granulations contained in the sinus bulged forward and looked exactly like hæmorrhoids of rectum. The same was the case with the right sinus. Both sinuses were curetted and then swabbed out with zinc chloride solution grs. xl to ℥j, and drainage-tubes were inserted into both sinuses, by means of which the sinuses were irrigated daily with boracic lotion for a week, when the tubes were removed. The wound healed and the patient is now perfectly free from any trouble, and there is no nasal discharge. The median scar is now almost invisible.

It should be stated that previously to operating on the frontal sinus the maxillary antrum was explored and found healthy.

These two cases were discussed at the same time.

Mr. C. Baber thought that Mr. Lack's case was interesting as having, after recovery, left only a slight scar hidden by the eyebrow. He related a case under his care in which there was protrusion of the eyeball from distension of the left frontal sinus with non-fœtid mucous liquid containing cholesterine crystals. On opening the sinus from the forehead it was found completely cut off from the nasal cavity,

where there existed purulent disease of the ethmoidal cells. The case was still under treatment.

Dr. Scanes Spicer would always remove the anterior extremity of the middle turbinate bones before doing anything further.

Dr. Wm. Hill had a case which had left a deep scar. He should certainly try operating through the brow, more especially in females.

The President related a case he had with Mr. Horsley in which a transverse incision was made, a portion of the front of the sinus taken away, and the whole mucous membrane removed. During this operation the hopelessness of operating through the nose was apparent, as it was impossible to get at all the disease through the nose. He asked whether in these cases it would not be possible to fill up the sinuses with foil or something to prevent the falling in of the cavity.

Mr. Spencer suggested plaster of Paris as being good for filling up bone.

Mr. Stewart thought that plaster of Paris would be too heavy for the frontal sinus.

Dr. Dundas Grant mentioned a case of Waterhouse in which decalcified bone was used to fill up a hole in the astragalus. He pointed out the difficulty of any bone healing without a drawing in of the cavity.

Mr. Lack thought the opening through the eyebrow caused no deformity. He considered it best to leave the mucous membrane untouched.

Dr. Herbert Tilley stated that he had recently examined the frontal sinuses in a large number of skulls (over a hundred), and that the constant and extreme variation in the size and extent of the sinuses was in favour of an external opening, and he preferred the vertical median incision in the majority of cases. He strongly deprecated any operation from the nose, but thought that syringing the frontal sinuses from the nose, where possible, might be practised for a short time before proceeding to the external operation; if, however, the naso-frontal canal could not be found, no passage should be forcibly made.

Dr. Bennett suggested that these 130 cases were normal skulls. In diseased conditions it was more possible to operate through the nose. He would operate through the nose first to relieve obstruction.

Case of Mycosis of Tonsils and Pharynx.

Shown by Dr. Scanes Spicer. Patient, a man æt. 35, had a well-developed thalloid projection from crypts of left tonsil, posterior pharyngeal wall, and base of tongue. Microscopically it consisted chiefly of cladothira. It had proved very resistent to paints, washes, &c. He proposed dissecting out the affected portion of faucial tonsil,

and applying the galvano-cautery to the pharyngeal and lingual crypts.

Dr. HALL recommended the use of the galvano-cautery for the destruction of the mycotic growths. Absolute alcohol had not given good results in his hands.

Dr. BENNETT suggested the application of pure carbolic acid.

Dr. BRADY (Sydney) showed a tonsilotome for removing hypertrophied lingual tonsils. It was an ordinary Mackenzie tonsilotome with the blade curved to fit over the back of the tongue.

MALIGNANT(?) DISEASE OF LARYNX.

Shown by Dr. FURNISS POTTER. M. C—, widow, aged 69, came to the London Throat Hospital on the 17th of March last complaining of difficulty and pain in swallowing (principally solids).

No very definite or satisfactory history obtainable. The patient states she has had difficulty in swallowing for many years, but has been worse during the last twelve months. She has had two children stillborn, and one miscarriage.

On examination with the laryngoscope a large red mass occupying the arytænoid region in its whole width was seen; this has increased considerably since the first examination. It bleeds easily on being touched, but there is no visible ulceration. Two distinctly enlarged glands can be felt on the left side of the neck behind the sterno-mastoid. The patient states that she has lost flesh rapidly lately. Dr. Potter thought that there was little doubt the growth was malignant, but would like to have the opinion of members on it.

OBSCURE CASE OF LARYNGEAL DISEASE.

Shown by Dr. DE HAVILLAND HALL. R. M. V— was shown to the Society on October 10th, 1894 (*see* p. 6, vol. ii).

The patient has continued in excellent health, and is able to cycle and dance.

In January, 1896, while at Munich, Prof. Schech detected some pale growths on the right side of the larynx filling up the glottis. These were removed with forceps and curette.

On January 21st a piece of the tip of the epiglottis was removed; very severe hæmorrhage followed. In view of the stationary condition of the laryngeal condition and the patient's excellent health,

the disease. The present case (which is, moreover, remarkable by its complication with purulent nasal discharge, probably due to empyema of the right frontal sinus) is particularly suitable for illustrating this fact, which has been observed by the author in three or four previous cases. The formation of granulation tissue is not limited to the interior of the wound, but also extends to the external scar, and is no doubt due to necrosis and sequestration of small portions of the completely ossified projecting angle of the thyroid cartilage. Granulations such as present now in the upper part of the wound also luxuriantly grew up from the lower parts. This, however, healed spontaneously and rapidly after elimination of two or three minute particles of necrosed cartilage, which were eliminated through the external wound, and there is hardly any doubt that the same will take place with regard to the parts in which granulations are still at present seen.

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The child's mother has had rheumatic fever, a brother has died from "irritation of the brain." The child has never had convulsions, nor worms. There is no history of chorea in the family.

The PRESIDENT did not think the mischief organic, and asked whether malingering might be excluded.

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The left side of the larynx was fixed. There was great swelling of the left ventricular band, which was red and coarsely granular, and at the back was superficially ulcerated. The front of left cord could be seen with difficulty. There were no enlarged glands; voice very husky.

The case seemed a doubtful one, and one on which an exploratory thyrotomy should be performed, and this was done on November 15th. The whole left ventricular band was found affected and was removed, and

Dr. Hall was doubtful whether the diagnosis of chronic tuberculosis could still be maintained.

A portion of the growth removed in January will be submitted to microscopic examination.

New Tracheotomy Tube.

Shown by Mr. de Santi. This is a tube adapted for patients who have to wear a permanent tube, and who have sufficient space to expire through the larynx though not room enough for inspiration. The tube is fitted with a small metal hollow plug with a small rim below, and in the plug is fitted a metal hinge valve something like a sewer trap: on inspiration the valve opens and the patient breathes through his tube; on expiration the valve closes tightly and air passes through the larynx.

The danger of the valve getting loose is avoided by the metal rim below.

The advantages of the plug and valve are—

(1) That the patient can speak distinctly and without putting his fingers on the tracheotomy tube.

(2) That he coughs up mucus, &c., through the larynx and out of the mouth normally.

(3) That the patient is able to wear a collar and shirt and go about comfortably.

In Dr. De Havilland's case shown at this meeting, Mr. de Santi has adapted his tube to the case. The patient has worn the tube and plug, which is removable, for six months, is able to talk well, wear evening dress, and bicycle twenty miles a day. He has tried the ordinary pea valve and finds it useless.

If the removable plug becomes at all blocked with mucus, it is taken out and boiled, and in the meanwhile a fresh plug inserted.

It is of course necessary that there should be an opening in the tracheotomy tube in the ordinary place at its greatest convexity.

The plug with its valve fits flush with the tube into which it is inserted.

Case of Abductor Paralysis.

Shown by Mr. Spencer. Patient, a man æt. 35, had worn a tracheotomy tube since June, 1882. He was a soldier who had served in Egypt, and an abscess formed in the neck in the site of a scar at the anterior border of the left sterno-mastoid just above its insertion. He had felt nothing wrong with his throat, but a few hours after the opening of the abscess he was eating his dinner when he was suddenly attacked by difficult breathing, for which tracheotomy was done the same evening. Subsequently an attempt to leave off the tube failed. He came concerning a warty growth in the tracheotomy wound, which has been removed. He can speak well with the finger over the tracheotomy tube. The vocal cords are apparently normal, but fixed in adduction, no abduction beyond 1—2 mm. can be done.

The affection is doubtless due to syphilis. A nerve lesion there may have been distinct from the above. If perichondritis, it is remarkable that he should have had no throat trouble beforehand.

Chronic Retro-pharyngeal Abscess in an Adult.

Shown by Dr. Felix Semon. The patient, a gentleman aged 37, had in September last an "abscess" in the throat which took about six weeks to develop, and caused at the time considerable difficulty in swallowing, but apparently no other symptoms. It was opened, a large quantity of matter escaped, and he was then sent on a voyage to South Africa. The incision, however, never healed, and he is still troubled with much secretion, and at the same time a feeling of dryness in the throat. There is an indistinct history of syphilis many years ago, but no secondary or tertiary symptoms have ever occurred.

On examination the posterior wall of the pharynx is enormously swollen, sodden, and reddened, and particularly the right side bulges much forward. There is a longitudinal opening filled with sanious matter at the angle formed between the posterior and right lateral wall, and a smaller fistulous opening near the middle line. The probe introduced into these openings does not touch any rough bone. The swelling extends a long way up into the naso-pharyngeal cavity, the movements of the head are particularly free, the vertebræ are not tender to touch at all ; no evidence of any pulmonary affection.

The patient was put on 10 grs. of iodide of potassium, and when he appeared a week after (April 22nd) a diminution of the pharyngeal swelling was noticeable, but no other change. A consultation was held with Mr. Horsley, who agreed that there was no bone affection or evidence of tubercular mischief. The patient is now still taking iodide of potassium. Should, after another three or four weeks, the abscess not close spontaneously, it is intended to connect the two openings by a horizontal incision at the lower part of the abscess, and to scrape out freely the walls of the abscess.

The case is shown because a chronic retro-pharyngeal abscess in an adult, without any traumatic or diathetic cause known, is exceedingly rare.

A Drawing of a Case of Extrinsic Malignant Disease of the Larynx.

Shown by Dr. Watson Williams.

A Coloured Drawing of a Case of Early Malignant Disease of the Vocal Cords.

Shown by Dr. Watson Williams. Dr. Williams thought that as the disease was intrinsic, localised, and early, it was suitable for radical extirpation after thyrotomy, but the fact that the patient was 74 years of age was considered sufficient to negative such a procedure. The movement of the vocal cords were greatly impaired. The voice had been hoarse two months, and this was the only symptom. There was no alcoholic or syphilitic history. As operation was negatived it was considered inadvisable to complete the diagnosis by removal of a fragment of the growth for histological examination, but he believed that the great impairment of the vocal cord movement in the absence of any appearance of thickening around the crico-arytænoid joint, pointed strongly towards it being a case of early malignant disease rather than of pachydermia laryngis.

The President did not think it was a case of malignant disease.

Dr. Scanes Spicer thought it was one of pachydermia.

INDEX.

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The President was of the same opinion.

Dr. Pegler would like a portion removed, and a section made.

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Case and Specimen of cured Polypi of Frontal Sinus.

Shown by Dr. H. Tilley. Patient was a man aged 45, who came to the London Throat Hospital complaining of slight discharge from both nostrils, and occasional frontal headache. Some polypi were seen under the middle turbinate on the left side, which were removed from time to time. A discharge of pus was also constantly seen in this situation.

On further examination a probe could be passed easily into the frontal sinus. The patient was therefore anæsthetised, and a vertical incision about two inches long made from the nasion upwards—the soft parts and periosteum were drawn aside and the anterior surface of the left sinus removed by means of gouge and mallet, when the granulations contained in the sinus bulged forward and looked exactly like hæmorrhoids of rectum. The same was the case with the right sinus. Both sinuses were curetted and then swabbed out with zinc chloride solution grs. xl to ℥j, and drainage-tubes were inserted into both sinuses, by means of which the sinuses were irrigated daily with boracic lotion for a week, when the tubes were removed. The wound healed and the patient is now perfectly free from any trouble, and there is no nasal discharge. The median scar is now almost invisible.

It should be stated that previously to operating on the frontal sinus the maxillary antrum was explored and found healthy.

These two cases were discussed at the same time.

Mr. C. Baber thought that Mr. Lack's case was interesting as having, after recovery, left only a slight scar hidden by the eyebrow. He related a case under his care in which there was protrusion of the eyeball from distension of the left frontal sinus with non-fœtid mucous liquid containing cholesterine crystals. On opening the sinus from the forehead it was found completely cut off from the nasal cavity,

where there existed purulent disease of the ethmoidal cells. The case was still under treatment.

Dr. SCANES SPICER would always remove the anterior extremity of the middle turbinate bones before doing anything further.

Dr. WM. HILL had a case which had left a deep scar. He should certainly try operating through the brow, more especially in females.

The PRESIDENT related a case he had with Mr. Horsley in which a transverse incision was made, a portion of the front of the sinus taken away, and the whole mucous membrane removed. During this operation the hopelessness of operating through the nose was apparent, as it was impossible to get at all the disease through the nose. He asked whether in these cases it would not be possible to fill up the sinuses with foil or something to prevent the falling in of the cavity.

Mr. SPENCER suggested plaster of Paris as being good for filling up bone.

Mr. STEWART thought that plaster of Paris would be too heavy for the frontal sinus.

Dr. DUNDAS GRANT mentioned a case of Waterhouse in which decalcified bone was used to fill up a hole in the astragalus. He pointed out the difficulty of any bone healing without a drawing in of the cavity.

Mr. LACK thought the opening through the eyebrow caused no deformity. He considered it best to leave the mucous membrane untouched.

Dr. HERBERT TILLEY stated that he had recently examined the frontal sinuses in a large number of skulls (over a hundred), and that the constant and extreme variation in the size and extent of the sinuses was in favour of an external opening, and he preferred the vertical median incision in the majority of cases. He strongly deprecated any operation from the nose, but thought that syringing the frontal sinuses from the nose, where possible, might be practised for a short time before proceeding to the external operation; if, however, the naso-frontal canal could not be found, no passage should be forcibly made.

Dr. BENNETT suggested that these 130 cases were normal skulls. In diseased conditions it was more possible to operate through the nose. He would operate through the nose first to relieve obstruction.

CASE OF MYCOSIS OF TONSILS AND PHARYNX.

Shown by Dr. SCANES SPICER. Patient, a man æt. 35, had a well-developed thalloid projection from crypts of left tonsil, posterior pharyngeal wall, and base of tongue. Microscopically it consisted chiefly of cladothira. It had proved very resistent to paints, washes, &c. He proposed dissecting out the affected portion of faucial tonsil,

and applying the galvano-cautery to the pharyngeal and lingual crypts.

Dr. HALL recommended the use of the galvano-cautery for the destruction of the mycotic growths. Absolute alcohol had not given good results in his hands.

Dr. BENNETT suggested the application of pure carbolic acid.

Dr. BRADY (Sydney) showed a tonsilotome for removing hypertrophied lingual tonsils. It was an ordinary Mackenzie tonsilotome with the blade curved to fit over the back of the tongue.

MALIGNANT(?) DISEASE OF LARYNX.

Shown by Dr. FURNISS POTTER. M. C—, widow, aged 69, came to the London Throat Hospital on the 17th of March last complaining of difficulty and pain in swallowing (principally solids).

No very definite or satisfactory history obtainable. The patient states she has had difficulty in swallowing for many years, but has been worse during the last twelve months. She has had two children stillborn, and one miscarriage.

On examination with the laryngoscope a large red mass occupying the arytænoid region in its whole width was seen; this has increased considerably since the first examination. It bleeds easily on being touched, but there is no visible ulceration. Two distinctly enlarged glands can be felt on the left side of the neck behind the sterno-mastoid. The patient states that she has lost flesh rapidly lately. Dr. Potter thought that there was little doubt the growth was malignant, but would like to have the opinion of members on it.

OBSCURE CASE OF LARYNGEAL DISEASE.

Shown by Dr. DE HAVILLAND HALL. R. M. V— was shown to the Society on October 10th, 1894 (*see* p. 6, vol. ii).

The patient has continued in excellent health, and is able to cycle and dance.

In January, 1896, while at Munich, Prof. Schech detected some pale growths on the right side of the larynx filling up the glottis. These were removed with forceps and curette.

On January 21st a piece of the tip of the epiglottis was removed; very severe hæmorrhage followed. In view of the stationary condition of the laryngeal condition and the patient's excellent health,

Dr. Hall was doubtful whether the diagnosis of chronic tuberculosis could still be maintained.

A portion of the growth removed in January will be submitted to microscopic examination.

New Tracheotomy Tube.

Shown by Mr. de Santi. This is a tube adapted for patients who have to wear a permanent tube, and who have sufficient space to expire through the larynx though not room enough for inspiration. The tube is fitted with a small metal hollow plug with a small rim below, and in the plug is fitted a metal hinge valve something like a sewer trap: on inspiration the valve opens and the patient breathes through his tube; on expiration the valve closes tightly and air passes through the larynx.

The danger of the valve getting loose is avoided by the metal rim below.

The advantages of the plug and valve are—

(1) That the patient can speak distinctly and without putting his fingers on the tracheotomy tube.

(2) That he coughs up mucus, &c., through the larynx and out of the mouth normally.

(3) That the patient is able to wear a collar and shirt and go about comfortably.

In Dr. De Havilland's case shown at this meeting, Mr. de Santi has adapted his tube to the case. The patient has worn the tube and plug, which is removable, for six months, is able to talk well, wear evening dress, and bicycle twenty miles a day. He has tried the ordinary pea valve and finds it useless.

If the removable plug becomes at all blocked with mucus, it is taken out and boiled, and in the meanwhile a fresh plug inserted.

It is of course necessary that there should be an opening in the tracheotomy tube in the ordinary place at its greatest convexity.

The plug with its valve fits flush with the tube into which it is inserted.

Case of Abductor Paralysis.

Shown by Mr. Spencer. Patient, a man æt. 35, had worn a tracheotomy tube since June, 1882. He was a soldier who had served in Egypt, and an abscess formed in the neck in the site of a scar at the anterior border of the left sterno-mastoid just above its insertion. He had felt nothing wrong with his throat, but a few hours after the opening of the abscess he was eating his dinner when he was suddenly attacked by difficult breathing, for which tracheotomy was done the same evening. Subsequently an attempt to leave off the tube failed. He came concerning a warty growth in the tracheotomy wound, which has been removed. He can speak well with the finger over the tracheotomy tube. The vocal cords are apparently normal, but fixed in adduction, no abduction beyond 1—2 mm. can be done.

The affection is doubtless due to syphilis. A nerve lesion there may have been distinct from the above. If perichondritis, it is remarkable that he should have had no throat trouble beforehand.

Chronic Retro-pharyngeal Abscess in an Adult.

Shown by Dr. Felix Semon. The patient, a gentleman aged 37, had in September last an "abscess" in the throat which took about six weeks to develop, and caused at the time considerable difficulty in swallowing, but apparently no other symptoms. It was opened, a large quantity of matter escaped, and he was then sent on a voyage to South Africa. The incision, however, never healed, and he is still troubled with much secretion, and at the same time a feeling of dryness in the throat. There is an indistinct history of syphilis many years ago, but no secondary or tertiary symptoms have ever occurred.

On examination the posterior wall of the pharynx is enormously swollen, sodden, and reddened, and particularly the right side bulges much forward. There is a longitudinal opening filled with sanious matter at the angle formed between the posterior and right lateral wall, and a smaller fistulous opening near the middle line. The probe introduced into these openings does not touch any rough bone. The swelling extends a long way up into the naso-pharyngeal cavity, the movements of the head are particularly free, the vertebræ are not tender to touch at all ; no evidence of any pulmonary affection.

The patient was put on 10 grs. of iodide of potassium, and when he appeared a week after (April 22nd) a diminution of the pharyngeal swelling was noticeable, but no other change. A consultation was held with Mr. Horsley, who agreed that there was no bone affection or evidence of tubercular mischief. The patient is now still taking iodide of potassium. Should, after another three or four weeks, the abscess not close spontaneously, it is intended to connect the two openings by a horizontal incision at the lower part of the abscess, and to scrape out freely the walls of the abscess.

The case is shown because a chronic retro-pharyngeal abscess in an adult, without any traumatic or diathetic cause known, is exceedingly rare.

A Drawing of a Case of Extrinsic Malignant Disease of the Larynx.

Shown by Dr. Watson Williams.

A Coloured Drawing of a Case of Early Malignant Disease of the Vocal Cords.

Shown by Dr. Watson Williams. Dr. Williams thought that as the disease was intrinsic, localised, and early, it was suitable for radical extirpation after thyrotomy, but the fact that the patient was 74 years of age was considered sufficient to negative such a procedure. The movement of the vocal cords were greatly impaired. The voice had been hoarse two months, and this was the only symptom. There was no alcoholic or syphilitic history. As operation was negatived it was considered inadvisable to complete the diagnosis by removal of a fragment of the growth for histological examination, but he believed that the great impairment of the vocal cord movement in the absence of any appearance of thickening around the crico-arytænoid joint, pointed strongly towards it being a case of early malignant disease rather than of pachydermia laryngis.

The President did not think it was a case of malignant disease.

Dr. Scanes Spicer thought it was one of pachydermia.

INDEX.

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