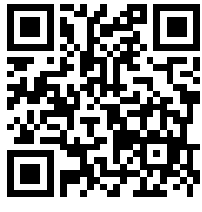

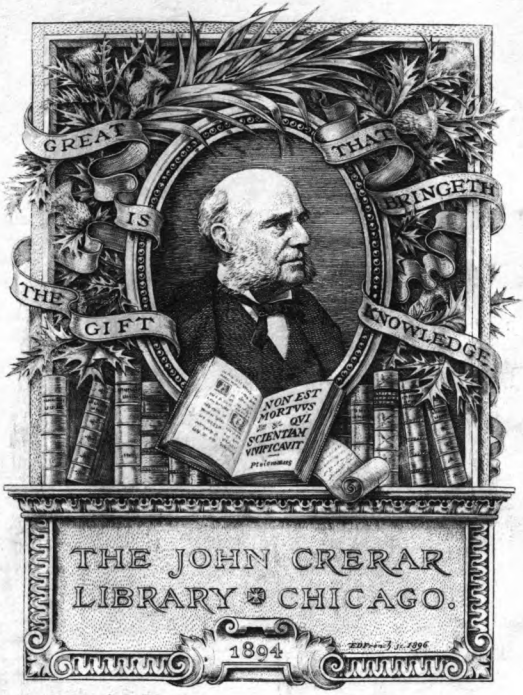

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

NINETY-SECOND ORDINARY MEETING, *November* 4, 1904.

P. McBRIDE, M.D., F.R.C.P.Ed., President, in the Chair.

E. FURNISS POTTER, M.D., P. DE SANTI, F.R.C.S., } Secretaries.

Present—40 members and 7 visitors.

The minutes of the previous meeting were read and confirmed.

The following cases and specimens were shown:

A DIAGNOSTIC SPECIMEN FROM ŒSOPHAGEAL STRICTURE REMOVED BY KILLAIN'S METHOD.

Shown by Mr. E. B. WAGGETT. The specimen was shown to emphasise the importance of examining strictures by Killian's tubes and thus making certain of the diagnosis:

The PRESIDENT asked why Mr. Waggett spoke of the procedure as "Killian's method." His own impression was that Kussman was the first to use the rigid tube for the œsophagus, and that Rosenheim and others had elaborated it.

Mr. WAGGETT, in reply, said he called it Killian's method because the instruments employed were devised by Killian. He thought the subject of œsophagoscopy ought to be taken up more largely in England than he believed was the case at present. He had now done some fifteen cases by that method, without difficulty, and there had been no danger to the patient. About half the cases were done under cocaine, and the remainder under a general anæsthetic. In every case he had assured himself of the presence of a stricture or of its absence. The tubes were valuable for removing growths from children's larynges, as he had found particularly on three occasions. It was easy to see the exact position of the papillomata in the larynx, and remove them with the tube forceps supplied in the case of instruments.

SPECIMENS OF CARCINOMA IN THE THROAT OF THE DOG AND THE CAT.

Shown by Professor HOBDAY, F.R.C.V.S. (introduced by Mr. de Santi). Professor HOBDAY demonstrated specimens from five cases of true epithelioma of the throat of the dog and the cat, all of which had been confirmed by microscopical examination either by Professor McFadyean, of the Royal Veterinary College, or by Dr. Bashford and Dr. Murray, of the Imperial Cancer Research Fund. All five cases had been under the care of Professor Hobday, and had been met with since January, and, in fact, four of them since June in this year. He particularly drew attention to this fact because it used to be thought, even until recently by some pathologists, that carcinoma in the lower animals was exceedingly rare. He did not think that it was as common as other tumours, but now that the disease was particularly looked for, numbers of well-authenticated cases had been found in the horse, the cow, the sheep, the dog, the cat, and even the pig. Professor Hobday pointed out that one must not forget that cancer is a disease most frequently met with in old age, and that in the varieties of animals used for food, opportunities for the growth of such tumours are comparatively rare because the host is killed before reaching even adult age.

CASE 1 occurred in January, 1904, in a foxhound bitch, between seven and eight years old. The tumour was situated on the left side of the throat. The symptoms were those of lassitude and emaciation. The growth at first was supposed to be an abscess. She was sent to London for operation, and at the request of Professor Hobday discretionary power was given to painlessly put an end to her before recovering from chloroform if the growth were found to be a cancer and inoperable.

CASE 2 occurred in June, 1904, in a poodle, aged seven, the right side being affected. Examination of the mouth revealed an ulcerated jagged sore on the right side of the fauces, just in front of the tonsil. The cervical glands were much enlarged, the patient had difficulty in swallowing, salivated freely, and was becoming emaciated. The growth had been observed about four months, but latterly had become much enlarged.

CASE 3 occurred in August, and was also a poodle which had been treated for some four months for an ulcer of the mouth. Dysphagia had been noticed for some months, and the enlargement of the cervical glands had latterly much increased. Salivation was profuse, the appetite capricious on account of the soreness of the mouth, and the patient was perceptibly becoming emaciated.

Case 4, seen in September, was a Pembrokeshire terrier, eight years old, of which a sketch and also the larynx was shown. There was a jagged ulcerating wound on the fauces and the cervical glands were enlarged. The owner had observed the patient to be "out of sorts" for about five months, but during the last six weeks had noticed considerable dysphagia, great lassitude, salivation, and general emaciation.

Case 5, met with last month, was of particular clinical interest on account of the situation of the growth. It was an epithelioma of the œsophagus of a cat. The animal was eight years of age, and was brought for advice on account of a continual gulping movement when swallowing, a capricious appetite, and inability to take solid food. An obstruction in the throat was suspected, and when the probang was passed it could be distinctly felt to go over some foreign body, and then to go on satisfactorily into the stomach. As a repetition of the process always gave the same result, and the obstruction could also be felt when the instrument was withdrawn, a growth of some kind was diagnosed and, as the owner did not (for sentimental reasons) wish for any cutting operation, the patient was chloroformed to death.

All the specimens were proved to be of the squamous-celled variety of epithelioma; in each dog the larynx, floor of the mouth, and palate were affected, there being secondary infection of the cervical glands. In none of the cases had the infection spread to the lungs or digestive tract.

Professor Hobday remarked that there was a popular impression to the effect that true carcinoma was not common in the animal kingdom, though veterinary surgeons had for many years known of its occurrence, as also had those who did work in comparative anatomy. But so much attention had been drawn to the subject by the Imperial Cancer Research Fund, that it was found to be comparatively common in animals. Still, he frequently saw it stated in the medical papers that carcinoma was not common in animals. If such an assertion was in the minds of those who had facilities for expert work on the subject, certain analogies were drawn which were incorrect. For instance, it was said that in the human subject the irritation produced by a pipe and such things was a common precursor of cancer; animals did not smoke, but irritants got across the mouth which produced abrasions in the mucous membrane. In each of the laryngeal cases exhibited the primary wound was apparently just where a bone would get fixed across the back of the throat. That frequently happened in the dog, and it was possible that some irritant there might have caused the sore from which the carcinoma started. The horse and the cow had long been known to suffer from cancer, and in all situations, and he had other specimens. The five exhibited were shown because, being in the larynx, he thought they would possess special interest for members of the Society.

The President said the thanks of the Society were due to Professor

Hobday and Mr. de Santi for bringing forward such interesting matter. He did not know that carcinoma was supposed to be so rare in dogs, of which he had kept a fair number during his life, and among these he had only two affected with cancer. The first case was one of carcinoma in the mamma of a bitch, which he had had removed by a veterinary surgeon, as he suggested malignancy. But the veterinary surgeon, in the spirit of Professor Hobday's statement, replied that cancer did not occur in dogs. However, he (Dr. McBride) had it examined microscopically, when it was found to be typical carcinoma. The next was in a favourite dog of his. He did not have it microscopically examined, but it was undoubtedly typical epithelioma of the lip. He removed it himself. Three months later a large gland was found, and he had to have the dog destroyed because it could not swallow.

A Lesion of the Soft Palate for Diagnosis.

Shown by Mr. de Santi. The patient, a girl, aged twenty-two, applied to Mr. de Santi's Out-Patient Department, a week previously, complaining of pain and discomfort in the throat, localised to the left side. She said she had had discomfort in the throat for some weeks.

On examination a bright red patch was observed on the left side of the soft palate, about the size of a shilling; a similar erythematous blush extended from this patch down to and over the pillars of the fauces and tonsil on the left side. The appearance was simply that of erythema; the hyperæmic area presented no signs of enlarged blood-vessels, and was in no sense a tumour. The patient explained that she had seen the condition in her throat for some seven months and that the patch had got larger during that time. Application locally of cocaine and adrenalin solution produced no diminution in the size or brightness of the blush.

The President said the case appeared to him to be one of angioma of the pharynx, or at least a red tumour composed of minute vessels, though he had never seen anything exactly like it before. He showed before the Society some years ago a drawing of a case in which were very large blood-vessels, in very much the same situation, and that undoubtedly was angioma.

Mr. Cresswell Baber thought the condition was probably congenital. It reminded him in an exaggerated degree of the blush met with sometimes in sclerosis of the middle ear, which was, however, usually bilateral.

Mr. de Santi, in reply, regretted no suggestions had been offered as to how the case should be dealt with.

A Case of Growth in the Aryteno-Aryepiglottic Region in a Man, aged Sixty-Four (previously exhibited).

Shown by Dr. Furniss Potter. The case was shown at the May Meeting.[1] Since then the swelling had steadily increased.

[1] *Vide Proceedings of the Laryngological Society of London*, May, 1904, p. 168.

Anti-syphilitic remedies had been administered, but with no appreciable result. There was no pain, and no enlarged glands could be felt.

The case was shown with the view of obtaining expressions of opinion as to diagnosis and treatment.

Mr. Butlin said he had not heard Dr. Potter's remarks on the case, and therefore did not know whether he proposed removal of the growth. It appeared to him (Mr. Butlin) to possess all the characteristics of malignant disease, and as Dr. Potter had watched it since October of last year, its progress must have been very slow. Even now he could not feel any enlarged glands, though probably there were some. If there ever was a case in which excision should be practised for cancer of extrinsic origin, the present instance seemed to be one.

Mr. de Santi said he remembered seeing the case when previously exhibited, and from what he recollected about the case then and the appearances now, he thought there could be no question about its malignancy.

Dr. StClair Thomson said he supposed it might be a case of malignant disease in a syphilitic larynx, but he would like to ask Mr. Butlin whether it was not like a case which was seen by Mr. Butlin, Sir Felix Semon, and himself, and in which the growth entirely disappeared after tracheotomy.[1] Dr. Furniss Potter said the present growth went down after tracheotomy, therefore it might be wise to have a second tracheotomy performed, for if syphilitic it would subside much more quickly under appropriate treatment with a tube in the trachea to give the larynx rest. For was it not exceptional for extrinsic malignant disease of the larynx to go so long without more distinct involvement of the glands?

Mr. Butlin, in reply to Dr. StClair Thomson's question, said his point was that it was an exceptionally slow case, but it was really so easily within reach that he did not see why one should not be sure about it. A sufficient piece could be removed with cutting forceps to enable the diagnosis to be certainly made.

Dr. Furniss Potter, in reply, thanked members for their comments. The tracheotomy tube was removed in less than a week; the man had an acute attack of swelling, producing sufficient embarrassment to necessitate tracheotomy. Immediately after the operation the swelling rapidly subsided. He brought the case in order to get an expression of opinion as to whether it was desirable to operate in the uncertain state of the diagnosis. He intended following Mr. Butlin's advice, namely, to try to procure a piece of the growth and submit it to microscopical examination before doing anything further.

A Specimen of Actinomycosis of the Tonsil.

Shown by Mr. Arthur Cheatle and Dr. W. D'Este Emery. A girl, aged sixteen, living in the country, was seen on account of deafness. The left tonsil was enlarged and had a rounded, overlapping appearance. The glands on both sides of the neck

[1] *Proceedings of the Laryngological Society of London*, vol. vii, December, 1899, p. 15.

were enlarged. There was no suppurative lesion anywhere. The tonsil was so curious in appearance that it was sent to Dr. Emery, Clinical Pathologist to King's College Hospital, for examination. This was the first case reported in which actinomycosis had been found in the tonsil in this country. Dr. Wright, of New York, has lately published a similar case.

Dr. Emery's Report.—The tonsil was greatly enlarged, and on section it was found to be hyperplastic, and on further examination several "tubercles" (using the word in the histological sense) were found grouped around a crypt, the lower portion of which was greatly dilated. This cyst-like cavity contained large numbers of lymphocytes and of desquamated squamous epithelium, in addition to which there were four colonies of an interesting form of streptothrix. The smallest colony was similar in every way to the colonies of actinomyces usually met with in human pus, and showed a tangled mycelium, with a radial arrangement at the periphery, and a few chain-spores in the middle. The larger colonies showed more spore-formation at the centre, and at the periphery the radial filaments showed a peculiar thickening, which was thought to indicate a form of conidium formation, and not the presence of "clubs." The epithelial walls of the crypt were thickened and showed signs of inflammation, being infiltrated with leucocytes that were obviously making their way through into the central cavity. In one place, however (where it was touched by the mass of streptothrix), the epithelium had disappeared and the fungus impinged directly on an ulcerated surface. Beneath the epithelium there was a narrow band of lymphoid tissue, which was, in its turn, surrounded by a zone of well-formed tubercles, in which, however, no tubercle bacilli could be detected.

It was pointed out that in this case (as in that described by Wright, of New York) the masses of actinomyces were inside the crypts—*i.e.* in a region which is physiologically outside the body. In this situation they must have elaborated their toxins, which attracted the leucocytes from the tissues, produced inflammation of the epithelium and sub-epithelial tissues, and finally gave rise to a hollow shell of tubercles at some distance from the mycelial masses.

Dr. HERBERT TILLEY suggested, as such cases were so rare, that some micro-photographs should be taken for publication in the *Proceedings*.

Mr. BUTLIN said a curious case was sent to him from Nottingham, which was one of the noted centres for actinomycosis, several years ago. The patient was a young gentleman, who was sent with a flat tumour of the neck. The question was raised as to whether it was malignant disease or not. He concluded that it was not a new growth, but one of the infective tumours, though he had no idea which. It did not appear

to be syphilitic, and was not like ordinary tubercle. Then he was asked —as the people from that district were well up in the subject—whether it might be actinomycosis. He replied that he had not seen actinomycosis in that early condition, but he did not know why it should not be. The patient gave a very clear history of having, three or four months previously, walked through a field of wheat, a head of which he had plucked and began to chew. Presently one of the husks lodged in his tonsil, making it bleed. He did not get rid of it for two or three days, but at the end of that time his tonsil got well. Shortly afterwards he found the tumour for which advice was sought. It was opened by Dr. Anderson and found to be actinomycosis. There was a clear history of infection through his tonsil, but the tonsil did not retain the actinomyces. He had seen many cases of actinomycosis, but never one in the tonsil.

Mr. CHEATLE, in reply, said he would gladly supply a photo-lithograph for the *Proceedings* if Dr. Emery could do it. It was entirely due to Dr. Emery that the case was detected at all.

A Case of Laryngeal Growth in a Boy aged Six.

Shown by Dr. W. H. KELSON. The patient had complained of steadily increasing loss of voice, first noticed after measles, two years previously; on examination a growth could be seen the size of two peas at the anterior commissure. The growth was removed with Mackenzie's forceps under chloroform, the patient being in the sitting position. It was found on microscopical examination to be a fibroma. On recovering from the anæsthetic the patient's voice was quite clear.

Dr. HERBERT TILLEY said that he could lay no claim to having suggested the removal of papillomata of the larynx under general anæsthesia. What he had frequently asserted was that in order for this method to be successful it was necessary that the anæsthesia should be deep—in fact, pushed so far that the laryngeal reflex was abolished. An expert anæsthetist could, without much danger, provide such a deep narcosis lasting from twenty to thirty seconds, and during those intervals it was possible to remove the growths by means of suitable forceps, because the operator was not hampered by the patient coughing or swallowing.

Dr. FURNISS POTTER asked Dr. Kelson in what position he placed the patient when he removed the papilloma under a general anæsthetic.

Dr. KELSON, in reply, apologised to Dr. Scanes Spicer for not connecting his name with the operative procedure, but he mentioned Dr. Tilley's name because he had heard that gentleman, in the first instance some years ago, speak about that method at some length. The child was sitting on the matron's lap in practically the upright posture. The anæsthetic was chloroform and ether, and was pushed fairly deeply, so that there was no probability of the child moving during the operation.

A Case of Pharyngeal Obstruction from a Diaphragm between the Back of the Tongue and the Posterior Wall of the Pharynx.

Shown by Mr. H. BETHAM ROBINSON. The following conditions were observed in a female child aged ten: There was a central

destruction of the soft palate with loss of the uvula, and the faucial pillars were dragged back to the posterior pharyngeal wall by firm fibrous adhesions. On the left faucial pillar and tonsil there was active ulceration when she was first seen by Mr. Robinson in September last. From the posterior part of the tongue to the posterior wall of the pharynx there was a horizontal membrane, due to a contracted cicatrix; in the centre of this an oval opening, longer from before backwards, through which just the tip of the epiglottis projected. The left edge of the epiglottis was adherent to the scar. Through the posterior part of the opening was seen the glottic orifice and the very limited communication with the lower pharynx. As to the cause, syphilis seemed to be the most probable, but there was no other evidence to support it; there was no history of it being the sequel of a specific fever like scarlet fever. Dysphagia, which was very marked, had almost disappeared with the use of bougies.

Mr. Cresswell Baber said the case was much like one which he himself showed before the Society some years ago, and which was described in Vol I of the *Proceedings*. In that case the diaphragm contained a heart-shaped aperture which was about two inches across. He thought it was situated rather lower down than in the present instance. He enlarged the opening by removing a small piece about the size of half a sixpence from the posterior part, and dilating it with the finger. There was some difficulty in swallowing, which was relieved, but slight noise during sleep remained. There was no dyspnœa. The trouble supervened upon scarlet fever.

Foreign Body removed by Direct Laryngoscopy from a Child aged Twelve Months.

Shown by Dr. D. R. Paterson. The body was a metal collar-stud, which had been impacted in the larynx for three months. While playing with a stud, the child had a coughing fit, and it was noticed directly afterwards that it made a crowing noise in sleep. Two months later difficulty of breathing set in, and this had increased latterly to well-marked stridor. Skiagraphs taken showed the stud fixed in the larynx in an oblique position with its head anteriorly. This was confirmed on examination by the direct method, when considerable œdema of the entrance of the larynx was made out. The stud was readily seized by the head, but it required firm traction to free it from the œdematous tissue around. The breathing was at once relieved, but it was quite ten days before all trace of stridor had vanished. The absence of interference with respiration at first was no doubt due to the situation of the body, which kept the glottis open, and the gradual onset of œdema caused the block.

The PRESIDENT asked what instrument Dr. Paterson used for the purpose. Was it the röhrenspatel of Killian? It was most interesting that that method should have been found useful in a child of that age.

Dr. PATERSON, in reply, said he used the "röhrenspatel" of Killian and the straight crocodile forceps which he showed at the June meeting of the Society. The patient was under chloroform, with the head over the table. By that means one avoided the nuisance of the mucus in the throat. In two instances he had removed papillomata of the larynx by that method, which possessed enormous advantages over the means he formerly employed, viz. that introduced by Dr. Scanes Spicer. One was also able to dispense with the number of assistants which the old method required.

A CASE OF INCRUSTATION IN THE TRACHEA, WITH, AT TIMES, WELL-MARKED STENOSIS.

Shown by Dr. EDWARD LAW. The patient, aged eighteen, had suffered from hoarseness during the last four years, particularly in the winter; this symptom had greatly increased during the last three months and had been accompanied at times by great difficulty in breathing. There had never been any severe spasm except for two days, two months ago, when she was several times afraid of suffocation. Ipecacuanha was administered, and, after vomiting, the choking sensations were greatly diminished. A disagreeable odour of the breath has been noticed during the last four months. The general health had been good, only breathlessness had troubled the patient on running, going upstairs, or any exertion. The friends considered that the hoarseness was due to living in a damp house.

A week ago the patient was seen for the first time on account of difficulty in breathing; she was anæmic and the voice very hoarse and breathy.

On examination, a little purulent secretion was seen over the middle turbinates and over the remains of Luschka's tonsil, but no incrustations nor dryness were present in the nostrils or naso-pharynx. In the larynx a few black particles, looking like small pieces of charcoal, were lying on the ventricular bands and vocal cords; whilst, lower down, the trachea appeared to be almost occluded by large, dry, black incrustations, which reduced the lumen of the canal to the size of a quill. The patient tolerated an examination very well, and the peculiarly black incrustations could be followed for a considerable distance down the windpipe. There was a very fœtid odour in the breath and some dyspnœa. The symptoms appeared so urgent that the patient was advised to go into the London Throat Hospital for observation. A nasal solution had been employed, and the black incrustations in the trachea had

almost disappeared, small greenish-yellow crusts having taken the place of the large black masses; these crusts were now smaller in size and less in number.

The patient had never complained of cough or expectoration, and had apparently swallowed the offensive crusts. This probably accounted for her somewhat unhealthy appearance.

The PRESIDENT said the case was very interesting, and must have been more so when first examined by Dr. Law. To his mind it was certainly a case of laryngitis sicca, with crusting in the trachea. He had seen many such cases where the nose was not affected, but only once a case like that which Dr. Law described his case to be at the beginning. In that case, too, there was immense crusting and obstruction of the lumen, to such an extent as to cause very marked dyspnœa.

Dr. MILLIGAN said that about two years ago he saw, in consultation with Dr. Brooke, of Manchester, a similar case in a young girl, who had typical ozæna, with the condition of the larynx and trachea which had been described. Accessory sinus disease was examined for, but not found, and she was put under routine treatment, without effect, for the crusts continued to form in the larynx and trachea and the stenosis increased. He then suggested that the treatment might be carried on by injecting anti-diphtheritic serum, on the idea first mentioned by Belfonti and della-Vedova, who suggested that those cases might be due to an attenuated form of diphtheria. The patient was taken into a surgical home, where she had the injections, which were continued for nearly two months. The result was very marked improvement; indeed, he thought the condition had ceased altogether.

A CASE OF NEW GROWTHS IN THE LARYNX.

Shown by Dr. DUNDAS GRANT. Louisa H—, aged seventeen, was sent to the Central London Throat and Ear Hospital on August 25, 1904, on account of attacks of dyspnœa for several months so serious as to place her life in danger. In the absence of Dr. Grant, Mr. Stuart-Low examined her and found a growth covering the whole of the upper part of the larynx of an appearance suggesting that of the top of a toadstool. He performed a temporary laryngotomy and removed a large portion of the growth through the mouth. The dyspnœa entirely disappeared. When seen three weeks after by Dr. Grant, there remained a round growth of about the size of a small cherry, which appeared to several observers to be growing larger, though with no great rapidity. It was impossible by inspection to decide as to its site of attachment, but from the way in which it could be moved by the probe it appeared to arise from the upper margin of the aryepiglottic fold, near its anterior part. Dr. Grant managed to get a snare round it in such a way as to make it certain that its attachment was well to the front. It proved to be so firm that its removal was impossible without an anæsthetic, and gas was administered while a snare was still *in situ*. Then, by the exercise

of a considerable amount of force, the growth was dragged away with a tag of mucous membrane hanging from it. The larynx was then quite clear, although the aryepiglottic fold seemed somewhat ragged and raw. The right vocal cord was fixed. The section made of the first portion of the growth showed what Dr. Wingrave considered to be a spindle-celled sarcoma, but he stated that the difficulty in the diagnosis of growths of mesoblastic tissue was always one of immense difficulty. Another pathologist thought it presented more the appearance of a fibroma. The second portion was found to consist of a capsule and a core, and the neoplasm seems to have been eradicated *in toto*. There is now a slight degree of movement of the right vocal cord, and the raw surface on the aryepiglottic fold has cicatrised. A microscopical section was exhibited for the opinion of the members.

Mr. DE SANTI said he had carefully looked at the microscopic section, and his feeling was that it was more like a sarcomatous growth than a fibromatous one. Of course there was a certain amount of fibrous tissue in the section, but he thought the sarcomatous elements predominated.

Dr. STCLAIR THOMSON asked whether Dr. Grant was still a supporter of the use of the snare for operations on the larynx. Dr. Grant seemed to have had an unhappy moment when the snare gripped that growth and it would not come away, and the snare would not let go. When the subject was discussed at Oxford there was, of course, a difference of opinion, but many of those who then spoke condemned snares. He wished to know whether the experience of the present case left Dr. Grant a supporter of the snare.

Dr. PEGLER suggested that as the specimen seemed to merit a very careful examination, it should be submitted to the Morbid Growths Committee to report upon.

Dr. DUNDAS GRANT, in reply, said he would be pleased to place the slide at the disposal of the Pathological Committee, whose report he would await with interest. In any event he would bring the case before the Society again at a future meeting. In answer to Dr. StClair Thomson's question concerning the snare, he did not believe in absolute condemnation of one instrument. He thought there was room for the snare, even though it was much more limited than some of its former admirers thought. He regarded the present case as a very good one for its application. There was no particular anxiety, and if there had been he would simply have cut the wires and pulled the stem of the instrument away. Where there was a pedunculated growth which the snare could be got round, it was the instrument to use. As he had said in his description, the fact of getting the snare round it enabled him to decide as to its origin, and as to the possibility of getting it away. He was more or less probing with the snare.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

NINETY-THIRD ORDINARY MEETING, *December* 2, 1904.

P. McBRIDE, M.D., F.R.C.P.Ed., President, in the Chair.

E. FURNISS POTTER, M.D., P. DE SANTI, F.R.C.S., } Secretaries.

Present—25 members and 2 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were nominated for election as Ordinary Members at the next meeting:

G. A. Garry Simpson, M.R.C.S., L.S.A., East Acton.
Joseph William Leech, M.D., F.R.C.S., Newcastle-on-Tyne.

The following cases and specimens were shown:

CASE OF INCRUSTATIONS IN THE TRACHEA.

Shown at last meeting by Dr. LAW.

Sir FELIX SEMON said he saw the case a little while ago, after his return from America. Dr. Law brought the patient to him, and he saw some crusts far down in the trachea. At that time Dr. Law said the patient was better than when he demonstrated her before the Society. He, Sir Felix, did not know anything of an examination of the case by Killian's tracheoscope having been suggested, and he recommended it; but Dr. Law told him of the objection—which he had to admit was justified—that by the introduction of the tube possibly crusts might be torn off, pushed in front of the instrument, and cause dangerous dyspnœa. It was Dr. Law's intention to first try to make the crusts softer by the inhalation of steam, and the patient was taken to the hospital for the purpose. To-day he found the stridor certainly greater than when he saw her a week ago, and the crusts seemed more extensive. Under those circumstances he submitted that it might be legitimate, if

the obstruction should further increase, to perform tracheotomy, remove the crusts, and see whether they re-formed.

Mr. Robinson said a better mode of treatment would perhaps be to try a formalin spray before doing tracheotomy.

Crusts from a Case of Dry Catarrh of the Nose and Naso-Pharynx, treated by Formalin Spray.

Shown by Dr. Bronner. Dr. Bronner (Bradford) showed a specimen of large crust removed from the naso-pharynx of a case of atrophic rhinitis. The girl, aged twenty-one, had had nasal discharge for some years, and no less than three operations had been performed on the nose under chloroform. The nares were very large and full of crusts, and the naso-pharynx completely filled with a large crust. This was removed with forceps. There was frequent recurrence of the naso-pharyngeal crust, which not only caused much discomfort, but also occasional œdema of the soft palate and uvula. The patient used a formalin spray, and in a few weeks there was only slight recurrence of the crusts. Dr. Bronner had shown the specimen partly because of its unusual size and thickness, and also to advocate the use of formalin in these cases. It not only prevented the recurrence of the crusts, but also at once removed the offensive odour in cases of ozæna. He should like also to protest against the common custom of scraping the nares in cases of atrophic rhinitis and ozæna. This case had been scraped no less than three times.

The President asked what strength of formalin Dr. Bronner used. He thought he said up to 1 per cent.

Dr. Herbert Tilley asked what Dr. Bronner's procedure was in this case (or in an ordinary one of atrophic rhinitis) with regard to the application of formalin. Did he wash the nose free from crusts and then apply formalin? Also, how did he apply the formalin—on a mop or by spraying? And how much did he apply at a time?

Dr. Bronner, in reply, said the strength of formalin he applied varied from 1 in 500 to 1 in 100. When there were any large crusts he removed them with forceps; then he applied formalin or trichloracetic acid. The patient attended perhaps once a week as long as there was recurrence of the crusts, and then less frequently. In some cases it was necessary to use a syringe with weak formalin solution, 1 in 1000, in order to remove the crusts.

Epithelioma of Larynx; Thyrotomy; Recurrence; Removal of Greater Part of Larynx; Recovery.

Shown by Sir Felix Semon. The patient, Mr. R. M., an Indian barrister, was brought to me by Mr. Waggett on May 6 of the

present year on account of his laryngeal condition. He had had syphilis twenty-five years ago, followed occasionally by secondary symptoms. In 1902 he had an ulcer on the front part of the right ventricular band, which yielded under the use of mercury and iodide of potassium. Later on an ulcer appeared on the opposite vocal process, which yielded to the same treatment. Shortly after this a fresh ulcer appeared on the original spot on the right ventricular band, and although resort was again had to iodide of potassium in large and long-continued doses, and to mercury, gradual tumefaction of the ventricular band took place, with correspondingly increasing hoarseness.

On May 6 there was very considerable tumefaction of the whole right half of the larynx, with almost complete immobility. The tumefaction involved the whole of the right ventricular band, which was irregular, dusky red, rather mamillated, and the vocal cord, of which only the front part could be seen, and on which there was also a red irregular tumefaction. All this left practically no doubt as to the disease being of the nature of a slowly growing infiltrating epithelioma.

On May 16 I performed thyrotomy. The operation went off without the slightest hitch, and the patient made an excellent recovery. The microscopic examination made by Mr. Shattock confirmed the diagnosis of epithelioma. Mr. Shattock, however, already then expressed a fear that recurrence would be likely to take place on account of the great extent of the disease, and the fact that the growth was apparently not far from the margin of the wound. Unfortunately, his prediction came true, the growth recurred rapidly, and on August 27 the patient, who had been at St. Moritz, under the care of Dr. Veraguth, returned to me.

Repeated slight hæmorrhages from the throat having occurred, Dr. Veraguth had made a laryngoscopic examination and had seen a distinct tumour. It was button-shaped, smooth, but indentated, the size of a bean, and situated in the middle of the scar, corresponding to where the border of the anterior and middle third of the vocal cord had been. There was no enlargement of glands externally. I at once removed the greater part of the tumour intra-laryngeally. The report of the microscopist was as follows: "The bulk of the specimen consists of granulations and fibro-cicatricial tissue. Within young lymphatic spaces in the latter are seen aggregations of malignant epithelial cells."

On August 30 a renewed and much more extensive operation was undertaken. This consisted in reopening of the old wound (in part rather difficult, as the landmarks were lost through cicatrisa-

tion), insertion of Hahn's tube and of sponges in the pharynx and above the cannula, cocaine application, all as usual. On reopening the larynx the front part of the left ala of thyroid and a little part of the front part of the left vocal cord certainly looked rather fishy. This portion was removed by oval-shaped resection of cartilage, with its covering mucous membrane, and with the left vocal cord. Not much of actual tumefaction seen in scar on *right* side, but the right half of the thyroid cartilage was in parts œdematous, in parts soft, easily breaking down, and discoloured. I thought that very likely there was cancerous invasion of the cartilage. Nothing wrong was detected outside the larynx; not a single enlarged gland was to be seen. I removed the entire right wing of the thyroid, and upper part of right side aspect of cricoid, until everywhere glistening white cartilage was visible. Thus the only parts left of the cartilaginous framework was the left ala of thyroid cartilage and the greater part of the cricoid cartilage.

The patient recovered from this operation in the most pleasing manner. The condition as noted on November 19th was as follows:

The patient looks as well as possible, has gained a good deal of flesh since the last operation, breathes freely, though with a slight stridulous noise, and speaks with an astonishingly loud voice. He swallows with some care, because he has got a sensation of pressure in the left side of his neck, due, no doubt, to cicatricial contraction of the parts. On examination of the larynx it is astounding, in view of the extent of the second operation, to see how little the larynx is distorted in the laryngoscopic image. The epiglottis is perfectly normal, and so is the mucous membrane over the arytenoid cartilages. The left half of the larynx, *i.e.* the ventricular band, and the left arytenoid cartilage move freely towards the middle line, and the left arytenoid cartilage completely joins the right one, which is immovable. It is no doubt due to the free action of the left ventricular band, which compensates for the left vocal cord, that the astonishing loudness of the voice is produced. In the interior of the larynx not the slightest trace of any recurrence can be seen. Everything is covered either by normal mucous membrane or by healthy-looking cicatricial tissue. There is no enlarged gland anywhere in the neck. The external wound is perfectly normal but somewhat tense.

It need not be said that there will still be anxiety as to further recurrence, but the fact that the pieces of cartilage removed at the last operation were, on careful microscopic examination, found not to have been invaded by the growth, and that the laryngeal condition, as well as that of the glands, is at the present time so

satisfactory, gives one reason to hope that the cure this time may be lasting.

The PRESIDENT said he was sure members felt very much obliged to Sir Felix Semon for bringing the case forward. It showed what could be done, especially in the preservation of the voice. There did not seem to be much room for criticism, only for congratulation.

CASE OF HYPERTROPHIC RHINITIS WITH SESSILE OUTGROWTH ON THE SEPTUM IN A MALE PATIENT AGED TWENTY-TWO, THE GROWTH OF SUCH A SIZE AND SHAPE AS AT FIRST SIGHT TO SIMULATE THE MIDDLE TURBINATED BODY.

Shown by Dr. DUNDAS GRANT. A. W—, aged twenty-two, complained of stuffiness of the left nostril of three months' duration. On the left side of the septum, at the level of the middle turbinated body, is the outgrowth described, which simulates a middle turbinated body adherent to the septum. A probe can, however, be passed between the growth and the middle turbinated body. On the right side there is also a hypertrophy in the same position, but of much smaller size. There was no opacity on transillumination and no tenderness in the region of either frontal sinus.

Dr. PEGLER said that if the hypertrophy of the tubercle of the septum were removed, the specimen would be almost precisely like the one shown by Mr. Arthur Cheatle some years ago, of which a full-sized plate appeared in the "Proceedings."

Mr. CRESSWELL BABER thought such hypertrophies on the septum in the region of the tubercle were not very uncommon. In the case of the young woman there was a very anæmic mucous membrane, and the chief feature seemed to be a deflected septum.

CASE OF BONY TUMOUR OF THE NOSE.

Shown by Dr. LAMBERT LACK. The patient, a young girl, was sent to me at the London Hospital by Dr. Keigwin. She was suffering from complete nasal obstruction of some months' duration. On examination a smooth mass was seen in the left nostril, apparently continuous with the septum. It was covered with mucous membrane, normal in colour. The septum was pushed over so as to block completely the right nostril. On transillumination the left cheek was opaque. Under chloroform, a large mass was found completely filling the left nostril, and projecting posteriorly into the post-nasal space. The mass seemed to consist of soft bone, and could easily be scraped away with a sharp spoon. In this way the nose was cleared out. The tumour was apparently growing from the ethmoid in the region of the middle turbinate.

The septum was markedly deflected but otherwise intact. On opening the antrum it was found to be filled with mucous contents. Under the microscope the tumour is seen to consist of cellular elements interspersed with bone.

So far as I know, the case is unique. It was certainly not an ordinary osteoma, but might perhaps be an ossifying sarcoma.

The other point of interest is the condition of the antrum. I assume that the maxillary ostium was obstructed and that the normal secretions accumulated; it was not empyema, but mucocele of the antrum. I have found similar conditions of the antrum before. This observation is interesting, as it is in direct opposition to the views of Logan Turner, who, in a recently published paper on the bony cysts or mucoceles of the nose, stated that in his opinion mucocele of the antrum was unknown.

The patient was operated on in February, 1904, and there is so far no sign of return of the growth, although the operation performed was obviously an incomplete one.

Dr. PEGLER said the section seemed to be made up entirely of bone and fibrous tissue. There was no evidence of malignant disease, but the growth was very interesting.

Mr. STEWARD asked whether sections through other parts of the growth showed anything further. The small piece shown looked rather mysterious.

Dr. LAMBERT LACK, in reply, said the growth was uniform in structure throughout. It was a solid mass without air-cells. The sections exhibited were from two different portions of the growth. The operation was undertaken with a view to diagnosis; otherwise some better method of removal might have been devised.

CASE OF CARCINOMA OF THE NOSE IN A MAN AGED SIXTY.

Shown by Dr. LAMBERT LACK. The patient is at present under my care in the London Hospital. For the past two months he has been suffering from nasal obstruction on the left side with a considerable amount of purulent discharge and intermittent attacks of rather severe neuralgic pain. When first seen the left nostril was filled with what appeared to be ordinary mucous polypi between which pus exuded. On transillumination the left cheek was dark. The patient was admitted for the radical cure of the polypi. Under a general anæsthetic the antrum was punctured from the inferior meatus and thick curdy matter exuded. The ethmoidal region was then thoroughly curetted. Extensive bone disease was found and the orbital cavity was freely opened. The antrum was opened both from the middle and inferior meatus. Whilst operating it was noticed that the base of the polypi consisted of a tough fleshy mass. This was scraped away with difficulty and prepared

for microscopic examination. The sections show the ordinary appearance of carcinoma of this region. A fortnight later a more radical operation was undertaken. An incision was made all round the inner wall of the orbit and the periosteum separated from the remains of the orbital plate. Rouge's operation was then performed, and a large opening made into the antrum through the anterior wall. The whole outer wall of the nose from the floor as high up in the ethmoidal region as could be reached through the orbital incision was cut away. The lining membrane of the antrum was thickened and was completely scraped away. These two incisions give free access to the outer wall of the nose and allow every step of the operation to be seen without leaving any disfigurement of the face.

Dr. PEGLER regarded the section as one of epithelioma.

Dr. HERBERT TILLEY thought one should lay stress on the point which Dr. Lack had remarked on in the diagnosis of the case, namely, the associated pain. He believed that where a growth in the nose was accompanied by a deep-seated boring pain, that symptom in itself was sufficient to justify a serious view of the case. It was a sweeping assertion, but would be found to be true in a large number of malignant cases. He remembered making a mistake in a case where there was a discharge of pus from the antrum, which was also dark on transillumination, and in which deep-seated lancinating pain existed. When he opened the canine fossa, prepared to clear out the antrum, he found it was filled by a malignant growth, which had otherwise not produced symptoms of pressure.

Dr. WYATT WINGRAVE said that squamous epitheliomata from the nasal mucous membrane were of special interest, since they were not only atypical of the normal epithelium covering the area from which they grew, but they did not quite conform to the characters usually associated with that class of growth. Dr. Lack's specimen did not exhibit any solid cylindrical masses or "nests"; he therefore classified it with the "diffuse" or non-pearly variety, which in its deeper parts was strongly suggestive of an endothelial origin. He had seen several similar specimens, one forming part of a large polypus. He considered the specimen a squamous epithelioma of the "diffuse" or non-cylindrical type, originating in modified surface epithelium.

CASE OF TUMOUR OF TONSIL IN FEMALE AGED SIXTY-FOUR.

Shown by Dr. WYATT WINGRAVE. Mary W., aged sixty-four, complains of enlarged tonsil and stoppage of nose of fourteen months' duration. It commenced with cold and total deafness, which continued till last July, when hearing returned, but right tonsil rapidly enlarged, involving the corresponding nostril. The swelling extends upwards into the naso-pharynx, downwards to the glosso-epiglottic fossa, and inwards to middle line of soft palate. Its surface is not ulcerated; it is firm to the touch and only slightly

tender. There are some enlarged glands at angle of mandible. Both maxillary antra are somewhat symmetrically dull, the infra-ocular crescents being absent.

During the last six months she has lost much flesh; now she has some dyspnœa, excessive somnolence, great physical weakness, loss of taste and smell, with hallucinations.

Married at fifty-eight. No specific history.

Treatment (16 days): Pot. iodid. and Hyd. perchlor.

Case of Lymphosarcoma of Tonsil in which great benefit had been derived from Arsenic.

Shown by Dr. Herbert Tilley. A male patient aged nineteen, in whom eighteen months ago some enlarged glands had been removed on the right side of neck, and the scar along the anterior border of the sterno-mastoid was still visible. When first seen by Dr. Tilley in September, 1904, the patient had a very large, soft, red, and superficially ulcerated right tonsil. It almost completely blocked the fauces, so that the swallowing of liquid food was becoming a difficulty, and breathing was difficult. There was a large mass of glands on the right side of the neck which scarcely stretched the afore-mentioned scar. The patient was put on rapidly increasing doses of Liquor arsenicalis, until he was taking ℥xv three times daily. He has recently gone back to ℥v thrice daily, because the larger doses produced sickness and intestinal irritability. The tonsillar swelling and the glands in the neck have practically disappeared. Whether they will remain in abeyance is doubtful, because the general history of these cases was that they recurred, and then arsenic had no effect. The temporary effect of the drug was, however, very extraordinary.

Dr. de Havilland Hall said the case looked like one of lympho-sarcoma, and in view of the success which had attended the employment of arsenic in Dr. Tilley's case, he would advise the administration of large doses of that drug. In some cases of that nature arsenic had a wonderful effect. In a case of his own the tonsil was cleared out entirely, but, unfortunately, the patient afterwards developed diffuse lympho-sarcomatosis, and died in a very miserable condition. He regretted to say, also, that her misery during the last few months of life was much accentuated by the arsenical neuritis from which she suffered, the pain being most intense, and was not stopped by discontinuing the arsenic. A curious point was that the arsenic in these cases seemed to have only a limited power. In Dr. Tilley's case he thought it was fortunate that the glands had been removed before the arsenic was commenced, because he (Dr. Hall) had seen, in some cases where there were large masses of glands, arsenic have little effect; but if a mass of glands was removed, the remaining ones would clear up. So that it seemed as if the arsenic had the power of clearing up a moderate amount of glandular enlarge-

ment only. Some years ago, at Westminster Hospital, he had, with Mr. Spencer, a case in which that surgeon removed many glands, and then the remainder cleared up under arsenic.

The PRESIDENT thought Mr. Wingrave's case looked like lymphosarcoma, and asked whether a piece had been removed for examination. He did not know whether it had been the experience of others that where arsenic failed in such cases cacodylate of soda sometimes succeeded. Cacodylate was supposed to be an inert substance, but he had in mind one case in which a combination of cacodylate and iodoform produced a wonderful effect. He knew two cases of lymphosarcoma which disappeared under arsenic, but in both cases the patients died within a few months, of malignant disease in another part.

Dr. LAMBERT LACK said his view of Dr. Wingrave's case differed from that of the previous speakers. He did not consider the tonsil was involved at all, but that the growth was in the post-nasal space and pushed the soft palate and tonsil forward. Dr. Tilley's case looked now as if it would be possible to perform a radical operation, but perhaps it would be better to continue with the arsenic, and operate, if need be, later. The case rather suggested that it might be well to treat this disease with arsenic before attempting to operate.

Mr. ROBINSON asked whether a digital examination of the nasopharynx had been made in Dr. Wingrave's case.

Dr. WYATT WINGRAVE, in reply, said he had not removed a fragment, because there did not seem to be any portion sufficiently prominent. If only a small paring were taken from the surface, possibly it would only be a portion of tonsil, and therefore misleading. Lymphosarcoma at the time of life of this patient was not so serious as in early life. Digital examination afforded better evidence of its extensiveness than vision. The growth apparently began in the tonsil, and extended upwards, blocking the right choana, and also into the soft palate. It seemed to extend almost beyond the middle line of the soft palate into its substance.

Dr. HERBERT TILLEY, in reply, said his patient was doing so well under the arsenic that he felt inclined to continue with it until the limit of improvement was reached before suggesting operation.

CASE OF SUBMUCOUS RESECTION OF DEFLECTED NASAL SEPTUM (KILLIAN'S METHOD).

Shown by Dr. HERBERT TILLEY. Dr. Tilley showed a young man aged nineteen, to whom this operation had been carried out for the relief of almost complete obstruction of the right nasal cavity. The operation took thirty minutes, but since he had done more of them he thought that fifteen to twenty minutes would give ample time. In this case he had been obliged to remove some of the vomer and central plate of ethmoid because the obstruction continued a long way posteriorly. The removal of the bony incisor crest and the lower bony part of the obstruction was a most important part of the operation.

Subacute Frontal Sinus Empyema following Scarlet Fever in a Child.

Shown by Dr. Herbert Tilley. A lad, aged nine, had scarlet fever during latter half of September. Three weeks after onset he complained of headache and sickness, followed by swelling in the region of the left frontal sinus and œdema of eyelid, which quickly spread to the right lid and over the lower part of the forehead. The appearance of an abscess over the forehead when seen by exhibitor on November 4 was very similar to that of the caput succedaneum of a new-born child. The ordinary radical operation was carried out on the left frontal sinus, and it was found that the anterior sinus wall had been perforated through its inner median boundary. A free passage was made into the nose, and the sinus was now practically well and obliterated by granulation tissue. Dr. Tilley had never seen a case of the kind in so young a patient.

Case of Chronic Laryngitis in a Male aged Thirty-two.

Shown by Dr. Cathcart. For the last four years this patient has been hoarse every winter for two or three months at a time. This year the hoarseness did not come on till February. He came to my clinic in May complaining of hoarseness and a constant cough. On examination I found an enlarged Luschka's tonsil secreting pus, large faucial tonsils with deep crypts and a very long uvula. In the larynx there was thickening of the mucous membrane of the ventricular bands, and also very slightly in the interarytenoid space. There was likewise some subglottic thickening, more especially on the right side. He was taken into hospital and the uvula was snipped, the Luschka's faucial tonsil removed.

After the operation the hoarseness got much less and the patient ceased attending. In October he returned and said that the fogs had made the hoarseness worse than it had ever been. The laryngeal condition was also worse; besides an increase of thickening there were crusts in the larynx, although the nasal condition still remained good after the operation.

I shall be very glad to receive any hints in the way of treatment, as I have tried everything, and nothing seems to do him the slightest bit of good.

The President said the case looked to him excessively difficult to diagnose; but it was certainly more than chronic laryngitis. There was loss of substance, and, he thought, the presence of some adventitious substance. He would be sorry to say what form of infiltration was present.

Dr. Dundas Grant thought the case was one of extreme pachydermia of the larynx, with a projection on one side fitting into a hollow on the other. It seemed to approach the typical picture, though it was rather an exaggerated one. He recommended that the silence-cure should be tried for a time; not that which people often tried—speaking in a kind of husky voice—but speaking in a genuine whisper, or not speaking at all. The effect of that was sometimes very remarkable. This was quite apart from the question of the nose, which Dr. Cathcart said was originally the seat of some suppuration, and which Dr. Grant assumed was under treatment.

Mr. Atwood Thorne agreed that the case might be described as one of pachydermia, and suggested spraying with formalin.

Dr. de Havilland Hall asked whether the case could be brought again to a future meeting, as it was most interesting and important.

Dr. Cathcart, in reply, said a suggestion had been made that the larynx should be sprayed with mucin, and he would like to hear from any members who had tried it. He would bring the patient to the next meeting.

Case of Lupus of Pharynx and Larynx.

Shown by Mr. H. W. Carson. Patient is a healthy-looking nursemaid, aged twenty-three, who has suffered from pain of a burning character in the throat on swallowing for twelve months. There is also some cough and hoarseness. Her elder brother died of phthisis, and her father has had lupus of the face for twenty years.

Present condition.—Many discrete nodules are present on the uvula and posterior pillars of the fauces, particularly the left, the uvula being much thickened and clubbed. There is no destruction of tissue. The epiglottis is similarly affected, and its enlargement prevents a clear view of the ventricular bands and cords, which appear unaffected. There is no palpable enlargement of glands, no lupus anywhere else in the body, no pulmonary affection, and no tubercle bacilli have been discovered in the pharyngeal secretion. The case is shown as one of some interest, and particularly to obtain the views of members of the Society on treatment and for an expression of opinion on the possibility of transmissibility as the patient is in charge of several young children.

The President said it seemed to be an interesting and typical case of lupus, no doubt affecting the uvula and the epiglottis. His idea would be to scrape and possibly remove the uvula and epiglottis with Krause's double curette, followed by the application of lactic acid.

Mr. Parker suggested that arsenic should be tried. It seemed to act as well in lupus of the pharynx as in lymphosarcoma of that region.

Dr. Lambert Lack recommended the internal administration of arsenic in increasing doses. With a large experience of this affection he had found that pharyngeal lupus almost invariably got well with arsenic, and lupus in the larynx was cured in the great majority of cases. If

there were no tubercle bacilli in the sputum he should not consider the disease dangerous from the point of view of contagion. Lupus of the skin could rarely, if ever, be ascribed to direct infection.

Dr. BENNETT said he had found more good result from multiple puncture with the cautery than any other line of treatment for such cases.

Dr. DE HAVILLAND HALL said Sir Felix Semon mentioned a case many years ago which was cured after protracted treatment by multiple puncture with the cautery.

Mr. CARSON replied.

CASE OF PARALYSIS OF LEFT VOCAL CORD, CAUSED BY LOCALISED TUMOUR OF THE THYROID GLAND ? MALIGNANT.

Shown by Mr. F. J. STEWARD. The patient, a woman aged forty-six, stated that she had only noticed a swelling in her neck for six weeks, and for about the same period her voice had been altered. On examination of the larynx the left vocal cord was seen to be completely paralysed. A localised tumour, about one and a half inches in diameter, and oval in shape, is present in the lower part of the left lobe of the thyroid gland. The tumour is quite smooth, elastic in consistence, and is freely movable in all directions.

CASE OF HYPERTROPHIC RHINITIS INVOLVING BOTH INFERIOR TURBINATED BODIES (RECENTLY CAUTERISED) AND FIBRO-MYXOMATOID OUTGROWTH ON THE RIGHT SIDE OPPOSITE THE MIDDLE TURBINATED BODY IN A FEMALE PATIENT AGED TWENTY-TWO.

Shown by Dr. DUNDAS GRANT. A probe can be passed between the two structures; no bare cartilage can be felt on the septum. There is a growth of papillomatous appearance on the middle of the lower border of the left middle turbinal. The nasal stuffiness has been perceived for between two and three years, but has got worse of late.

CASE OF ULCER OF THE TONGUE IN A BOY AGED TWO AND A HALF YEARS.

Shown by Dr. DUNDAS GRANT. The patient was brought to the hospital on account of a sore on the tongue of six months' duration. On the middle of the dorsum of the tongue there is an elongated shallow ulcer; the edges are irregular; it is slightly increasing in size; there is no pain. The father was the subject of tuberculosis. Pending a bacteriological examination it was thought probable that the ulcer might be tuberculous.

Mr. ROBINSON said his opinion was that it was a tuberculous ulcer.

A Case of Post-Pharyngeal Swelling, shown at the May Meeting.

Dr. Bennett reported that a section was made of a small piece of the pharyngeal wall, but no evidence of tuberculosis was detected. The patient was sent to the country for several weeks and given iodide of mercury internally. The swelling gradually diminished, and has now almost completely gone. There has been, however, no reason to suspect any syphilitic process, and the swelling was most probably a chronic inflammatory process.

Two Cases of Ethmoidal Necrosis.

Shown by Dr. W. Hill. Dr. Hill showed a brother and sister suffering from ethmoidal necrosis due to hereditary syphilis.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

THIRTEENTH ANNUAL GENERAL MEETING, *January* 13, 1905.

CHARTERS J. SYMONDS in the Chair in the absence of P. McBRIDE, M.D., F.R.C.P.Ed., President.

Present—The Honorary Officers and 33 members.

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

Dr. Donelan and Dr. Peters were appointed scrutineers of the ballot and the following officers were appointed for the year:

President.—Charters J. Symonds, F.R.C.S.

Vice-Presidents—Wm. Milligan, M.D., F. Willcocks, M.D., J. B. Ball, M.D., William Hill, M.D.

Hon. Treasurer—H. B. Robinson, F.R.C.S.

Hon. Librarian—StClair Thomson, M.D.

Hon. Secretaries—P. R. W. de Santi, F.R.C.S.; H. J. Davis, M.B., M.R.C.P.

Council—L. H. Pegler, M.D., J. Walker Downie, M.B., P. McBride, M.D., W. R. H. Stewart, F.R.C.S.Ed., Felix Semon, C.V.O., M.D., E. Furniss Potter, M.D.

The Report of the Council was then read and unanimously adopted:

REPORT OF COUNCIL FOR YEAR ENDING JANUARY 13TH, 1905.

The Council have much pleasure in announcing that the past year has been one of continued success. The supply of clinical material has been abundant, and the meetings have been well attended, the average number of those present being thirty-three.

During the year thirteen Ordinary members have been elected, and two have resigned.

The Council record with regret the loss of one member by death—Dr. J. Scatliffe.

The Council look forward to celebrating the centenary of Senor Manuel Garcia, the Society's oldest honorary member, in March next, and it is hoped that every member of the Society will co-operate with the Council by doing all in his power to make the occasion a distinct success. In March last a committee was formed, consisting of the office-bearers and ex-Presidents of the Society, to organise the centenary celebration.

This Committee decided:

1st.—To present Senor Garcia with his portrait, to be painted by Mr. John Sargent, R.A.

2nd.—That addresses should be presented by laryngological societies and musical bodies.

3rd.—To hold a festival dinner in honour of the event.

4th.—To hold a special meeting of the Society on March 17th—the day of the centenary—instead of the ordinary meeting fixed for the 3rd of the month.

The distinguished artist has completed the portrait, which is an excellent likeness, and a masterpiece worthy to be ranked as one of the finest examples of work emanating from Mr. Sargent's brush.

The Librarian's Report was then read and adopted:

The Honorary Librarian's Report.

It will be remembered that our books are now housed on the shelves of the Royal Medical and Chirurgical Society's library, in return for their being made accessible to the Fellows of that Society.

During the past year this arrangement has continued to work quite satisfactorily. The librarian of the latter Society reports that our books have been fairly used by our own members, and by the Royal Medical and Chirurgical Fellows, and have been found most useful.

We possess a complete card index, and any of our books can be taken out by members applying to the librarian any day during the hours of 11 a.m. to 6.30 p.m.

Several of our exchanges have ceased to reach us—in spite of repeated requests for a continuance, and of the fact that our own *Proceedings* have been sent regularly. The delivery of the latter has been discontinued, and our exchange list, therefore, is now limited to the following: *The Laryngoscope*, American Laryngological Association, *Archiv. für Laryngologie, Monatsschrift für Ohrenheilkunde, Annales des Maladies de l'Oreille, Revue de Laryngologie, Archives Internationales de Laryngologie, Archivii Italiani di Laryngologia, Archivio Italiano di Otologia*, and *Bolletino delle Malattie del Orecchio*, etc. Our thanks are due to Sir Felix Semon for presenting the bound volume of the *Centralblatt für Laryngologie* for the year 1904, and to the editors for a similar gift of the Journal of Laryngology.

At the beginning of the year we had forty-five names of colleges and institutions on our Free List. The Council decided that thirty of these should be discontinued, and a free copy of our *Proceedings* is now sent only to the following: The British Museum, the Royal College of Physicians, the Royal College of Surgeons, British Medical Association, Royal Medical and Chirurgical Society.

The omitted institutions and colleges were invited to subscribe for our *Proceedings* at the moderate price of 4*s*. per volume, but only one body (the Birmingham Medical Institute) has taken up a subscription. One member has bought a complete set of the eleven volumes of *Proceedings*, and several odd back numbers have been sold, and in this way I have received £3 4*s*. 4*d*.

By reducing our Free List we have been able to reduce the number of our monthly edition from 250 to 200 copies. Of these about 150 go to members, 10 to exchanges, 5 free, and 35 go to our stock of back numbers. Five back numbers were out of stock, and during the year these have been reprinted, so that we are now able to supply single back numbers

or complete sets of *Proceedings*. The Council have decided that the price be 6*d*. per copy for members, and 1*s*. per copy for non-members. These back numbers are now stored by Messrs. Adlard in a half-berth, which we rent at 10*s*. per annum. This includes the return of an annual stock-taking. We possess seven bound copies of Vol. I, and two bound copies of Vols. I and II (together), and these we should be glad to sell. We have also cases for binding at the cost price of 6*d*. each.

A complete bound set of our eleven volumes has been added to the library. It will be valuable for reference, and can readily be consulted at our meetings.

I regret to say that the library has not been enriched this year by any gifts of books, though several reprints have been sent us.

It will be noticed that the *Proceedings* are now issued in a different size and type. It is hoped that the arrangement by which this has been effected, together with a large reduction of our Free List, and the curtailment of our monthly edition to 200 instead of 250 copies, will all bring about considerable diminution in the expenses of the Society. It would be a help if members possessing duplicate copies of back numbers would kindly present them to our reserve stock, as certain editions are getting rather low.

The following Report of the Treasurer was read and adopted:

The receipts this year have been £160 12*s*. 9*d*. This, with £18 10*s*. 6*d*., the balance brought forward from 1903, and £50 transferred from the Deposit Account, gives a total of £229 3*s*. 3*d*. The expenses have been £203 12*s*. 4½*d*., thus leaving a balance of £25 10*s*. 10½*d*.

The sum of £158 11*s*. was received in subscriptions and entrance fees. Of this amount £13 13*s*. are entrance fees and £3 3*s*. for 1905. All subscriptions have been paid with the exception of those of two gentlemen who live in South Africa.

BALANCE SHEET, 1904.

Income.	£	s.	d.
Subscriptions, 1904	141	15	0
„ 1905	3	3	0
Entrance Fees	13	13	0
Interest on Deposit	2	1	9
Balance, 1903	18	10	6
Brought forward from Deposit Account.	50	0	0
	£229	3	3

Expenditure.	£	s.	d.
Adlard—Printing	109	15	5
Garcia Testimonial	25	0	0
Rent	31	10	0
Reporting	13	11	0
Annual Dinner	7	1	0
A. Clarke—Indexing	2	14	0
Baker—Microscopes	2	4	0
Christmas Boxes	1	0	0
Pathological Committee	0	6	0
Hodgkinson, Preston and King	0	3	4
Pulman—Binding	1	3	9
Electric lamps	1	12	0
Arthur—Tongue-cloths	0	16	3
Mathew (Porter)	2	0	0
Bank commission	0	0	10
Librarian	0	6	9
Secretaries' Petty Cash	3	3	1½
Treasurer „ „	1	5	0
Balance	25	10	10½
	£229	3	3

Deposit at Bankers—£150.

Examined and found correct,
H. FITZGERALD POWELL,
W. H. KELSON,
Auditors.

January 9, 1905.

W. R. H. STEWART, *Hon. Treasurer.*

The Report of the Curator of the Morbid Growths Collection was then read and adopted:

In presenting my annual statement, I have first to thank those gentlemen who have generously contributed to the Society's collection since the last general meeting. We now possess in the cabinet a fairly representative proportion of our histological exhibits and a very valuable series of specimens. The additions include some sections illustrative of various records of past proceedings, and amongst recent exhibits of last year's date are some exquisite specimens of bleeding polypus of the septum; endothelioma of the soft palate, antrum, and larynx; angio-fibroma of the naso-pharynx; actinomycosis of the tonsil; papilliferous columnar-celled carcinoma of the nose, etc. Sir Felix Semon has allowed his collection of epithelioma of the larynx, eighteen very beautiful examples, to be catalogued. They are all operation cases, some of which are referred to in the pages of our "Transactions." The following is the list, chronologically arranged, with the names of the contributors. Some further additions have been promised. For the convenience of members a copy of the complete catalogue is about to be placed in the Society's library.

I. *Nose and Accessory Cavities.*

1. Sarcoma (small round-cell) of the Septum, November, 1896, vol. iv, p. 4, Dr. J. W. Bond.
2. Papilloma of the Septum (cauliflower growth, 6½ inches in circumference), November, 1896, vol. iv, p. 21, Mr. Logan Turner.
3. Section of Middle Turbinal from a Case of Early Polypus, February 5th, 1904, vol. xi, p. 107, Dr. Eugene Yonge.
4. Endothelioma of Maxillary Antrum, February, 1904, vol. xi, p. 111, Dr. Lambert Lack.
5. Angioma of Left Maxillary Antrum, May 6th, 1904, vol. xi, p. 164, Dr. Bronner.
6. New Growth from Chronic Antral and Ethmoidal Disease, May, 1904, vol. xi, p. 165, Dr. Scanes Spicer.
7. Bleeding Polypus of the Septum, May, 1904, vol. xi, p. 165, Dr. Scanes Spicer.
8. Cystic Polypus from the Middle Meatus, June, 1904, vol. xi, p. 184, Dr. McBride.
9. Papilliferous Columnar-Celled Carcinoma, June, 1904, vol. xi, p. 188, Sir Felix Semon.
10. Primary Tubercular Growth of Septum, vol. xi, p. 184, Dr. Smurthwaite.

II. *Naso-pharynx.*

1. Angio-fibroma of Naso-pharynx, Nasal and Accessory Cavities, November 7th, 1902, vol. x, p. 19, Dr. Herbert Tilley.

III. *Pharynx, Soft Palate, etc.*

1. Section from Case of Rapid Ulceration of Nose and Face, December, 1896, vol. iv, p. 18, Dr. McBride.
2. Lympho-Sarcoma of the Tonsil, April, 1899, vol. vi, p. 80, Dr. Lambert Lack.
3. Epithelioma of Soft Palate, May, 1904, vol. xi, p. 167, Dr. Scanes Spicer.
4. Tumour of the Soft Palate (Endothelial), June, 1904, vol. xi, pp. 172, 185, Dr. James Donelan.
5. Actinomycosis of the Tonsil, November, 1904, vol. xii, p. 5, Mr. Arthur Cheatle.

IV. *Larynx.*

1. Endothelioma of the Larynx in a Case of Syphilis, February 5th, 1904, vol. xi, p. 110, Dr. Lambert Lack.
2. Fibromatous (? Sarcomatous) New Growth of Right Aryepiglottic Fold, November, 1904, vol. xii, p. 10, Dr. Dundas Grant.
3 to 19 (inclusive): Eighteen Characteristic Examples of Squamous Epithelioma, particulars of which will be found in the Catalogue, Sir Felix Semon.

Supplementary Catalogue.

1. Fibroma of the Nasal Septum, Dr. Dundas Grant.
2. Cartilaginous Tumour of Left Ventricular Band, Dr. Lambert Lack.

The following gentlemen constitute the Morbid Growths Committee:

Mr. Walter Spencer (Chairman).
Dr. Wyatt Wingrave.
Dr. Lambert Lack.
Mr. Ernest Waggett (Hon. Sec.).
Dr. Pegler—Curator of Morbid Growths Collection.

It was proposed by Sir Felix Semon, and seconded by Dr. de Havilland Hall, that:

"The Laryngological Society of London re-affirms its resolution of February, 1900, viz. that at all International Medical Congresses a full and separate section should be formed for Laryngology and Otology, and that Laryngology should not on these occasions be combined with Otology. It views with deep regret the fact that, in spite of the wishes of both Laryngologists and Otologists having been clearly expressed at the International Medical Congress of Paris in 1900, attempts have been made at Madrid in 1903, and are now again renewed on the occasion of the forthcoming International Medical Congress at Lisbon, to assign to Laryngology a position inferior to that of other recognised specialities, and to combine it with Otology in one sub-section.

"The Laryngological Society of London, in its corporate capacity, declines to assent to any arrangement derogatory to the dignity of Laryngology and to the position held by it at all International Medical Congresses ever since 1881."

This was carried unanimously.

The meeting then adjourned.

NINETY-FOURTH ORDINARY MEETING, *January 13th*, 1905.

CHARTERS J. SYMONDS, President, in the Chair.

P. R. W. DE SANTI, F.R.C.S.,
HENRY J. DAVIS, M.B., M.R.C.P., } Secretaries.

Present—33 members, 5 visitors.

The minutes of the preceding meeting were read and confirmed.

W. Stuart Low, F.R.C.S., 45, Welbeck Street, W., was nominated for election as an ordinary member at the next meeting.

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

G. A. Garry Simpson, M.R.C.S., L.S.A., East Acton.
Joseph William Leech, M.D., F.R.C.S.Ed., Newcastle-on-Tyne.

THE HON. SECRETARY (Mr. DE SANTI) read the following Report of the Morbid Growths Committee:

Report of Specimens.

1. Dr. Donelan's Case of Malignant Disease under Schmidt's Serum Treatment. A section of epithelioma.

2. Mr. Hunter Tod's Case of Tumour of the Nasal Septum. A section of vascular fibroma.

3. Mr. Waggett's Case of Primary Tuberculoma of the Septum. A section of tuberculous tissue.

4. Tumour of Larynx, Dr. Dundas Grant (*Proceedings*, November, 1904). The histological appearances make a diagnosis between sarcoma and young fibroma tissue impossible.

5. Tumour of Palate, Dr. Donelan (*Proceedings*, May and June, 1904). We believe this tumour to be an endothelioma. It is based upon the growth of the endothelial cells, which are large in size, polygonal in shape, and which contain an oval nucleus. In some places these cells are grouped in uniform masses, in others they are tending to form fibrous tissue, while elsewhere they are producing a homogeneous material, scattered through which are vacuoles containing nuclei and which thus acquire the false appearance of cartilage.

6. Nasal Cyst, Dr. McBride (June, 1904, p. 184). The histological appearances give no clue to the origin of the cysts, that portion of the wall which was examined being composed of œdematous fibrous tissue containing some glands.

Report of Morbid Growths' Committee.

1. Dr. Donelan's Case of Malignant Disease of Larynx Undergoing Schmidt's Serum Treatment (*Proceedings*, December, 1903). The section was one of epithelioma.

2. Mr Waggett's Primary Tuberculosis of Septum Nasi. The section was one of tuberculous tissue.

3. Dr. Scanes Spicer's Bleeding Polypus of the Septum (*Proceedings*, May, 1904). The section was that of a fibro-angioma.

4. Dr. Scanes Spicer's Tumour of the Antrum (*Proceedings*, May, 1904). The slide contained sections of two distinct structures. One of these was blood-clot containing a number of mononucleated leucocytes. The other had the usual characters of polypoid tissue found in cases of chronic antral suppuration, gland tissue being present in parts. In some of the fragment portions of polypi tissue (? necrotic) were seen embedded in the blood-clot. There was no evidence of sarcoma or endothelioma.

The following cases, specimens, and instruments were then shown:

During the discussion on the cases, in the absence of the President, the chair was taken by Sir Felix Semon.

Epithelioma of Larynx: Laryngo-Fissure: No Recurrence after Six Months.

Shown by Dr. StClair Thomson. Man, aged forty-nine, shown to the Society on December 4th, 1903 (*vide Proceedings*, vol. xi, p. 68). The previous history of this case, the history of the development

of the laryngeal neoplasm, and the progress of the convalescence after operation, all present points of considerable interest.

In the year 1893 this man was treated with Koch's tuberculin in the Victoria Park Chest Hospital by Dr. Heron. Dr. Clifford Beale (*vide Proceedings*, vol. xi, December 1903) says that there was a good deal of tuberculosis in his system at that time, there was a remarkable reaction, and the patient was exceedingly ill for a long time. The result is eminently satisfactory, as for eleven years he has carried on the unhygienic occupation of a baker, and at present he shows no traces of tubercle beyond slight dulness over the left front upper chest.

When shown to the Society in December of last year he had been hoarse for fifteen months, and presented an infiltrating growth of the anterior two thirds of the left cord. The surface of the growth projected into the glottis and was dimpled in a peculiar way. Members may recollect that the case was thought to resemble closely one shown by Sir Felix Semon at the same meeting, and the general vieww as thatb oth of them were either tubercular or simply inflammatory. But whereas in Sir Felix's case—in which, however, the surface was distinctly ulcerated—the condition spontaneously disappeared (*vide Proceedings*, xi, pp. 51 and 187), in mine it slowly became more marked. It was not, however, until July last—seven months after we saw the patient here, nine months after I had first examined the case, and nearly two years from the onset of hoarseness—that I was able to decide that the growth was malignant. This opinion was founded on the steady though slow increase of the growth, and the onset of mobility of the cord—evidently due to infiltration and not to mere mechanical obstruction. The only suspicion of an enlarged gland was below the *right* jaw—*i.e.* on the opposite side.

Thyrotomy was performed on July 16th, 1904, in the presence of Dr. Newcomb, of New York. I employed Mr. Waggett's thyroid shears for the first time, and found them most satisfactory. The growth was seen by direct inspection to be very much like its reflection in the laryngeal mirror. The dimple on it was found to be a retracted depression and not an ulceration. The growth was clipped off, the whole cord and a good margin being included. The sketch that I hand round was made at once by a skilled artist. As the piece removed appeared infiltrated up to its margin, a second portion was clipped away, exposing the white inner surface of the thyroid cartilage.

Unfortunately, there was some trouble with the Hahn's tube and

some blood was inspired during the operation. Consequently, the patient developed a double pneumónia and a temperature of 102°, respirations 40, and pulse 120. But I kept him sitting up in bed between two widely open windows, and he made a good recovery.

I would like to invite opinions as to the situation of the new, cicatricial, cord. I have never tried to produce exact coaptation of the two halves of the thyroid, but have contented myself with letting them fall together and stitching over them the reflected perichondrium. This is the first time I have noticed that the cicatricial cord has not been quite *vis-à-vis* the healthy one.

When the larynx was inspected a fortnight after the operation the arytenoid on the diseased side was quite mobile. As the new, cicatricial, cord formed it became fixed. Could this have been avoided, say, by allowing the patient to speak more?

I propose showing the patient again, when his year of probation is completed.

TRACHEOTOMY FOR LARYNGEAL STENOSIS. MARKED IMPROVEMENT. DIAGNOSIS: TUBERCULOSIS, LUPUS, OR CONGENITAL SYPHILIS? BOY AGED FOURTEEN.

Shown by Dr. ST.CLAIR THOMSON. This boy came under notice in November, 1904. He reported that his adenoids had been removed at St. Thomas's Hospital seventeen months previously, that three months afterwards he caught cold on his chest and his throat became sore, and had remained so ever since. Three months before coming under observation he had lost his voice, and for the last month his breathing had been obstructed.

On admission there was long inspiratory and expiratory stridor, no cyanosis. The epiglottis, ventricular bands, vocal cords, and laryngeal surface of the aryepiglottic folds were infiltrated with indolent nodules, ulcerated and catarrhal, just like a case of chronic tubercular laryngitis. But the ulcerated vocal cords were absolutely fixed in the middle line, leaving only a narrow slit for respiration. The pillars of the fauces and both tonsillar fossæ were infiltrated with the pale, indolent nodules still visible. One of these was microscoped, but showed only granulomatous inflammatory tissue, without indication of syphilis or tubercle.

There were crepitations over the upper lobe, with slight dul-

ness; but the temperature was normal, the pulse 74, and there were no tubercle bacilli in the abundant tenacious sputum.

He was watched for five nights, but with everything at hand for tracheotomy. The stenosis was constant, and after coughing he had attacks of dyspnœa, with cyanosis and retraction.

Tracheotomy was performed on November 10th, 1904, and in three weeks the boy put on eleven pounds in weight. All chest symptoms disappeared. As soon as a view of the larynx was obtained the cords were seen to be moving, and gradually the glottis became fully open. It will be seen that the posterior two thirds of the cords have entirely ulcerated away, showing a clear view of the subglottic space. Much of the nodular infiltration has broken down, and healing appears to be taking place. The boy can talk easily with a hoarse voice, and breathes freely through the larynx, but in view of the marked improvement the tracheotomy tube is still worn. The fauces are *in statu quo*. Neither mercury, iodide, or arsenic have been given. I am inclined to view the condition as one of lupus, but the fixation of the cords is unusual and difficult to explain.

A Case of Swelling in the Left Arytenoid Region in a Woman aged thirty-five.

Shown by Mr. de Santi. The patient complains of pain in swallowing, localised to the left side: this she has suffered from for about three months.

On examination, some anæmia of the pharynx is noticeable. Occupying the left arytenoid region is a large œdematous inflammatory swelling reaching forwards along the aryepiglottic fold, and downwards towards the cricoid cartilage. The whole swelling is covered with frothy muco-pus. The rest of the larynx is normal.

The appearance of the disease is such as to point strongly to tubercular mischief, but repeated examinations of the muco-pus, sputa, and lungs for tubercle bacilli have been quite negative. The patient, moreover, has no temperature, cough, or night-sweats. There is no history or evidence of syphilis. Patient has been treated with carbonate of guaiacol, but so far with no good results.

There seems a considerable element of doubt about the case; the trouble may be of a malignant nature (there are one or two

enlarged glands in the left side of the neck), although it is uncommon in women, and the age of the patient is only thirty-five.

The case is brought forward to elicit opinions as to diagnosis.

Dr. WATSON WILLIAMS suggested that it was a case of perichondritis of the cricoid, though, of course, that was only a general statement. He asked whether Mr. de Santi could exclude that.

Mr. W. G. SPENCER suggested the performance of thyrotomy with the object of scraping probably a tuberculoma or possibly a chronic abscess in connection with the cartilage.

Dr. FITZGERALD POWELL thought this case ought to be dealt with very carefully. He was of opinion that it was most probably of a malignant nature, possibly sarcoma. He would advise removing a portion of the growth for microscopic examination to determine definitely its character.

Dr. SMURTHWAITE suggested that a thorough examination of the lungs should be made to see if there was any marked condition indicating phthisis. If so, one would suppose the lesion in the larynx was tubercular.

Mr. DE SANTI said the lungs were free, but there might be a very small focus of inflammation in the lungs, centrally situated, making it difficult of detection, of which the local laryngeal signs were the first indication. He had seen cases of tubercular lesions in the larynx in which at the time no objective tubercular lung signs were present, though three or four months later well-marked and rapid disease in the lungs developed, the laryngeal mischief, though in all probability of secondary origin, being the first danger signal. Certainly, in this case, the left crico-arytenoid joint was very much infiltrated, the infiltration extending well down on to the cricoid; in addition, the false cord showed signs of implication. Again, the patient was flushed and seemed to be a phthisical subject.

Dr. ST.CLAIR THOMSON thought the diagnosis rested between tuberculosis and malignant growth. It was possibly malignant, and he suggested that examination with the finger would be a help. If there were any confirmatory signs of tuberculosis, he could not see what would be gained by thyrotomy; it would only hasten the woman to an early grave. It would be impossible to excise the tuberculous condition in the larynx. The records of thyrotomy for tuberculous larynx with cures were so few and far between, even in quite limited disease, that it did not seem wise. In the present case the cartilage was distinctly involved, and the crico-arytenoid joint fixed. If it proved to be malignant, he would leave others to say whether any radical operation would be possible; but he thought it was doubtful.

SIR FELIX SEMON (in the Chair) said that in his own mind the diagnosis in the case rested between tubercle and malignant disease. The mere expression "perichondritis" did not convey much, and primary perichondritis was nowadays hardly believed in, other than traumatic. Neither could he see that thyrotomy would be of any considerable service. Surely the disease was not inside the larynx, but on the posterior surface of the cricoid cartilage, so that thyrotomy would not be of much help. The best suggestion seemed to be that digital examination should be made, and that a small piece should be removed for microscopical investigation. If the disease were tubercular, one might do good by scraping it from

within. His personal experience of thyrotomy in tubercular disease had been uncommonly good, but it was limited to two cases, both of whom ultimately recovered. In both, however, the wound became infected, and a second and more extensive operation became necessary before a cure was obtained. If the disease should prove to be malignant, he feared the prospect would be very grave, and did not think that anything short of total extirpation of the larynx, with removal of the lymphatics on the corresponding side, would be of any use.

Mr. DE SANTI, in reply, expressed his intention of removing a piece of the swelling and having it microscoped, so as to determine, if possible, the nature of the disease. He had thought all along that it was tubercular, and he agreed with Dr. Smurthwaite that in some of these cases the symptoms were masked and slight in the lungs. The lungs of the patient had been carefully examined, and the sputum had been on two separate occasions examined for tubercle bacilli; it was because the result was negative that he brought the case forward. Whether it was malignant or not could be ascertained partly by examining with the finger, and more decidedly by extirpating a piece for microscopical investigation. He regarded the case as of sufficient interest to justify a subsequent later report; the sequelæ of many cases shown were their chief interest.

CASE OF TRACHEAL OBSTRUCTION OF UNCERTAIN ORIGIN AND NATURE.

Shown by Dr. HERBERT TILLEY. The patient was a young man, aged twenty-eight, of exceptionally fine physique. His general health had always been good, but there was considerable probability of his having had syphilis some six years ago. He applied to hospital on account of increasing difficulty in breathing and incessant cough, which was peculiarly trying at night. Examination of the larynx and trachea showed that about the level of the fifth ring there was what appeared to be a diaphragm of a reddish colour, the opening in which was eccentric and more towards the right side; it would possibly admit an ordinary lead pencil.

Ordinary exertion caused the patient much distress, hence he was admitted to hospital and rested in bed, while the house-surgeon was prepared to insert a Konig's tracheotomy tube at a moment's notice. Mercury inunctions were applied daily. The breathing became less stridulous, and the obstruction in the trachea, which was at first so easily visible, seemed to recede, so that now it could only be seen with difficulty, and, apparently, almost as low as the bifurcation. The general improvement under mercury seemed to point to a syphilitic origin, but it was quite unlike the usual effects of tertiary syphilis on the trachea.

Mr. C. A. PARKER said he had had the opportunity of seeing the case before, and one day examined it very carefully. He noticed some prominence of the left sterno-clavicular joint, with a little redness and œdema over it. The man's breath at that time was very offensive, and he thought

that probably there were some suppurating bronchial glands causing stenosis.

Dr. Scanes Spicer said he could not distinguish anything abnormal in the trachea. The cords were reddened and a little bowed, and he did not think they approximated perfectly on phonation. At one time the patient's inspiration was stridulous, at another free. As two or three members had seen something abnormal in the trachea that day, tracheal polypus, pedunculated and movable, was a possible hypothesis, though he himself had failed to make out anything positively in an examination which was only cursory and with indifferent illumination.

Mr. Cresswell Baber asked whether there was any enlargement of the thyroid in the case, causing pressure on the trachea.

Dr. H. FitzGerald Powell thought, from Dr. Tilley's description of the case, that it was very much like a syphilitic gumma, which had become absorbed on account of the anti-syphilitic remedies which the man had been taking. The diaphragm previously noticed by Dr. Tilley was not now to be seen. Possibly it was a general swelling, extending from above downwards, and as it was now said to be seen further down, it might be due to the upper part having cleared up.

Dr. Edward Law said he believed the condition to be syphilitic. Both the appearance of the swelling—which was on the left side, and more prominent in front than behind—and the fact that there had been a diminution after specific treatment, were in favour of that view.

Sir Felix Semon suggested that it would be well to continue the use of iodide of potassium. If further improvement resulted under its administration the syphilitic nature of the entire disease would be clear. If it remained stationary or got worse, he thought Killian's tracheoscopy would be an excellent course to adopt.

Dr. Herbert Tilley, in reply to Mr. Baber, said there had been no enlargement of the thyroid. He failed to grasp Dr. Spicer's line of thought in the matter, viz. that it might be a papilloma, because that would not explain the marked shifting in the position of the swelling. To-day it was difficult for even experts to see the obstruction at all. Dr. Law saw it, but it seemed to be only possible to do so when the patient leaned slightly forwards and sat up very straight. It had vastly improved under anti-syphilitic treatment. He could not explain the curious œdematous swelling over the left sterno-clavicular joint, with associated redness, which Mr. Parker noted the first day the patient came to the hospital. A few days after his admission there seemed to be some œdema over the right sterno-clavicular joint also. The temperature was 101° on the first night he was in hospital, 100° the next day, after which it became normal, and had remained so ten days. Since he came in with a bad cold, this slight pyrexia did not seem to throw much light on the case.

Pharyngeal and Laryngeal Nystagmus in a Case of (?) Tumour of the Pons.

Shown by Sir Felix Semon. The patient, C. C—, aged twenty-seven, is at present an inmate of the National Hospital for Epilepsy and Paralysis, Queen Square, under the care of my colleague, Dr. Ormerod, to whom I am much obliged for permission to show him

here, whilst I am equally indebted to our senior house-physician, Dr. Gordon Holmes, for the following notes about the patient's general condition.

The patient was admitted on August 5, 1904, with the following history: He had a blow on the right side of his head eight years ago, and denies that he has ever had syphilis. His present disease began suddenly two years ago, when he found his eyes turned and his mouth pulled over to the left. Four hours later he began to feel giddy, and his left hand felt numb. For the next ten days he walked reeling to the left. From this attack he recovered, but during the next few weeks had frequent diplopia. Seventeen weeks later on he lost power in the right side of his face, and the diplopia returned. He recovered again, after a few weeks, and again relapsed, losing all power on the right side of the face. Subsequently he had two more relapses, accompanied by diplopia. Ten weeks before admission there was weakness in the left arm and left leg, and, for the first time, a change in the voice was noted.

On December 8, 1904, Sir Felix Semon described the condition of the pharynx and larynx as follows: "Distinct irregular spasm of soft palate and uvula in a vertical direction, uvula being energetically drawn upward about twenty-five times in ten seconds. The spasm is, however, not absolutely rhythmical, a few quick contractions following a series of slower ones. At the same time mucous membrane of the posterior wall of the pharynx is moved in a somewhat oblique direction from left and below to right and above. These movements are synchronous to those of the uvula. The tongue and mucous membrane of the cheek do not participate in the spasm, neither when at rest nor when the tongue is protruded, nor are there any fibrillary twitchings of the tongue.

The larynx is, with exception of the epiglottis, affected by a clonic spasm similar to the pharyngeal one, and perfectly synchronous with the latter. This can be well seen if one allows the tip of the uvula to appear in the lower part of the laryngoscopic mirror. The vocal cords and arytenoid cartilages are constantly carrying out, quite independently of respiration, a series of adduction movements, which do not go to the extreme of complete adduction and closure of the glottis, but are pendulous between the position of ordinary respiration and that of the cadaveric position."

December 12, 1904. Patient has again developed complete paralysis of the third nerve.

Remarks.—Whilst the ultimate cause of pharyngeal and

laryngeal nystagmus is as yet unexplained, it is remarkable that this rare symptom has been comparatively often observed in tumours of either the pons or the cerebellum. In the present case, at one time, nystagmus of the diaphragm was believed to be associated with the pharyngeal and laryngeal movements, but I have not been able to satisfy myself as to its existence.

Dr. BRONNER expressed the hope that when Sir Felix Semon published the case it would include some description of the patient's eye symptoms, such as exact condition of eye-muscles, of the optic nerves fields of vision.

Dr. PEGLER remarked upon the difficulty of drawing a line of demarcation between severe cases of pharyngeal and laryngeal nystagmus in which a tumour of the pons or cerebellum was suspected and the milder cases in which no such focal centre of irritation was thought of. In the latter cases possibly local sources of reflex irritation had been removed without benefit. In Dr. Bond's case (a male, vol. iii, p. 41) and Dr. Lack's (No. 38) the spasm was mild in degree and confined to the pharynx. In Sir Felix Semon's former case (vol. viii, p. 49) and his own two (vol. x, pp. 105, 106) the movements were more extensive and involved the larynx. These three cases, therefore, shared more of the character of Mr. Steward's (vol. x, p. 84) and the present, in which tumour of the cerebellum and pons were provisionally diagnosed respectively, and one was led to think that in these mild or "functional" cases some undiscovered central lesion might exist. He had reason to know that his own two cases—accompanied by entotic tinnitus—remained as they were when exhibited for him in 1903. The references to the Society's previous cases were given to assist those who might be interested in obtaining fuller details of them.

Dr. HERBERT TILLEY asked whether Dr. Pegler could refer the Society to any account which recorded such cases as of functional origin. He did not remember any, nor did the text-books describe the condition as functional. He showed a case before the Society about seven years ago, in which a man had twitching of the pharyngeal wall, exactly similar to that seen in the present case. He heard that that patient died about two years ago of general paralysis. When shown before the Society he had irregular pupils, but otherwise was in perfect health. Later on, his speech became blurred, and other symptoms of general paralysis rapidly supervened.

Mr. W. G. SPENCER thought the patient was already getting paralysis of his vagus centre; his pulse was 120, and intermittent. He would soon have further symptoms of general paralysis.

Mr. CRESSWELL BABER said that he had several times seen cases of spasm of the palate in connection with objective tinnitus, but was not aware that they afterwards went to the bad. He thought these symptoms occurred in neurotic patients, but they might have an organic origin.

Dr. ST. CLAIR THOMSON said one case was shown by Dr. Bond, but most of them had been brought together by Dr. Lack in a paper which he contributed to *The Laryngoscope*. The disease was extremely rare, but some of the cases to be found in the above reference were in young people at an age when organic disease of the nervous system was seldom met with.

SLIDE FROM A CASE OF EPITHELIOMA OF THE RIGHT VOCAL CORD AND NEIGHBOURHOOD, IN A GENTLEMAN AGED FIFTY.

Shown by SIR FELIX SEMON. The patient was sent to me by Sir Francis Laking on November 21st, 1904, on account of hoarseness, which had existed for many months. On laryngoscopic examination the whole of the anterior three fourths of the right vocal cord was seen to be occupied by an irregular mamillated pale growth, which materially encroached upon the glottis, but was as yet not ulcerated. The mobility of the right vocal cord was considerably affected. There were no glands in the neck. Some months previously a piece of the tumefaction had been intra-laryngeally removed in Paris, and M. Cornil was stated to have pronounced it an innocent growth. Nevertheless, the appearances were so characteristic of malignancy that, without renewed intra-laryngeal removal and microscopic examination of a piece, I felt practically certain that it was malignant. Thyrotomy was performed on December 17th with the assistance of Mr. Stabb, Mr. Tyrrell giving the chloroform. The growth, with a zone of healthy tissue all round it, was thoroughly removed. The wound was closed by stitches above and below, an opening was left in the upper part of the lower third for drainage, and this too was closed on the second day, as there was very little secretion. The patient made an otherwise excellent recovery, but an abscess formed below the lower part of the incision, and a small part of the wound had to be reopened in this region to allow the matter to escape. Now this part of the wound is also closed by granulations from the bottom of the wound, but the duration of the after-treatment has in consequence of the formation of this abscess been unnecessarily prolonged, and one of the reasons why the case is put on record is that the experience made enforces the lesson that the part of the wound to be left open immediately after the operation should not be in the middle, but in the lower part of the incision. Another reason for its publication is the misleading result of the microscopic examination of a small portion intra-laryngeally removed. This is, of course, only a further illustration of an experience often made before. I am recording the case in the *Proceedings* of the Society because they have become associated with the results of thyrotomy in malignant disease of the larynx.

EPITHELIOMA OF PALATE, TONSIL, TONGUE, AND CHEEK.

Shown by Dr. FITZGERALD POWELL. Male, aged forty years, said that twelve months ago he noticed a difficulty in swallowing.

There was a sore at the base of the tongue, which had gradually extended to the tonsil, palate, and cheek on left side. It interfered with his swallowing, but did not cause much pain.

On examination a large red ulcerating surface with considerable overgrowth was observed extending over the soft and hard palate, the tonsil, and on to the cheek.

A portion of the growth was removed with the snare and submitted to microscopical examination. It was found to be an epithelioma.

Mr. DE SANTI thought the condition of the patient was so bad that it would be best to leave him alone and not subject him to any form of treatment, whether by rays or anything else.

Mr. WESTMACOTT said he thought the experience of those who had used X rays in those cases was one which would lead them to avoid that method. He had had two similar cases which were sent for X-ray treatment; in both there was a very rapid enlargement of cervical glands, though there had previously been but little enlargement. One was a case of excision of the tongue for epithelioma, with some feeling of irritation remaining in the scar, and the other was epithelioma of the fauces on the right side. There had been no infiltration until about three weeks after commencing the rays, and then the neck got into a very deplorable state. He would be very careful about submitting a patient with epithelioma in that region to X rays.

Dr. WATSON WILLIAMS said there was a case which had been sent up by Dr. de Havilland Hall, reported by Dr. Dobson as having been treated by X rays—inoperable epithelioma of the larynx. The result as reported was very different to what appeared to have been Dr. Westmacott's experience. If the X rays were to be continued it would be worth while looking up the facts of the case.

Dr. BRONNER asked whether there was much pain, and whether orthoform had been used, and if so, with what result.

Sir FELIX SEMON said it was remarkable to notice how different were the reports as to the effect of X rays on malignant disease of the pharynx and larynx. With regard to the larynx, he confessed he could not see how any good could be effected by X rays. So far as he knew, the only good effect of the rays, universally admitted, had been upon places where the disease was *directly* amenable to the action of the rays. He knew, however, that a successful case of laryngeal cancer had been reported by Scheppegrell. With regard to malignant disease of the mouth, tonsils, etc., he had, on several occasions, by the urgent desire of the patients, consented to the employment of X rays, but he had to join with those who had never seen any lasting good result from it.

Mr. WESTMACOTT said, in drawing conclusions from the result of treatment it was necessary to know who was administering the X rays, as there were hardly two cases in which a similiar therapeutic effect was obtained. In certain cases where there was much thickening the rays did not penetrate deeply, but if scarification of the part were carried out before raying, the effect was greater. In recording cases, one should state, as far as possible, the therapeutic strength of the rays. That could not yet be done exactly, but an instrument had recently come from Berlin which was useful for the purpose.

Dr. FitzGerald Powell in reply, said the expression of opinion seemed to be against the use of the rays. But such cases seemed so utterly hopeless, that one grasped at any means which might cause benefit. He understood a number of such cases had been treated with the rays at Middlesex Hospital. The patient had not had pain. He thanked the members for their opinions.

Dr. Smurthwaite showed a beautiful series of paintings in oil illustrating diseases of the throat and larynx:

The President said he was sure all the members greatly admired Dr. Smurthwaite's paintings, which were very beautiful.

Laryngeal Forceps for use in Direct Laryngoscopy.

Shown by Dr. Paterson. It is fashioned on the crocodile principle and terminates in a beak with cutting edges. From the bend on the shank to the tip the length is nearly eight inches. It is used through the "röhrenspatel," and is lightly built so as to interfere with the vein as little as possible. At the same time, it is quite capable of dealing with fairly tough tissue. It was found exceedingly useful in clearing the larynx in papillomata in children, the pieces being picked off with great ease.

Dr. Paterson, in reply, said that he found the forceps very useful in the way to which a member objected. The beak which lifted up just fitted into the anterior commissure and got the papillomata out. He thought the thorough way in which the anterior commissure could be cleared marked a distinct advance on the old procedure by the indirect method.

Ulceration of Soft Palate for Diagnosis.

Mr. Westmacott showed a gentleman who exhibited a slow recurrent ulceration of the oropharynx.

In March, 1903, he showed the left tonsil which he had removed in January of that year, and which he believed to be the seat of acute primary tuberculosis. The wound healed, but between two and three months later the part around the upper end of the tonsillar region began to ulcerate and spread to the soft palate, associated with great pain in the fauces on the left side, and extending into the ear. The left nostril was obstructed and the posterior end of the inferior turbinate bone on the left side was hypertrophied and pale. After six weeks the part began to heal under the galvano-cautery and lactic acid, and the pain disappeared. It healed entirely, but ulceration again appeared on the anterior pillar of the

left fauces, and a piece was examined, but no tubercular evidence was present. In July, 1903, X rays were employed daily for several weeks, and the pain was much relieved by the treatment, although the ulceration spread very slowly. It healed perfectly, however—recurring from time to time, always with great pain and loss of weight due to eating being difficult, and often commencing during spells of hot weather. When healing took place, no scarring was visible, and the weight lost was recovered; during July, 1904, the ulceration spread to the uvula and right faucial region, with considerable thickening of the parts, as well as pain in the affected area. All the thickened tissue was removed by free excision and scraping, and again perfect healing took place. Soon, however, ulceration recurred again on the left side, and has fluctuated in extent ever since under scrapings and applications of lactic acid and formalin.

There is no history of syphilis, nor other evidence of it in himself or wife and family. There is no history of tubercle. There has never been any glandular enlargement at any time, nor any chest symptoms indicative of phthisis. His health has been quite good in other respects. The patient has been under well-tried courses of mercury and of potassium iodide without the slightest effect. Arsenic has been given without benefit. Strong applications, as carbolic acid, lactic acid, and formalin and chromic acid, relieve pain quickly, as does also scraping. The sputum has never revealed tubercle bacilli, and guinea-pigs inoculated have remained healthy. Tissues removed from time to time have shown inflammatory exudation only.

The appearance of the affected area is described by Sir Felix Semon as follows: "One sees extensive ulceration of the middle part of the hard and soft palate of the naso-pharynx, and of both palatal arches, particularly of the left one, whilst the disease does not extend into the larynx. Within the area affected a sharp whitish serpiginous line of demarcation, which is in part surrounded by a zone of congestion, separates the healthy from the affected parts. Inside this whitish line of demarcation there are spots in part deep, in part superficial ulceration, and in part snow-white little nodules reminding one of either tuberculosis or lupus. The ulceration at the base of the uvula has a distinctly lupoid character, whilst in other parts it is perfectly nondescript."

Dr. PEGLER thought, in view of the fact that the section of tonsil shown to the Society in 1903 presented no appearance of tubercle, and despite that anti-syphilitic treatment at that time yielded negative results,

some form of syphilis seemed to be the inevitable diagnosis, perhaps acquired, and a late manifestation.

Mr. G. W. SPENCER remarked that the original experiments of Dr. Lingard, which he saw himself at the Brown Institute, showed that the lupus cases took any time up to a year to affect the guinea-pig. At that time the animals died of tuberculosis with enormous spleens. Lingard likewise showed that glandular tuberculosis took something like six months to affect the guinea-pig. He suggested adhering to the opinion that the case was one of lupus, and that the open-air treatment or a sea voyage should be tried.

Dr. FITZGERALD POWELL thought the case was one of tubercle, and suggested that it should be well curetted, lactic acid rubbed in, and iodoform applied regularly and continuously. Should any recurrence be seen, the curetting should be repeated. He had seen tuberculosis of the palate which curetting had relieved; but it had broken down again, and continuous curetting and painting with lactic acid had eventually cured it.

Dr. STCLAIR THOMSON said he had forgotten whether there was a syphilitic history in the case, and whether there had been the experimental administration of anti-syphilitic remedies. He thought a few inunctions of mercury, or a weekly injection of calomel into the buttock would soon settle whether it was syphilitic. If not, it might be lupus, in which case the galvano-cautery would be of great benefit, and it was much cheaper and quicker than a sea voyage.

Dr. WATSON WILLIAMS suggested that, for diagnosis purposes, in a case presenting difficulties, injections of tuberculin might throw some light on the matter.

Sir FELIX SEMON said that, having seen the case at a different stage, he inclined more to the diagnosis of tuberculosis or lupus than to any other, though he would not go so far as to say there could not be much doubt about it, as it was the sort of case which was doubtful both clinically and microscopically. He thought it was a good suggestion to inject tuberculin; that might help where microscopical and bacteriological examination, and even inoculation, had failed. The case had been treated antisyphilitically, but with negative results. As to the use of the galvano-cautery, he thought one should not be certain about that; at any rate, he would like to disabuse Dr. StClair Thomson's mind of the idea that it would be a very quick measure. He had once had a very good and lasting result in obstinate lupus, but it was necessary to make about 150 applications, and he would have given up the treatment long before if the patient had not insisted upon it.

Mr. WESTMACOTT, in reply, said his own opinion had always inclined to lupus, but if so it must be of the kind which was analagous to some skin cases—a very low form of ulceration and inflammation. Either the bacilli were very few or very attenuated, as in Bazin's disease, an ulceration of the front of the leg to which no pathological lesion could be definitely assigned. Possibly the present case was due to some form of nerve lesion, because the patient had an immense amount of pain when the ulceration started; or it might be due to some circulatory trouble, though he could find no change in the arteries. The man was positive he had not had syphilis; he understood what it was and said he would have sought treatment if it had been so. He thought the prognosis was favourable, but that the only treatment of use was scraping under an anæsthetic, with a Volkmann's spoon, applying lactic acid and formalin,

and painting over it a solution of ether, tincture of benzoin, and iodoform. That, however, was not sufficient; it should be followed up with the actual cautery at any spot which showed sign of recurrence. Professor Lorraine Smith, at Victoria University, suggested that specimens should be obtained from all stages of the ulceration and from all parts of the oro-pharynx for inoculation, and this was being done; he would report later on the case.

Case of Thickening of the External Plates of the Thyroid Cartilage and Infiltration of the Left Side of the Cartilaginous Septum Nasi.

Shown by Mr. Charles Parker. The patient, a woman aged forty-two years, was first seen ten days ago, when she gave the history of having noticed the swelling in the neck for four months and nasal obstruction for two weeks. She complained of very little pain or discomfort and no laryngeal dyspnœa.

On examination a very hard dense swelling was found over the laryngeal cartilages, taking more or less the shape of the thyroid cartilage, moving with it on deglutition and being inseparable from it. On the left side of the anterior triangular cartilage of the nose there was a diffuse swelling, being hard at its circumference, but showing some signs of softening at its centre.

Mr. Parker considered the condition of the septum more suggestive of a diffuse gummatous infiltration than of anything else, and therefore, on the chance that the condition of the thyroid was also of a syphilitic nature, treated the patient with twenty grains of iodide of potassium three times a day. When seen a week later somewhat to his surprise the swelling over the thyroid cartilage was undoubtedly very materially diminished in size, though there was very little, if any, alteration of the septum nasi.

Mr. Parker brought the case forward for opinions as to the nature of the swellings, as he did not think the fact that there was improvement under iodide of potassium clinched the diagnosis. He also thought the case a somewhat unusual one.

Mr. Cresswell Baber said he thought the case was probably syphilitic.

Dr. Pegler thought the case was one of syphilis; the growth on the septum was a gumma.

Inflammatory Œdema of Obscure Origin affecting the Posterior Parts of the Larynx in a Man aged forty-seven.

Shown by Sir Felix Semon. The patient, a gentleman of independent means and leading a healthy outdoor life, began to suffer

two or three months ago from slight huskiness and feeling of soreness in the throat. The sensations seem to be rather general, but are perhaps a little more felt on the right side, and there is also occasionally some pain shooting into the right ear. He has not used his voice excessively, has so far as he knows not caught a chill, has not been exposed to septic influences (drains, etc.) and the disease has not begun in an acute form, with rigors, etc. Very many years ago he had a chancre, but was treated with mercury, and has never had any secondary symptoms. He has not taken any iodide internally, and his general health has been very good.

When he came to consult me on Januury 9th localised but marked œdema of the larynx was seen over the interarytenoid fold and arytenoid cartilages, particularly the right. The œdematous portions were vividly red-coloured. No ulceration and no new growth could be seen anywhere. The movements of the vocal cords were quite free. External handling of the larynx did not cause pain, and there were no enlarged lymphatic glands. For the last two days he has lived on cold and fluid food only, has sucked ice, and has had ice-water compresses externally. No change, however, has taken place in the appearances and in the sensations, and since yesterday diarrhœa has made its appearance. The temperature this morning was normal, the pulse 80.

One has, of course, to think of a new growth further down causing the œdema, of syphilitic or tuberculous perichondritis, in addition to the possibility of a septic infection, but no definite clue could be obtained with regard to the existence of any of these diseases, and opinions are solicited as to the cause of the œdema.

Mr. W. G. Spencer said he thought the condition was a deep ulcer underneath œdematous overhanging edges. It was in an awkward region, very much like Mr. Butlin's case, which he spoke of early in the session. If it proved to be malignant, it would be a very bad case, but might be syphilitic.

Dr. Herbert Tilley asked what was the history in regard to syphilis, and remarked that on the right side low down on the posterior pharyngeal wall there was a ledge of ulcerated mucous membrane with a sharply-defined congested border. If he had approached the case with an unbiassed mind, he would have regarded it as a tertiary syphilitic ulceration.

Sir Felix Semon replied that there was a history of syphilis twenty-five years ago, but not of secondaries. He only saw the patient two days ago, and hesitated to give him iodide of potassium because of the œdema. He would now try antisyphilitic treatment, and report again to the Society.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

NINETY-FIFTH ORDINARY MEETING, *February* 3, 1905.

CHARTERS J. SYMONDS, F.R.C.S., President, in the Chair.

P. R. W. DE SANTI, F.R.C.S.,
HENRY J. DAVIS, M.B., M.R.C.P. } Secretaries.

Present—34 members and 4 visitors.

The minutes of the preceding meeting were read and confirmed.

The ballot was taken for W. STUART LOW, F.R.C.S., London, who was elected a member of the Society.

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AGED THIRTY-ONE,
ANCY, AND SINCE
NANCIES.

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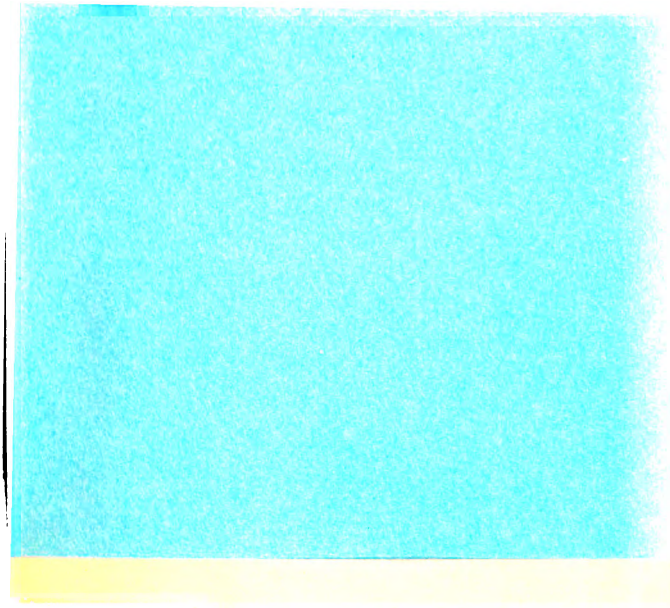
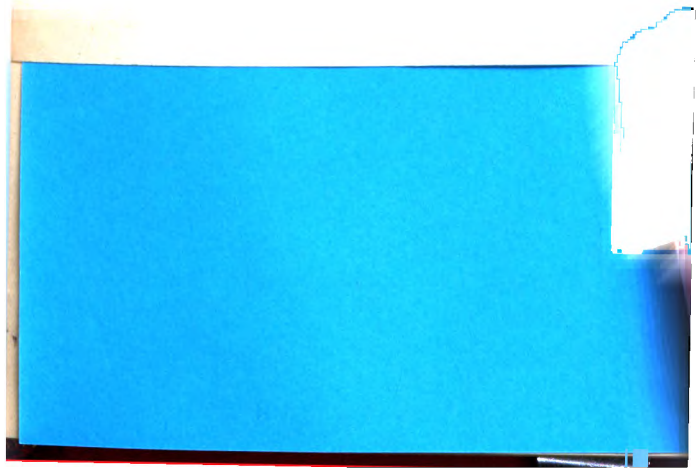
record of the fact could be found. The larynx also showed definite signs of tuberculous infection, the arytenoids being swollen, pale, and œdematous, and superficial ulceration in the interary-tenoid space was present. The patient looked ill, was short of breath, and wasting rapidly, and her whole condition suggested a very acute infection. She was treated with increasing doses of creosote internally and the application of lactic acid to the ulcerated surface locally. Contrary to expectation, she improved very much.



ERRATA.

On page 40 of the January 'Proceedings,' line 16 from the top, *for* "possibly" *read* "possible," and on line 18, *for* "No. 38" *read* "vol. v, p. 38."



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The minutes of the preceding meeting were read and confirmed.

The ballot was taken for W. STUART LOW, F.R.C.S., London, who was elected a member of the Society.

The following cases, specimens, and photographs were then shown:

CASE OF TUBERCULOSIS OF THE LARYNX IN A WOMAN AGED THIRTY-ONE, WHICH COMMENCED DURING HER FIFTH PREGNANCY, AND SINCE WHICH THERE HAVE BEEN FOUR SUBSEQUENT PREGNANCIES.

Shown by Mr. CHARLES PARKER. This case was first seen some five years ago, immediately after the birth of the patient's fifth child. She then had early, but active, tuberculosis of the right lung, and tubercle bacilli were found in the sputum. This last statement was made from memory, as, unfortunately, no written record of the fact could be found. The larynx also showed definite signs of tuberculous infection, the arytenoids being swollen, pale, and œdematous, and superficial ulceration in the interarytenoid space was present. The patient looked ill, was short of breath, and wasting rapidly, and her whole condition suggested a very acute infection. She was treated with increasing doses of creosote internally and the application of lactic acid to the ulcerated surface locally. Contrary to expectation, she improved very much.

She was under observation about eighteen months, during which time she again became pregnant and gave birth to a child, still living. Neither the laryngeal or pulmonary condition seemed to be materially affected, and before she ceased attending, the lung disease appeared to have become quiescent and the laryngeal ulceration had healed, though the infiltration and œdema of the arytenoids persisted. The patient was then lost sight of until three weeks ago, when she again sought advice, after nearly three years' interval, on account of loss of voice. At the present time there were no signs or symptoms of active lung disease, though there were definite signs in the right apex of past trouble, and the larynx, though greatly infiltrated and œdematous, did not suggest any very active tuberculous process but rather a chronic tuberculosis.

The interest of the case lay in its relation to the patient's pregnancies. It was extremely rare for patients to recover from pulmonary tuberculosis, especially if the larynx was involved, contracted during or immediately after pregnancy. Such cases seemed to be almost invariably rapidly fatal, and yet this woman had lived to become pregnant on four subsequent occasions, having had two living children and two miscarriages. She had in all been pregnant nine times, affording an interesting record: No. 1, child living and well, aged twelve; No. 2, miscarriage at fourth month; No. 3, child died of meningitis when three months old; No. 4, child living, aged six; No. 5 (during which the tuberculosis commenced), child died of meningitis when one year old; No. 6, child living, aged four; No. 7, child died of meningitis when two years old; No. 8, miscarriage; No. 9, miscarriage.

Finally, the question of treatment seemed to be important. Was it better to "let sleeping dogs lie," or to try and restore the patient's voice by surgical measures? His own feeling was to let well alone.

Mr. Steward asked whether there were any tubercle bacilli in the sputum. Otherwise the case suggested pachydermia rather than tuberculous disease.

Dr. J. W. Bond said he thought the patient looked tubercular. He found that she was nearly always troubled with bloody diarrhœa, with considerable pain, and he believed she had tubercle of the bowels at the present time. He thought it was not uncommon, when there was an outbreak of tubercle in one place, for the tubercle to be quiescent, or comparatively quiescent, in another. He thought there was also present much chronic laryngitis.

Dr. Herbert Tilley said the question raised by Mr. Parker as to the influence of pregnancy on tubercular laryngitis had interested him, because

eight years ago he saw a patient who had very marked tubercular laryngitis, and who was then expecting to be confined in five weeks. Her larynx was much swollen and ulcerated, she suffered much pain; and this, with sleeplessness, led him to think that she would not get through her pregnancy. The patient came under the care of Sir Felix Semon, who treated her by local applications of lactic acid. He (the speaker) met the general practitioner connected with the case two years ago, when he reported she was alive and in good health. Later, he heard that tubercle had reappeared in her larynx and lungs, and that she had succumbed. Her pregnancy, however, was got over without any trouble, and for a considerable time the laryngeal troubles were quite in abeyance.

Dr. Scanes Spicer said he would have thought the term "hypertrophic laryngitis" would have been more appropriate. The great hyperæmia and distribution of thickening of the posterior wall seemed to point to the condition being non-specific, perhaps some accidental chronic catarrh in a tubercular subject.

Dr. Lambert Lack felt that he could support Mr. Parker's views. He saw the patient four or five years ago, and the appearances at that time were very suggestive of an acute tubercular ulceration of the larynx. Now, it was difficult to recognise the affection because the ulceration had healed, and there was nothing but scarring and thickening left. With regard to the influence of tubercle of the larynx on pregnancy, a paper was published some years ago in the *Archiv für Laryngologie* in which all the recorded cases had been collected. Not a single case had survived a year, and of the babies, many were still-born, and a few only survived. Since reading this paper he had had one case brought to him with active tubercular disease in the lungs and larynx after parturition. There was pyrexia, she had great pain on swallowing, and was very weak. There was thickening and ulceration of the epiglottis and arytenoids. He did not wish to operate, but the patient was keen upon having her epiglottis removed, on account of the pain. He, therefore, did it, but told her doctor that she would be dead in three months. The patient was still well three years later. Although the disease was worse, the patient was much better off than Mr. Parker's case, was in good circumstances and able to avail herself of the open-air method. Until Dr. Tilley related his case to-night, Dr. Lack had looked on his patient as the only case of the kind which had survived so long a time.

Sir Felix Semon said he had unfortunately not looked at the patient, and therefore could not express an opinion on the case. It was of the very greatest importance. At the present time a lively discussion was in progress on the Continent on the subject, having been initiated by one of the gentlemen who would shortly be visiting us, Dr. A. Kuttner, of Berlin, and he trusted Mr. Parker would be good enough to bring his case forward again then. Dr. Kuttner had pursued an inquiry into the influence of gravidity upon laryngeal tuberculosis. His results showed even more disastrous figures than previous statistics, and the question which was now being discussed on the Continent was whether the presence of laryngeal tuberculosis in the mother should not be an indication for producing artificial abortion. There might be one or two exceptions, but in most cases the mother had died within a few months of having given birth to the child.

Dr. Clifford Beale said the case reminded him of one he showed before the Society ten years ago (*v. Proceedings*, February, 1894), in which similar conditions prevailed, with a considerable amount of sub-

mucous infiltration, the patient having at that time fairly active tubercular disease of the lungs. There, as in the present case, there was no breach of surface, there was a considerable fleshy prominence, and it was rather hyperæmic. The case was under observation several years, and the patient did not die until five years afterwards, and then from disease of the lung. The laryngeal condition varied only slightly, and he thought considerable improvement was caused by the periodic use of tannic acid. He strongly advised against the removal of the bosses in his case, as they did not interfere greatly with comfort or life, any more than those in the present case.

Mr. PARKER, in reply to Mr. Steward, said that no tubercle bacilli could be found at the present time, but he was confident that they were present five years ago, though the hospital paper containing the record was lost. At that time also there were undoubtedly active signs of phthisis at her right apex, whereas all that could now be found was a little patch of dulness, and harsh breathing, showing that the process in the lungs had become arrested. Anyone seeing the case now for the first time might possibly doubt the existence of tubercle, but five years ago it was absolutely typical; the arytenoids were œdematous and infiltrated, and there was distinct ulceration in the interarytenoid region. This had gradually improved during the eighteen months the patient was under treatment. Since then it had passed, as Dr. Bond said, into a condition in many ways resembling chronic laryngitis. With regard to the influence of pregnancy on such cases, he did not understand from Dr. Tilley whether in his case the pregnancy occurred in a patient with tuberculosis, or whether the tuberculosis commenced during pregnancy. He thought that made a good deal of difference. It was the cases starting during pregnancy, or immediately after the birth, which were so often fatal. He had asked Dr. Jane Walker about that point, and she stated that at her sanatorium she had had several cases of childbirth in women who had had tubercle for some time, and the pregnancy had not prejudicially affected the course of the case. She did not refer to tubercle of the larynx, but pulmonary tuberculosis. He agreed with Dr. Clifford Beale that it was better to let the patient suffer loss of voice than run the risk of re-awakening her quiescent condition. He would be pleased to bring the case up again in March.

NOTES OF DR. FREDERICK SPICER'S CASE OF "DIFFUSE PAPILLOMA OF THE VOCAL CORDS."

Shown by Mr. CLAYTON FOX. A. B— presented himself at the Metropolitan Ear, Nose, and Throat Hospital last September, complaining of hoarseness of six months' standing. He had wasted of late, but the family history was good, and patient had not had syphilis.

On examination of the larynx the anterior half of each cord was the seat of red granulations jutting beyond the level of the healthy portions of the cords, and arranged in such a manner that there was a convexity on the right which fitted into a concavity on the other side. There was some considerable nasal obstruction on

the right side, due to a defective septum. The chest was examined with no definite results.

The following November Sir Hugh Beevor examined the chest, and beyond some slight dulness at the left apex and a few crepitations nothing was found. The sputum was repeatedly examined for tubercle bacilli with negative results.

Treatment.—Alkaline douches for nose, $ZnCl_2$ and lactic acid applied to cords.

Recently the condition of the parts had undergone a marked change; the trouble on the right cord had almost gone, and in place of the granulations greyish-white glistening polypi now occupied the anterior half of the left cord and commissure.

Dr. BRONNER recommended the local application of formalin. He thought it was an ordinary case of papilloma.

Dr. DUNDAS GRANT said he thought the galvano-cautery point would be a very useful instrument for the condition. He had had several cases of fibroma and papilloma near the anterior commissure which had done extremely well under it, used, of course, with considerable discretion. He believed the present condition was papillomatous.

Mr. CLAYTON FOX, on behalf of Dr. Frederick Spicer, said the chief point of interest to Dr. Spicer was as to whether the laryngeal trouble was tubercular or simple in origin. The condition of the cords had markedly improved since the patient first came under notice; in fact, all the granulations and polypi had disappeared from the right one. As regards the chest, there was some slight dulness over the left apex, but nothing definite; possibly what physical signs existed could be attributed to an old tubercular lesion. An examination of the sputum for tubercle bacilli gave a negative result. The diseased parts of the cords had been treated by rubbing in lactic acid, and at times by painting with chloride of zinc. The nasal obstruction caused by a deflected septum and hypertrophic rhinitis had been treated by hot saline detergent douching. Dr. Spicer intended performing a Moure's operation shortly, and hoped that all the trouble would eventually clear up.

Dr. SCANES SPICER thought the surface appearance of the growths might be that of tubercular tumours, but that the larynx was so free from disease, except at the anterior commissure, the localisation of the growths was against this being tubercular disease. If they were tubercular the laryngeal disease would be more generalised. Therefore he inclined to regard them as papillomata.

Dr. STCLAIR THOMSON thought it seemed a case of simple papilloma. The situation would be unusual for tubercle; but could not the diagnosis be settled by removing a small piece of growth? It could be done by Dr. Lack's or Dr. Powell's beak-shaped modification of Mackenzie's forceps, and possibly a cure effected at the same time.

Sir FELIX SEMON said, with regard to the observations just made as to the growth not being likely to be tubercular because it was localised in the anterior commissure, that he had in three cases removed tumours from the anterior commissure which, on subsequent microscopic examination, turned out to be tuberculous.

Dr. DUNDAS GRANT in reference to tuberculous tumours said he ex-

hibited a case before the Society two years ago, the patient being an old man who had, in the commissure, a large sprouting growth, which on microscopical examination was found to be tuberculous.

Dr. FITZGERALD POWELL thought there was no appearance of tuberculosis about the larynx; it seemed to be a papilloma springing from anterior commissures, possibly subglottic, and he would have it removed. If tubercle bacilli were present, most probably they would be found in the sputum. [Mr. CLAYTON FOX said the sputum had been examined, but with negative results.]

The PRESIDENT remarked that if anything further arose in connection with the case it would be an advantage for the Society to be advised.

HOARSENESS, COUGH, PAIN, LITTLE BLOODY EXPECTORATION, MAN AGED SIXTY-NINE, FROM WHOM THE LATE DR. WHISTLER REMOVED A GROWTH FROM THE RIGHT VOCAL CORD TWENTY-TWO YEARS AGO.

Shown by Dr. EDWARD LAW. The patient was examined by Dr. Law several times between 1883 and 1896 whilst under the late Dr. Whistler's care, and the following extract from Dr. Whistler's case-book was interesting: "February 10, 1883.—On laryngoscopic examination I found a growth, the largest portion of which was the size of a large pea, pear-shaped, and attached by a pedicle to the inner and under surface of the right vocal cord about the anterior and middle third. In appearance it was like a reddened wart. The vocal cords were both broad and red. The entire growth was removed with a pair of Durham's forceps. April 20, 1883.—Right vocal cord nearly white excepting at posterior third. No return of growth; edge smooth; voice clear and good." This satisfactory condition remained, and permitted the patient to perform the duties of a schoolmaster until 1896, when he again complained of cough and expectoration, and received remedies for a pharyngeal trouble. He continued his duties until April, 1901, when he retired according to the regulations of the Education Act and not on account of any throat affection. He did not complain of hoarseness until a year ago.

The patient came to see him again last May on account of hoarseness, expectoration of mucus stained with blood, and slight difficulty in breathing on exertion. No pain, no loss of weight, no difficulty in swallowing.

On examination, both vocal cords were seen to be thickened, irregular, hyperæmic, and freely movable, with a thickening below both cords, causing slight tracheal stenosis, especially as the mucous membrane, immediately below the cords, was covered with dry blood-stained secretion. There was a small nodule with a

bleeding point on the posterior laryngeal wall immediately above the posterior insertion of the right vocal cord. Sir Felix Semon kindly examined the patient and expressed the opinion that there was no evidence of malignancy, but advised that he should be kept under observation. Patient was next seen October 17, when he complained of soreness at the root of the tongue on swallowing, and now and then a darting pain on the right side of the larynx, and an occasional trace of blood in the expectoration.

January 18, 1905. Patient was better until a fortnight ago, when he again complained of pain on the right side of the larynx, occasionally shooting into the right ear, worse at night. On examination, little change was noticeable in the larynx, except that the right side moved very imperfectly. Patient was sent into hospital under Dr. Waggett, who prescribed potassium iodide and Liquor. Hydrarg. Perchlor.

Dr. Scanes Spicer thought that at present there was ulceration below the vocal cord; it was an infra-glottic ulceration of a greyish yellow colour on the red infiltrated thickened right side. Its appearance was very suggestive of malignant disease. Also, on the opposite cord, below the vocal process, he saw a fleshy mass turning round from underneath. That could be accounted for by the swelling on the right side having dug into the left side and irritated it. It seemed to be of a totally different nature from the angry redness and ulceration below the cord on the right side where the greyish ulceration was now seen, and the latter he thought was malignant at the present time, whatever the original condition had been.

Sir Felix Semon said he had seen the patient on several occasions, and did not feel so certain about malignancy as Dr. Spicer did. He could only say that there was some chronic inflammatory process, leading to diminished mobility of the vocal cord, and would suggest keeping the patient still under observation before resorting to operation.

Mr. Waggett (replying for Dr. Law) thought the case had been somewhat spoiled by the exhibition of iodide of potassium. It looked different five or six days ago, before the iodide was given—not so red and angry. The mobility of the cord seemed to vary; that day it was less mobile than a week ago. He did not regard it as malignant.

Woman, aged Thirty-five, shown at last Meeting with Laryngeal Swelling thought to be Tubercular and Microscopic Slide showing undoubted Squamous-celled Carcinoma.

Shown by Mr. de Santi. The patient was brought before the Society at the last meeting as a case of doubtful nature. From the appearance of the swelling a month ago it was thought to be tubercular: no tubercle bacilli or tubercle in the lungs were, however, discoverable, and the question of diagnosis rested between tubercle

and malignant disease. There was a general opinion in favour of tubercle, but removal of a piece of the growth and examination digitally were recommended. Mr. de Santi removed a piece of the growth with endolaryngeal forceps, and microscopic examination by Dr. Helb proved the disease to be undoubted squamous-celled carcinoma. The slide was presented at the meeting for examination.

Since the last meeting the growth had increased considerably and now presented unmistakable naked-eye appearances of malignant disease; the cricoid plate was completely invaded and the growth extended well into the lateral pharyngeal region.

The point for discussion was as to operation; personally Mr. de Santi was of opinion that even total laryngectomy would fail to remove the disease *in toto*, that the attempt to remove it might prove disastrous, and that even if the patient recovered from the operation she would not be rid of the disease.

It was a curious fact that carcinoma, uncommon in the larynx in woman, if it did occur, frequently attacked the region of the cricoid plate, and was met with in them at a comparatively early age.

THE PRESIDENT said the patient was a woman with a hard irregular mass behind the arytenoids. He thought it had been previously pointed out how remarkable those cases were in occurring in women of about the age of this patient. He looked upon the disease as a primary pharyngeal growth invading the larynx from behind.

Dr. SCANES SPICER said the left cord in this case moved freely, in spite of the extraordinary amount of overhanging growth. He did not see any other course except that of total laryngectomy.

Dr. FITZGERALD POWELL was sorry the diagnosis he made when he saw the case previously—malignant disease—was confirmed. He thought the disease was now too far advanced to justify much hope of success from total extirpation.

SIR FELIX SEMON said the case interested him, particularly from the point of view just mentioned, namely, How was it that, while laryngeal cancer was so rare in women, it localised itself when they had it, in the majority of cases, on the posterior surface of the cricoid cartilage? He believed he was the first to draw attention to it in 1894 in the *Lancet*, and he had often since seen the fact corroborated. With regard to the question of operation, nothing short of total laryngectomy could be of any use in this sad case.

Dr. LAMBERT LACK asked whether such cases should be called *laryngeal* carcinoma at all. It seemed to him to be pharyngeal. This growth probably started from the lateral wall of the pharynx. The growths formed a ring round the pharynx, and though they might first come into view just behind the arytenoid body, if an attempt were made to remove them they were found to involve half or more of the pharynx. It was a question of pharyngectomy rather than laryngectomy if removal was attempted.

Dr. BRONNER said he had two similiar cases to the present one operated upon, and the disease was of far greater extent than at first appeared

When the surgeon cut down on the parts, he found that the growth extended into the pharynx and it could not be removed.

Mr. WESTMACOTT thought there was not much evidence of pharyngeal implication at present. With a growth that size and duration there would be some glandular infection on one side of the neck or the other. The glands were very little, if at all, enlarged.

Mr. STEWARD corroborated Dr. Lack's remarks. In Guy's Hospital Museum there were some eight or ten specimens of similar growths of the pharynx, from young women who died of that disease. In each case practically from the level of the arytenoid cartilages downwards the whole pharynx was a solid mass of growth. He had also seen four patients during life with the same condition. About eighteen months ago he had a young woman in hospital who had almost complete stenosis of the pharynx from a similar growth, and before death could not even be fed by means of a tube. In the end he did a gastrostomy so as to feed her, yet one could only see a small growth sprouting up above the arytenoids. The whole pharynx was found full of growth at the *post-mortem*.

The PRESIDENT said he had seen a good many such cases in his experience, and when one could see even a small grey edge—not one fourth as large as in the present case—one could conclude that the disease was fairly extensive below. Most of them had not required tracheotomy. He once, some years ago, attempted operation on such a case, where the disease was much more localised, but he found it impossible to complete it. He agreed with Dr. Lack that the growth was usually extensive, running so far round the pharynx that it precluded operation.

Mr. WAGGETT suggested that it had become almost a duty not to leave the question of whether or no the œsophagus was involved to conjecture, but to look and see if that was the case. This could easily be done by means of Killian's tubes. He did not think the specimen shown looked like carcinoma, though no doubt the disease was such. It seemed like normal epithelium cut on the flat.

Mr. DE SANTI, in reply, thanked the members for their opinions. He looked upon it as extrinsic carcinoma. He had watched it six weeks, and it started from the arytenoid region, extending from there to the pharynx and down to the cricoid plate. It now involved a greater area than could be seen by the mirror. He thought it was not originally of pharyngeal origin. With regard to operation, he had spoken to the woman and told her how very severe the operation would be. But as he had seen her twice during the last ten days and observed how it had spread, he felt that no operation could be undertaken for it with any safety. The glands were much enlarged, the pharynx was involved, and the pharynx would have to be operated on as well as the larynx, and he doubted if she would survive it; even if she did, the result would be disastrous. He would put the case fairly before her, but could not hold out hope of permanent success.

SIR FELIX SEMON asked if Mr. de Santi would bring the patient to the next meeting, as Professor Gluck would be coming.

Mr. DE SANTI: Yes, if she is alive, and well enough.

FIXATION OF THE LEFT VOCAL CORD IN A MAN AGED ABOUT FORTY.

Shown by Mr. PAGET for diagnosis.

Dr. H. J. DAVIS said he thought the pulses on the two sides were un-

equal, and that he regarded the case as one of aneurysm. The left was retarded and not so forcible as the right pulse.

Mr. Robinson agreed with the view expressed by Dr. Davis, and suggested that a skiagram be taken of the chest.

Dr. Scanes Spicer said there was a small local difference on the two sides. There was more swelling about the left crico-arytenoid front than on the other, and it might be a local condition of the larynx—a crico-arytenoid arthritis.

Dr. Furniss Potter said there was a distinct difference in the two pulses, the right one being much more easily felt than the left.

Mr. Stephen Paget, in reply, said the pulse had not been examined since two or three weeks ago, and then nothing in the nature of aneurysm was discovered. He agreed with Dr. Davis that the left pulse seemed weaker than the right.

Growth on the Right Vocal Cord in a Woman who had undergone Operation Twelve Years previously for Papilloma of the Larynx.

Shown by Mr. Paget for diagnosis.

Dr. Scanes Spicer agreed with Dr. William Hill that the condition was probably hypertrophic laryngitis.

Recurrent Ulceration of the Tonsils associated with Lymphadenoma in a Woman aged Sixty-four.

Shown by Mr. F. J. Steward. The case was a very unusual one, the outstanding feature being that several attacks of ulceration of the tonsils accompanied the onset of lymphadenoma.

The history of the case was as follows:

He first saw the patient, a woman aged sixty-four, on October 22, 1904. She then complained of sore throat on the right side, of a fortnight's duration. The right tonsil was a little enlarged and red, and there were several enlarged glands on the right side of the neck. There were then no other enlarged glands or other signs of disease.

After two weeks' treatment the tonsil was normal and the glands had almost disappeared. On November 27 the patient returned, complaining of soreness on the left side. The left tonsil was swollen, and on its surface was a shallow grey ulcer; there was also a considerable glandular enlargement on the left side of the neck.

A week later the ulceration of the left tonsil had disappeared, but the glands were not much smaller, but had considerably improved at the end of the next week. The patient was not seen again until January 7, 1905, when it was found that both tonsils were enlarged, purple in colour, and on the surface of each was a

greyish ulcer. There were also many enlarged glands on both sides of the neck.

Some improvement again took place, only to be followed by another relapse.

At the present time, February 2, 1905, the condition was as follows: The right tonsil had a small hæmorrhagic patch on its surface, but was otherwise normal. The left tonsil was considerably enlarged, purple in colour, soft to the touch, and on its surface was an ulcer with small adherent greyish sloughs. There were large masses of hard, painless glands on both sides of the neck extending from mastoid process to clavicle; considerable enlargement of the axillary glands was also present, and to a less extent of those in the groins. The liver was enlarged, but the spleen could not be felt.

Blood examination.—There was no evidence of leucocytosis; the red corpuscles were slightly diminished in number, and the hæmoglobulin below normal.

Mr. BABER thought the case was one of lymphadenoma. The patient had enlarged glands in the right groin, and he suggested treatment by arsenic if that had not already been employed.

Mr. DE SANTI said it was unusual to find such ulceration of the tonsils with lymphadenoma. He occasionally saw these cases, and the great point of interest seemed to be the recurrent ulceration, on the nature of which he could not form any opinion.

Dr. LAMBERT LACK asked whether it would have been possible, by removing pieces in the earlier stages, to have made the diagnosis before the case became inoperable. He had seen one case of relapsing ulceration of the tonsils with enlarged glands in the neck, and he removed pieces for microscopical examination. This proved to be a sarcoma, and operation was performed. He thought if a portion were removed early in such cases, operation might be undertaken with some prospect of success.

Mr. C. BABER said that some years ago he published a case of lymphadenoma of the tonsils. At first they seemed to be simply enlarged tonsils, and were removed once or twice. But they grew so much in the hospital that as much as possible of the tonsil had to be removed with a curette in order to prevent choking. Eventually the patient died. He did not see how any operation, however early, could do much good in such a case.

The PRESIDENT said the peculiarity in the present case was the ulceration beginning in the tonsil. Mr. Steward had referred to a case under his (Mr. Symonds') care brought before the Society, in which both sides were involved; it was recognised as ulcerating sarcoma of the pharynx.

Dr. HERBERT TILLEY said the case he showed two meetings ago was one in which there was extensive ulceration of the tonsil with enlarged glands in the neck. The glands and the tonsil were so large that he was going to insert a tracheotomy tube; but under the administration of xv ♏ of arsenic three times a day the whole condition had, at any rate temporarily, disappeared.

Dr. ATWOOD THORNE said he would like to hear if other members had seen such cases ulcerate, clear up, and again ulcerate.

Sir FELIX SEMON, replying to Dr. Atwood Thorne, said he had seen several such cases clear up temporarily under arsenic.

Dr. CLIFFORD BEALE reminded the Society that at a discussion at the Pathological Society ('Transactions,' vol. liii, Pl. IX) not many years ago, it was fairly well established that the definite structure of lymphadenoma could be recognised from the structures with which it was formerly confused. He believed it was first clearly laid down by the late Professor Kanthack, but Mr. Butlin brought the matter forward. Therefore, he thought it would be well to examine whenever any suspicion existed, to see if such structure was beginning to show itself in the tonsil.

Mr. STEWARD, in reply, said the peculiarity of the case was that the ulceration occurred first on one side and then on the other, with complete healing between attacks. The enlargement of the glands, and so forth, he looked upon as signs of the general disease, rather than as being secondary to local growth of any kind.

PHOTOGRAPHS OF A MALIGNANT GROWTH OF THE LARYNX.

Shown by Dr. BENNETT. R—, aged forty-eight, a hotel keeper, who had taken alcohol rather freely, consulted Dr. Bennett at the beginning of October, on account of hoarseness of three months' duration. There was some glandular enlargement on the left side, and a little on the right. On laryngoscopic examination the left side of the larynx was fixed, and there was a growth occupying the position of the left arytenoid cartilage. It seemed to extend about half an inch downwards into the larynx and œsophagus. There was little dysphagia and very little pain. The chances of operation did not seem very good, but after consultation with Mr. Bond, of Leicester, it was decided that an attempt might be made to remove the growth.

Two or three days later Mr. Bond removed the glands on the left side. It was soon seen that the extent of the mischief was far beyond what could be detected from external examination. The glands were found to involve the common carotid artery, the vein, and also the hypoglossal nerve. Part of these structures had to be removed, and all gland enlargements seemed to have been successfully removed. Some glands were then removed from the right side. Tracheotomy was now performed, and the larynx opened. The right half of the larynx was removed. The growth extended for more than one inch down the gullet, and the œsophageal wall had to be extensively removed. The trachea was now completely divided from the larynx, and stitched to the skin.

The patient rallied from the severe operation, but suffered from loss of memory, delirium, and excitement, which caused great difficulty in nursing. He was fed through the gaping œsophageal

wound. After about six weeks Mr. Bond removed the remaining half of the larynx, and by utilising the laryngeal mucous membrane he succeeded in largely closing the œsophageal wound. As far as the operation was concerned, there seemed for some time to be a good chance of recovery, but later, in December, there was progressive mental failure following influenza, and the patient died early in January, from exhaustion. At the *post-mortem* examination some of the prevertebral glands were found affected.

No difficulty arose through the utilisation of the laryngeal membrane for the closure of the œsophageal wound, but a marked improvement in the patient's general condition followed, when he could again take food through the mouth, although the quantity was not greater than that taken through the wound in the neck after the first operation. The mental condition was seriously affected by the ligation of the carotid, and memory never thoroughly returned. It was interesting to notice that during sleep, when the cerebral tissues were presumably still more anæmic, the excitement and delusions seemed most marked.

Man aged Sixty: Mass of Malignant Glands in the Neck, Swelling of Larynx same side.

Shown by Mr. de Santi. The patient was referred to Mr. de Santi by his colleague, Mr. Stonham, for an opinion as to the condition of the larynx. There was no history of hoarseness, pain, dysphagia, or anything pointing to laryngeal or œsophageal trouble.

On examination of the larynx a large swelling was seen occupying the right arytenoid and aryepiglottic region. The swelling looked more like an œdema than a distinct tumour; it was on the same side as the affected glands, hid the true and false vocal cord on that side, and was fixed.

Mr. de Santi had no doubt that it was carcinoma and the cause of the mass of enlarged glands in the neck. Sometimes a small extrinsic malignant tumour would cause enormous glandular infiltration; in other cases, though usually intrinsic in origin, a large growth would cause little, if any, glandular infection. The case was quite inoperable.

Mr. Robinson said the impression from the feel of the glands strongly suggested malignant disease, and one would imagine that it started in the larynx, especially as the larynx was so markedly affected.

Dr. Bond thought there seemed to be some malignant growth about the right arytenoid. There was also considerable thickening behind the posterior pillar, extending into the naso-pharynx. Now and then one

found cases with enlarged glands in the neck, malignant, where it was very difficult to find out the origin of the condition. Sometimes there was a growth in the naso-pharynx which was first manifested by glands in the neck. He would like to know whether the naso-pharynx had been thoroughly examined with the finger.

Dr. SCANES SPICER pointed out that there was considerable thickening on the right side of the larynx, and the cord was quite immobile. He regarded it as malignant disease of the larynx.

CASE OF PRIMARY SORE OF TONGUE.

Shown by Dr. HERBERT TILLEY. A man, aged forty, who presented on the tip of the tongue, and slightly to the left side, a dark-coloured, slightly raised ulcerated and painful swelling the size of a sixpence. The tissues immediately around the sore were livid, red, and much congested, and a well-marked induration passed gradually away into the normal tissues of the tongue. There were one or two small indurated glands under the left ramus of the mandible. He saw the patient twenty-four hours ago and had prescribed for him full doses of mercury and inunction by the same drug.

Mr. C. BABER thought it was the kind of case to be shown again to observe the result of treatment. It did not seem quite clear whether or not the ulcer was a chancre. The patient appeared to have irritated it with caustic applications many times a day. Moreover, there was a prominent tooth which might cause irritation.

Mr. ROBINSON asked whether there were enlarged glands. He had seen two or three tongue cases like that, but they were simple granulomata.

Mr. DE SANTI did not think the glands at all typical of hard chancre. There was one smallish gland to be felt in the middle line, but it could be accounted for by the septic condition of the irritant ulcer. In a case of hard chancre of the tonsil, recently seen by him, there was a large number of enlarged glands in the neck, hard, discrete, and shotty, and in other cases of chancre of the lip he had invariably seen a similar enlargement. He was doubtful about the case and would watch it carefully.

Dr. FITZGERALD POWELL thought it would be better not to put the patient on antispecific remedies for the present, until some definite manifestations of syphilis appeared, to enable one to be certain of the diagnosis.

Dr. HERBERT TILLEY, in reply to Mr. Baber, said some importance had been attached to a prominent tooth, but this tooth was not rough or jagged; it was simply a little behind the level of those on either side of it. If the man had nothing the matter with the tongue he would not have noticed the prominent tooth. Dr. Powell's remark raised an ethical point, and he (the speaker) thought that if one was fairly certain that a patient was suffering from a primary syphilitic lesion, it was the bounden duty of the physician to apply remedial treatment at once, and not to wait for secondary symptoms which might pass unnoticed by the patient. The harm induced by even a prolonged course of mercury would probably be far less harmful than allowing the specific virus to run unchecked for months.

Case of Pachydermia Laryngis—Tubercular (?).

Shown by Dr. Cathcart at previous meeting.

Combined Functional and Organic Paresis of Larynx in a Singer aged Thirty-four.

Shown by Dr. Cathcart.

Mr. C. Baber said he thought the nasal obstruction on the left side which was complained of was subjective; there seemed to be plenty of room. Possibly crusts occasionally formed. If there existed want of abduction in the right cord, it was very slight. There was a slight fulness of the left ventricular band.

Dr. Scanes Spicer said the nose was unusually patent, but the man was a foreigner and did not express himself in English very well. When asked whether it was not a feeling of pressure rather than obstruction he said yes. He had some abnormal sensation there, which had an objective explanation in the contact between the septum quite high up and the outer wall of the nose.

Dr. Pegler said, as touching the nasal obstruction complained of, the cavities were both roomy and somewhat atrophic. Taking into consideration the important symptom of hemianæsthesia and the generally neurotic aspect of the case, he should be inclined to regard it as on all fours with the cases of so-called subjective nasal obstruction that he had shown to the Society. In them the close rhinolalia was absolute, but even in Dr. Cathcart's case the patient admitted some degree of it at times. If his view were correct, it was an interesting instance of functional contraction of the elevators of the soft palate in the male.

Sir Felix Semon expressed doubt as to any organic element being present in the case. He regarded it as wholly functional.

Dr. Dundas Grant felt no doubt that the man was suffering from chronic laryngitis. He saw him some years ago, when his left antrum contained a good deal of pus. There was an atrophic condition in the left nasal cavity, and no doubt crusts formed, some of which might get inhaled into the larynx. The patient was obviously a hysterical subject, of which he had evidence some years ago.

Case of Extensive Ulceration of the Nasal Septum for Diagnosis.

Shown by Dr. Bennett. The patient was shown in March, 1902, when the trouble had existed for four years. It would be seen that the septal cartilage was almost entirely destroyed. The severe pain and the frequent hæmorrhages had continued throughout the whole period of six years. No evidence of any sinus suppuration had been obtained. Mercury and iodides had no effect. Cauterisation of the surface had done little good. Packing had been tried with little success. No evidence of tuberculosis had been obtained.

Mr. Robinson thought it was an old syphilitic case, in which there had been destruction of the septum.

Dr. StClair Thomson said he remembered the case being shown previously, when he thought it was due to sinus troubles; and that opinion he still held. There was pus in the middle meatus, besides polypoid hypertrophy, and he thought there was considerable ethmoiditis as well. He added that if ever an abrasion occurred on the mucous membrane of the septum—probably traumatic in origin—in a case of nasal suppuration, that ulceration would take place, remain septic, and easily lead to perforation and extensive destruction of the septum.

Dr. Dundas Grant asked whether the disease had come to an end, or was still active. It seemed to him as if it were an exhausted process, probably some low form of tubercle which had led to the destruction of cartilages and then stopped.

Mr. Waggett echoed Dr. StClair Thomson's remarks; such a case could properly be called one of ethmoiditis.

Dr. Bennett agreed that there had been ethmoidal trouble, but believed it was coming to an end. The surface seemed to be smoothing over, and was less angry. In the last fifteen months there was a change for the better.

Growth on the Left Vocal Cord in a Man aged Forty-six, who had noticed Slight Hoarseness of the Voice for the last Fifteen Months.

Shown by Mr. Stephen Paget for diagnosis.

Mr. Waggett thought it was a large papilloma.

Mr. de Santi suggested that a piece should be removed from the growth for examination, as its nature seemed doubtful. He inclined to the belief that the disease was malignant, though he hoped members would not think he was always "plumping" for malignant disease.

Dr. StClair Thomson thought the growth looked suspiciously like malignant disease, and he would be prepared to find it such. As it did not extend up to the arytenoid, it might be examined by laryngo-fissure, with a view to extirpation. If malignant, then, so far as could be judged by the laryngoscope, it was a suitable case for thyrotomy.

Dr. Fitzgerald Powell thought that the overgrowth was papillomatous; he did not believe it was malignant; there was, in his opinion, too free movement of the cords. It was usual in malignant cases in such a state of advancement as this appeared to be to find considerable interference with movement.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

NINETY-SIXTH ORDINARY MEETING, *March* 17, 1905.

CHARTERS J. SYMONDS, F.R.C.S., President, in the Chair.

PHILIP R. W. DE SANTI, F.R.C.S.
HENRY J. DAVIS, M.B., M.R.C.P. } Secretaries.

Present—64 members and 27 visitors.

The meeting was a large one owing to the number of Continental visitors who were paying an official visit to London on the occasion of the Garcia Centenary Celebration.

The minutes of the preceding meeting were read and confirmed.

The PRESIDENT in his opening remarks called attention to the special character of the meeting, in its relation to the Garcia Celebration. The cases had been all carefully selected by the secretaries, the exhibition of specimens had been arranged by Dr. Pegler with much care, and would be found instructive. The President also directed the attention of the members to the improvements in the lamps, to the glass bowls and holders, and the new spirit lamps, these additions being the gift of one of the members—Mr. Waggett. He was sure he might convey to the donor the best thanks of the Society.

The President further welcomed the foreign visitors, especially Dr. Fränkel from Berlin, who had come as the bearer of the decoration to Senor Garcia from the German Emperor; Professor Chiari from Vienna; Professor Glück from Berlin, who he would remind the Society had arranged to give a demonstration of his methods of removing the larynx the next day at 2 p.m.; also Dr. Moure of Bordeaux; Dr. Botella and Dr. Tapia of Madrid; Professor Landgraf and Dr. Küttner from Berlin; Dr. Lermoyez and Professor Koenig, Dr. Mahu, Dr. Texier, and Dr. Molinié from Paris, and

Dr. Molle, Dr. Goris, Dr. Lieven, and many others. He begged all visitors to join in the discussion.

The following cases, specimens, and photographs were then shown.

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

Shown at the February meeting by Mr. CHARLES PARKER. The disease commenced during her fourth pregnancy, since which she had been pregnant five times; on three occasions the child was born alive, and on two occasions she had miscarriages.

Mr. SYMONDS said opinions would be particularly interesting, because the case was shown to illustrate the bearing of gestation upon tuberculosis of the larynx. At a recent meeting there was considerable discussion on the point.

SIX PATIENTS UPON WHOM RADICAL OPERATIONS HAD BEEN PERFORMED FOR THE CURE OF CHRONIC EMPYEMATA OF THE FRONTAL AND OTHER NASAL ACCESSORY SINUSES.

Shown by Dr. HERBERT TILLEY.

(1) Mrs. C—, aged fifty. Radical operation upon left frontal and maxillary sinuses, May 15, 1900.

(2) Miss H—, aged forty. Bilateral empyemata of frontal, maxillary, and sphenoidal sinuses. Both frontal, ethmoid, and sphenoidal sinuses were operated upon at one operation, and the maxillary sinuses at another operation a fortnight later—January 21, 1903.

(3) Miss W—, aged twenty-one. Right frontal and maxillary empyemata. Radical operation March, 1904.

(4) Mr. H—, aged twenty-one. Right frontal, ethmoidal, and sphenoidal sinus with right maxillary. Operation March, 1904.

(5) Mrs. B—, aged thirty-three. Left frontal, ethmoidal, and maxillary sinuses. Radical operation March, 1903.

(6) Miss B—, aged twenty-three. Left frontal, ethmoid, and maxillary sinuses. Radical operation (modified Killian) September, 1904.

In none of these cases could any pus be found in the nasal cavities nor any sign of recurrent disease.

By the term "radical operation" as used above was meant:

(*A*) *Frontal sinus*: complete removal of the anterior wall, curetting away of all diseased mucous membrane, establishment of free communication with the nose, in which process diseased anterior ethmoidal cells were broken down. The removal of the

anterior half of the middle turbinal was the first step in operation. The cavity was then lightly packed with gauze and dressed every second day until the sinus was obliterated by granulation tissue.

(*B*) *Maxillary antrum*: a large opening in the canine fossa, curettage, removal of greater part of inner antral wall, suture of bucco-antral mucous membrane. This sinus was not packed. The anterior half of the inferior turbinal was removed as a preliminary step.

(*C*) *Sphenoidal sinus*: removal of middle turbinal, breaking down of anterior wall of sinus by means of suitable hooks. The mucous membrane was not curetted, but free drainage of the sinus secured, and local medicaments could be applied during the after-treatment.

Mr. Cresswell Baber congratulated Dr. Tilley on the success of his frontal sinus cases. The radical operation appeared to be a modification of Kuhntz's. He asked how long Dr. Tilley left the nasal tube in position. He suggested it was only necessary to keep the tube in the nose for a short time, so as to allow the canal to granulate up as soon as possible.

Professor Chiari (Vienna) expressed his admiration at the results achieved by Dr. Tilley. He found the cicatrix everywhere without deformity, either of the skin or face, a rare result in such cases. The method used by Dr. Tilley was not quite new, but the results were so excellent that he was glad of the opportunity of seeing the cases.

Dr. Herbert Tilley, in reply, said that the time the tube (extending from the sinus *viâ* the fronto-nasal canal into the nasal cavity) remained in position depended upon the size of the sinus and of the naso-frontal canal. If these were small, the tube could be removed even before the external skin wound had completely healed, because the fronto-nasal canal became obliterated and the sinus cavity could be treated as an ordinary granulating wound. Generally speaking, the tube, which could constantly be reduced in calibre during the after-treatment, was removed last of all, *i. e.* when the whole sinus was obliterated by granulation tissue which gripped the tube. The resulting fistula quickly healed. If the tube was dispensed with too quickly, there was a tendency for the granulation in the naso-frontal canal to become œdematous and infected by nasal discharges, with the result that the sinus itself became unhealthy again. He did not claim any originality in the operation but selected for each particular case what seemed best of the various operations which had been described by Kühntz, Killian, Luc, Ogston, Jansen, and others. The speaker thought that whatever method of operation was selected, the final degree of excellence obtained would very largely depend on the degree of patience coupled with attention to detail which the surgeon bestowed upon the case.

Woman, aged thirty-five, with Pharyngo-Laryngeal Epithelioma.

Shown by Mr. de Santi. The patient was exhibited in January, 1905, as doubtful tubercular disease, in February as

undoubted malignant disease, and condemned as inoperable. She was now shown again for opinions as to operative interference.

Professor MOURE (Bordeaux) expressed some doubt as to the diagnosis of malignant disease being correct. Admittedly there were some small glands in the neck, but they might not be malignant. He inclined to the view that it was tertiary syphilitic perichondritis, and advised that before any operation—which would have to be a radical one—were attempted, an energetic course of antisyphilitic treatment should be tried.

Professor GLÜCK (Berlin) said he would be able to show on the following day a specimen which he removed from a patient two weeks since, which was a mixed tubercular and syphilitic affection, and which he removed from a similar case to the one now shown. He extirpated the larynx, and he hoped the pharynx would heal. If the tumour in Mr. de Santi's case were malignant, the case was operable, as he himself had removed a more extensive growth than the present one. He was of Professor Moure's opinion, that the malignant nature of the growth was not decided.

Professor CHIARI (Vienna) recommended that a large piece of the growth should be removed for examination by a pathologist, which would do no harm, and would afford a satisfactory diagnosis. If it proved to be cancer he would operate immediately. Of course, he would not operate without knowing the nature of the condition.

Mr. DE SANTI, in reply, thanked especially those foreign visitors who had expressed their opinion on the case, which was one of considerable interest from the point of view of diagnosis. He had observed the patient for three months, and members had seen her twice before, offering various opinions as to diagnosis. At first he showed the case as possibly tuberculous, the evidence, however, in regard to bacilli and chest mischief being negative. Then the question of possible malignancy arose, and he was advised, at one meeting, to remove a piece of the growth endolaryngeally and submit it to the microscope, also that he should feel the growth with his finger *viâ* the mouth. Both these were done. Though Dr. Moure was correct as to some doubt having arisen as to the nature of the microscopic section, this was the view of only one member, Mr. Waggett, who took the specimen home and pronounced it doubtful. The sections were made by an eminent pathologist, Dr. Hebb, who expressed the opinion that it was undoubted epithelioma, and this was also his (Mr. de Santi's) view. That would answer Professor Chiari's suggestion. He agreed with Dr. Moure that there had been a large element of doubt about the case; the small amount of glandular infiltration was noteworthy for such an extensive case. The general health of the patient struck him as extraordinary each week he saw the patient. He thought the best course would be to put the woman under a general anæsthetic, to tell her beforehand that there was an element of doubt in the case, and perform ordinary thyrotomy. If naked-eye inspection showed the disease to be malignant, one should go further and do what was necessary, which, according to Professor Glück, would mean a very extensive operation. The woman had been treated with iodide of potassium, but only for about ten days, which was not long enough to determine whether it was specific or not. But having shown her to the Society before and heard such definite opinions expressed that it was malignant, he had not again put her upon iodide of potassium. Ought he to put her upon a thorough course of iodide of potassium, or to operate and see the nature of the disease? He

was in favour of an exploratory operation, and if necessary a much larger piece of growth could be excised for examination; subsequently the case could be dealt with by a very extensive operation, namely, removal of the whole larynx and pharnyx, part of œsophagus, and removal of glands on both sides of the neck. As to such an operation and its effects, he had come to the conclusion that the German subject must be "tougher" than the English subject.

A Case of Unilateral Congenital Lesion of the Medulla and Spinal Cord, with brief Notes of the Pathological Changes in the Mouth, Throat, and Ear in a Man aged forty-one.

Photographs shown by Mr. de Santi and Dr. Purves Stewart. For the following brief account of this most interesting and unique case he (Mr. de Santi) was indebted to his colleague, Dr. Purves Stewart, under whose care the patient remained until his death, from pontine hæmorrhage.

The case was brought to Mr. de Santi's notice by Dr. Purves Stewart, who asked him to examine the patient's throat, mouth, and ear.

A complete description of the case had been published by Dr. Purves Stewart in *Brain*, Spring number, 1904, Part CV, and he had to thank Dr. Stewart for his courtesy in allowing him to bring the case to the Society's notice, and for the following notes, extracted from Dr. Purves Stewart's fully reported account.

The following was a brief account of the conditions found in the mouth, throat, and ear: Lower jaw, right side, absence of any molar teeth either of the first or second dentition. All the other teeth erupted normally. General intelligence only moderate; speech and articulation normal, but the voice was hoarse; smell and taste normal both sides. Hearing dull both sides, but much more so right side. Right auditory meatus narrower than left and on a higher plane. Right pinna much smaller than left. Right mastoid process absent. Right arch of palate at rest was nearer to mid line than the left, and on phonation the left side moved alone, pulling the raphi upwards and to the left. Sensibility of the mouth, pharynx and larynx was normal. Right vocal cord was immobile in the middle line: the left cord moved freely. Right omo-hyoid, stylo-hyoid, and posterior belly of digastric absent. Right side of tongue smaller than the left, and the tongue on protrusion pointed to the right. The right sterno-hyoid, sterno-thyroid, and thyro-hyoid muscles were absent. All the above-mentioned muscles, which were clinically non-active, were non-responsive to the strongest electric stimulation, faradic or galvanic.

On both sides of the tongue the reaction was normal. The right sterno-mastoid muscle and part of the trapezius were absent, and Dr. Purves Stewart concluded that the absence of these muscles, together with the paralysis of the palate and vocal cord on the same side, pointed to a congenital lesion of the spinal accessory and vagus nuclei on the right side.

He further in his very complete published report of the case (*Brain*, Spring number, 1904, Part CV) stated that the partial hemiatrophy of the tongue indicated an implication of the hypoglossal nucleus; the absence of the depressor muscles of the hyoid bone and of the posterior belly of the digastric indicated that the lesion extended down the anterior cornua of the spinal cord at least as far as the third cervical segment.

The patient, whilst under Dr. Stewart's care, suddenly died from pontine hæmorrhage, and thus a complete *post-mortem* examination was obtainable.

The following points he had, with Dr. Stewart's permission, abstracted from his description of the autopsy: Total absence of sterno-mastoid, sterno-hyoid, sterno-thyroid, thyro-hyoid, stylo-hyoid, digastric (posterior belly) and omo-hyoid muscles. Absence of upper fibres of trapezius, middle fibres from seventh cervical to fourth dorsal spine well developed, fibres below that level absent. No signs of spinal accessory nerve discoverable. Right soft palate thinner than left, and subsequent microscopic examination showed on right side absence of levator palati and diminution in size of azygos uvulæ. Right side of tongue was smaller than the left. The epiglottis was bent over towards the right side.

Examination of larynx, post-mortem.—General atrophy of right half. The thyroid cartilage with its pomum Adami was thrust across to right side. The right middle constrictor of the pharynx was very defective, and the styloid muscles hardly recognisable. Right crico-thyroid entirely absent, also the right crico-arytenoidens posticus. Right crico-arytenoideus lateralis only a thin film of functional pale muscle-fibres. Kerato-cricoid muscle was present. Arytenoideus transversus and obliquus small. Right thyro-arytenoideus feebly developed. *Nerves*—Absence of right hypo-glossal nerve. Right superior laryngeal (internal laryngeal branch) and right recurrent laryngeal nerve, although smaller than on the left side, were recognised. Foramen cæcum on dorsum of tongue deeper than usual. Right external auditory meatus shorter and narrower than left, but the tympanum and auditory ossicles were normal.

Examination of the medulla oblongata showed marked abnormality. On the right side the hypoglossal nucleus and the adjacent lower part of the accessorio-vagus nucleus were absent, whilst the corresponding nuclei on the left side were well developed. The spinal root of the trigeminus was much smaller on the right than on the left side.

In the spinal cord the anterior median fissure was expanded into a deep cleft extending from the lower part of the second cervical to the upper part of the seventh cervical segment; the cleft extended into the grey matter on the right side, causing much distortion. Below the seventh cervical segment the cord showed no abnormality.

Some conclusions arrived at by Dr. Stewart in connection with the pathological changes in the parts referred to in this communication: "The atrophy of the laryngeal muscles is due to the lesion of the vagus, the lower part of whose nucleus was deficient, and whose trunk was much diminished in size, especially its supra-laryngeal and recurrent laryngeal branches.

"The absence of the right levator palate and diminution in size of right azygos uvulæ and right middle constrictor of pharynx corresponds with remarkable accuracy to a lesion of that part of the vagus formerly named the 'bulbar part of the spinal accessory.'

"The deformity of the temporal bone and lower jaw is probably to be associated with the congenital smallness of the spinal root of the trigeminus."

A Case of Soft Fibroma of the Larynx and Neck removed by External Operation without opening the Cavity of the Larynx.

Shown by Sir Felix Semon. The case was previously demonstrated at the meeting of the Society on March 9, 1898, further described to the Society on June 3, 1904, and in the *British Medical Journal* of January 7, 1905. Besides the patient, the tumour which had been removed and microscopical preparations taken from sections of the growth were also shown.

Professor Chiari (Vienna) said the results were very satisfactory. It was an extremely rare and interesting case, and though the operation was not new, he believed this was only the second time it had been performed. One could not imagine a better result. The patient could breathe and speak very well. Perhaps a more energetic operator would have extirpated half the larynx, and the patient would then have been forced to always wear a cannula.

The President considered the result was excellent.

A Case of Complete Extirpation of the Larynx.

Shown by the President. William B——, aged fifty-two, was admitted into Guy's Hospital July, 1904, under the care of Mr. Symonds, for laryngeal obstruction. The larynx showed a mass of new growth, nearly filling its interior, evidently growing from the left side. On considering the case the larynx on the left side appeared somewhat swollen externally, suggesting that extension had already taken place through the cartilage, but no glands could be felt. On opening the larynx the disease was seen to be very extensive on the left side, while the anterior part of the right cord was free. On separating the skin on the left half it was found that the disease had penetrated the larynx and already infiltrated the overlying muscles. It was, therefore, decided to perform complete extirpation. In order to effect a more complete removal the left lobe of the thyroid gland was included with all the surrounding deep fascia so as to take up as far as possible the lymphatic tract. The trachea was fastened to the skin, the pharynx was closed with two rows of sutures, the muscles and skin left open, and this cavity packed with gauze. The patient made a good recovery, primary union taking place, except for one small spot.

The preparation showed the usual appearance of an epithelium involving the left half of the larynx and extending across to the right side. The extension to the muscles was not well seen, as the preparation was imperfect. The left lobe of the thyroid body would be seen.

Epithelioma of the Larynx in a Man aged forty-nine; Laryngo-Fissure eight months ago; no Recurrence.

Shown by Dr. StClair Thomson. In this case pulmonary tuberculosis had been arrested twelve years ago after injection of tuberculin (*vide Proceedings*, vol. xi, p. 68; and vol. xii, p. 32).

Dr. Botella (Madrid) said he did not regard eight months as sufficiently long to determine whether epithelioma would recur after operation; at least two years should elapse before regarding recurrence as unlikely. In a very similar case in Spain recurrence occurred more than two years after operation.

Professor Glück (Berlin) said he had operated upon a patient aged sixty-five, and eight and a half years after healing he had cancer in the other side of his larynx. That and the glands were removed, and the patient lived to the age of seventy-seven; so that operation prolonged the man's life eleven and a half years. Thus recurrence might take place even eight years after the operation.

Professor MOURE (Bordeaux) asked whether Dr. StClair Thomson removed the cannula immediately after the operation and then closed the whole wound.

Sir FELIX SEMON said he thought *any* period which might be mentioned as constituting a "cure" of cancer of the larynx, whether one, two, three, or even eight years, was purely arbitrary. There was no time after which one could safely say the case was cured. He had had a very considerable experience of that class of cases, as he had operated upon about thirty cases in private practice, and had been able to follow up their subsequent history. He would say that if operation were performed *early*, and the patient remained well one full year afterwards, the chances of recurrence were extremely remote. Practically he had never seen recurrence after one year of immunity. Still, he deprecated the use of the word "cure" in such cases, because, as Professor Glück had just shown, recurrence might take place at any period. Moreover, Mr. Butlin had a case of recurrence three and a half years after operation, and there were other similar cases on record. Thus the three years' limit was as arbitrary as any other. Nothing which anyone else might say would alter his opinion on this matter. Every patient would, of course, ask whether there was a reasonable prospect of his remaining free, and he could be conscientiously told that if he remained free one year, he might reasonably expect to remain free always. All this, however, applied to such cases only in which the disease was of the intrinsic variety, and in which early and thorough operation was performed.

Professor MOURE (Bordeaux) made some further remarks confirming the opinions expressed by Sir Felix Semon.

Professor GLÜCK (Berlin) said he had operated on a physician aged sixty-three and removed the right vocal cord and ventricular band. The larynx healed perfectly, but three years afterwards he died from a cylindrical-celled growth, the previous tumour having been one of the flat-celled variety. There must, therefore, have been two separate cancers in one individual. *Post mortem* the larynx was removed, and was found to be perfectly healed.

Dr. WALKER DOWNIE said he was very pleased to see the case, and congratulated Dr. St.Clair Thomson on the result. On several occasions he had performed thyrotomy for intra-laryngeal disease. One was in 1888, the patient being fifty-two years of age, and he had a small localised epithelioma of the left cord. The cord was completely removed and healed satisfactorily, and the man was still living, the cord having been replaced by firm scar-tissue. The cicatricial band was not so marked as in Dr. StClair Thomson's case, but there was a fairly good voice, and seventeen years had passed without recurrence.

Mr. DE SANTI agreed that the question as to a cure or not in any given case of epithelioma of the larynx was a very difficult one, but those who had spoken had referred to intrinsic carcinoma. He thought a distinction must be made between intrinsic and extrinsic. His experience had been that in extrinsic cases, if there were freedom from recurrence for a year after operation, one could not say that in another year or so the patient would not have a recurrence. Recurrence was very apt to take place in the extrinsic form. In the intrinsic form there was a very fair chance of a long immunity if no recurrence appeared within a year. But in all cases of cancer in any part of the body it was difficult to tell a patient whether he could be definitely cured or not. He thought the only way the case could fairly be put to the patient was to tell him

that from the nature of the growth and the extent of the disease, there was a fair chance of deriving what was called a cure, *i. e.* non-return for some three years, or possibly longer. It was the same with cancer of the breast; one's experience was that a fairly early case might not recur for three to five years after operation, but that it did so afterwards. The only case of carcinoma of the body which had not recurred within his own experience and recollection was a carcinoma of the tongue in an old Irishman, who came with a small growth on the tongue, which he removed, taking away half the tongue and the glands in the neck. The patient was very angry when he found that half the tongue had been removed, but as he had not lost his Irish brogue, and he was eighty years old when the operation was done and lived to be ninety-two and died of bronchitis, there was good reason to be satisfied. Still, he might have had recurrence if he had lived another year.

The Chair was here taken by Dr. BALL, Vice-President.

Dr. STCLAIR THOMSON, in reply, said he omitted to exhibit in the adjoining room a pair of thyroid shears designed by Mr. Waggett. He (Dr. Thomson) had only been able to use the instrument on one occasion, but he had found it most effective, and a great improvement on cutting through from the outside. Division could thus be made exactly in the middle line of the larynx. In reply to Dr. Moure, he did not leave the cannula in place. He sewed up the soft tissues over the larynx, but not opposite to where the tube had been inserted. Dr. Moure suggested that it was a precaution against pulmonary and other infections if the whole wound were closed at once, but that was a view which he (Dr. Thomson) did not think was shared in this country. There was no harm in leaving an opening in the trachea, and it had been beneficial in the present case, because the patient had some pneumonia from the blood inspired, and he recovered more easily through being able to expectorate the muco-pus through the tracheal wound. With regard to recurrence, in one of his cases of epithelioma of the larynx, the larynx was apparently cured, but one year later the patient developed epithelioma of the base of the tongue on the opposite side. He thought there was no connection between the two, for the larynx was quite free from recurrence up to the time—three years later—when the patient died from cancer on the opposite side of his tongue. His present case was especially interesting, as the man was hoarse for a year before he was operated upon, and was shown at the Society six months before the operation and no one would venture a diagnosis. Finally the diagnosis was made by the fixation of the vocal cord. The value of this symptom had been much discussed, and even doubted by some Continental writers, but Sir Felix Semon had taught laryngologists to lay great stress on it. The diagnosis was made without any prior microscopical examination. The sections in the next room showed that, as diagnosed clinically, it was undoubted epithelioma.

PRIMARY LUPUS OF LARYNX (QUITE HEALED) AND PHARYNX (NEARLY HEALED) IN A WOMAN AGED TWENTY-TWO, WITH DRAWINGS OF ORIGINAL CONDITION.

Shown by Dr. STCLAIR THOMSON.

A Case of Incrustations in the Trachea, with, at times, well-marked Stenosis.

Shown by Dr. Edward Law. The patient, a young woman, had been shown at a previous meeting.

Professor Chiari (Vienna) said Dr. Law showed him the patient that morning, and he had just seen her again. He examined the nose and naso-pharynx, but could not find much in the nose except chronic catarrh; there was no stenosis of the posterior nares. He thought it was rhino-scleroma, but did not know what the condition was in the trachea. In the morning he saw yellow mucous crusts, but now there were white crusts; he had no idea where they came from.

Dr. Edward Law, in reply, said the tracheal symptoms had materially improved since he showed the case two months ago. The patient had been under the care of Dr. George Stoker in the Oxygen Hospital, and had inhalations of oxygen and ozone for several hours daily, and had been sleeping in a cubicle designed for such treatment. The first inch of the trachea was now free from incrustations, and the patient was in a better condition than three months ago, when she was having various sprays and inhalations. If the present treatment did not cure her he would try formalin later.

Series of Microphotographs.

A beautiful series of microphotographs was shown by Dr. Milligan: (1) Angioma of left vocal cord; (2) lymphangioma of vocal cord; (3) papilloma of uvula; (4) tubercular diseases of the uvula; (5) laryngeal papilloma; (6) papilloma of tonsil; (7) sarcoma of nasal septum; (8) angio-sarcoma of middle turbinated body; (9) epithelioma of nasal mucosa.

Case of Epithelioma of the Nose (shown at the January Meeting, 1904); Patient, Macroscopic and Microscopic Specimens and Photographs.

Shown by Mr. Atwood Thorne and Mr. J. R. Lunn. This was the case of a man, aged seventy, first seen at the London Throat Hospital in January, 1904. He had then complained of increasing difficulty of breathing through the right nostril for a month or so. The nose was a good deal enlarged, and the right nostril was occupied by a granular mass arising from both the inner and outer walls of the vestibule. A portion of the growth was removed, and this both gave the patient a better breathing space and enabled a diagnosis of epithelioma to be made.

The condition about this time was well shown in the photographs. At a previous meeting he (Dr. Atwood Thorne) asked if the nose

should be removed, but opinions were on the whole unfavourable to operation.

After the meeting the growth increased somewhat in size. No bed being available at the London Throat Hospital, he was admitted on February 2 to the Marylebone Infirmary.

When admitted there the patient's nose was occupied by a large everted ulcerating growth about the size of a small apple which was breaking down, he had a tender gland in the neck on the right side. The patient's general condition was fairly good, except for the inconvenience of the discharge from the growth into the nose. He stated he had always had excellent health; he had been in the habit of taking snuff for the last thirty-five years. No history of syphilis or tuberculous disease could be obtained. Mr. Lunn operated on February 4th, 1904; the sides and front of the large mass occupying the nose was injected with half an ounce of a sterlised solution of adrenalin 1—5,000. This made the nose quite blanched and bloodless, and it was then excised, no bleeding took place, and no vessels were tied. The nasal bones in front and the vomer were cut away, the upper and lower edges of the wound were brought together by catgut sutures. On February 9th the patient was submitted to the X rays, and this treatment was continued twice a week for some time, when he developed eczema, but no good results apparently followed the application of the X rays. Mr. Lunn also tried grafting the raw surface, but the grafts did not take owing to the profuse discharge from the Schneiderian membrane. After the removal of the growth, the gland in the neck disappeared. Before he left the infirmary, the patient was given glasses for distance and reading, and the false nose was fixed to the spectacle frame.

Report of the specimen by the Clinical Research Association, February 12th, 1904.—Sections (1) showed some irregular masses of epithelium which probably represented the outlying processes of an epithelioma. (This specimen was taken from the centre of the growth.) The other section (2) was removed from the outer side of the incernus to see if one had got clear of the growth; it contained many large sebaceous glands, and a few foci of inflammatory cells, but no traces of epithelioma.

The patient was shown with his nose as removed, and also microscopic specimens (1) taken from the growth and showing distinct epithelioma; and (2) a specimen taken at the completion of the operation from the edges of the wound, containing many sebaceous cysts and inflammatory cells, but no traces of epithelioma.

Cicatricial Diaphragm due to Inherited Syphilis passing from the Posterior Third of the Tongue to the Posterior Wall of the Pharynx.

Shown by Mr. H. Betham Robinson. The patient who exhibited the above condition was a female, aged twenty-two. The cicatricial diaphragm passed backwards almost horizontally to the pharynx at the junction of the upper third with the lower two thirds of the epiglottis: the latter projected through the central opening and its right margin at the point of crossing of the diaphragm was adherent to it. Out of the left margin of the epiglottis was a notch due to specific destruction, and the whole epiglottis was drawn down over the larynx so as to put the median glosso-epiglottic fold upon the stretch. Below the diaphragm the larynx could be seen quite healthy, the view of the latter being particularly seen through the deficiency in the left margin of the epiglottis. There was no marked difficulty in swallowing. The soft palate was adherent to the posterior pharyngeal wall, mainly on the left side, and its lower edge was here eroded. There were evident specific changes in the nose, and externally the bridge was depressed and broadened.

She had interstitial keratitis at seven years old. The teeth were bad but showed nothing characteristic.

The syphilitic history was very complete. The mother at the present time attended Mr. Robinson's department with necrosis of the septum nasi, and the father had been in the hospital with a syphilitic nerve lesion. The mother never had any miscarriages, but had nine children, the last five of whom were born dead.

Case of Pharyngeal Diverticulum opening into the Pyriform Fossa in a Woman aged fifty-one, with Röntgen Ray Photograph showing the Pouch when filled with Bismuth.

Shown by Dr. Dundas Grant. The patient was a sparsely built woman of small stature, aged fifty-one, who for about a year had been conscious of a slight difficulty in swallowing. On examination the right pyriform fossa was seen to be filled with frothy fluid; the larynx was otherwise normal. An œsophageal bougie passed without any difficulty. At first suspicions were entertained that it might have been a case of early epithelioma in the pyriform fossa, but after careful mopping no signs of epithelial sprouting were found. To the right side of the thyroid cartilage was an elongated swelling resembling a mass of enlarged lymphatic glands

lying on the carotid artery, from which it received a communicated pulsation. When this swelling was compressed the fluid in the pyriform fossa exuded in increased quantity. On inquiry it was elicited that small particles of food returned at intervals of several hours after swallowing, and the condition was then believed to be a diverticulum of the pharynx. Attempts were made to introduce a curved probe into the cavity, but without success. Röntgen ray photographs were taken by Dr. Mackenzie Davidson before and after the swallowing of bismuth by the patient; in the latter the bismuth emulsion was seen to collect like ink at the level of the swelling, and in the subsequent photograph there could be seen an elongated area of opacity in the same region, which was not visible in the previous one, and which could only be accounted for by the bismuth (opaque to the Röntgen rays) having collected in the sac. This appeared to confirm the diagnosis, and it was proposed to remove the sac by an operation from outside.

Dr. Watson Williams asked whether the opening could be seen, and whether food lodged in the pouch.

Dr. Dundas Grant, in reply, said he could not see the opening, but only frothy mucus exuding from the pyriform fossa on the right side. That was increased by pressing the little swelling at the level of the thyroid cartilage, and apparently it lay upon the carotid artery, from which it received a slight pulsation. He showed a Röntgen ray picture of the condition after the patient swallowed bismuth. Before doing so the oval black mark was not visible. He proposed to operate on the case. On no occasion had food remained in the pouch till the next day.

Fixation of Left Vocal Cord in a Man aged forty-nine, with a Pulsating Thoracic Aneurysm.

Shown by Dr. H. J. Davis. The patient had been shown to the Society in May, 1904, through the kindness of his colleague, Mr. Stephen Paget, when no signs of aneurysm were present either by examination or radiogram. When he first presented himself at the hospital in January, 1904, he complained only of intense weakness and regurgitation of fluids through the nose There was paralysis of the right side of the palate, weakness and wasting of the muscles of the right arm, a "squeaky" voice and slight hoarseness. The left vocal cord was seen to be fixed and the right cord swung across the middle line in phonation. The pulses and pupils were unequal, the heart-beats were feeble, but there was no evidence of hypertrophy or any other signs of aneurysm. The patient was a hansom cab driver; formerly he

had served fifteen years in the United States Mercantile Marine. There was a history of syphilis contracted on two occasions, and the knee-jerks were exaggerated.

Dr. de Havilland Hall had then expressed the opinion that the case was one of aneurysm.

The patient had since been treated with 15 grains of iodide of potassium in a mixture containing a dram of Easton's syrup, and he (Dr. Davis) had found this a useful prescription, as the Easton's syrup acted as a good general "tonic" and markedly counteracted the depressing effects which usually resulted when iodides were taken for a long period. The mixture had to be well diluted.

All the symptoms of weakness, and regurgitation of food into the nose, disappeared under iodides, but four months ago distinct "heaving" was noticeable to the left of the sternum. The patient had constant pain in the chest, and on three occasions an attack of Angina Pectoris.

The signs of aneurysm were now well marked. The constant hacking cough had been markedly relieved by ʒjss. of Syr. Codeine, and this accounted for the fact that the pupils were now symmetrical and both contracted.

The points of interest in the case were:

(1) That the voice was not hoarse or gruff, but high pitched and "squeaky."

(2) That the typical signs of aneurysm were so long delayed after the patient's first appearance at the hospital for treatment.

(3) That the fixation of the left vocal cord co-existed with a paralysis of the right half of the palate and paresis and wasting of the right arm, which tended to mask the signs on which we relied in diagnosing aneurysm, and pointed rather to a lesion of central origin.

(4) That all the symptoms of central trouble had disappeared under iodides.

(5) That the pulsating swelling was too far to the left of the sternum, and too low down to have originated in the first or second part of the arch, and that it was, therefore, a deep-seated aneurysm which had reached the surface of the chest.

(6) That the patient had twice contracted syphilis, infected his wife, and that she had now marked signs of tabes dorsalis, with gastric crises and lightning pains.

He (Dr. Davis) had seen and heard of so many cases of fixation of a left vocal cord attributed to early aneurysm, and where this diagnosis had subsequently been proved to be incorrect, that he

thought it was of interest to see a case where an aneurysm really existed, and was the undoubted cause of the lesion.

Dr. PERMEWAN said he had come to the conclusion that the great majority of cases of paralysis of the left vocal cord were due to aortic aneurysm, where no particular cause could be found for it. He, and probably others also, could think of cases in which no signs had shown themselves for several years, but in which aortic aneurysm had eventually been found. He believed fully nine tenths of such cases of paralysis of the left cord were due to that cause.

Professor POLI (Italy) expressed the view that a paralysed left vocal cord did not by any means prove the presence of aneurysm, though in the main his experience confirmed what the previous speaker had stated. He asked if any tracheal tugging was present.

Dr. FITZGERALD POWELL said he would be sorry for Dr. Permewan's statement to go forth as a dictum from the Society. Aneurysm of the aorta occurred in many cases in one's experience, but most of the cases of paralysis of the cords were due to syphilitic and tubercular lesions. He had shown a case in which the paralysis occurred as a result of the toxin of influenza.

Dr. JOBSON HORNE concurred with Dr. Permewan that the vast majority of the cases of paralysis of the left vocal cord without signs to account for the fixation were due to aneurysm. Dr. Horne added that he would not regard the search for signs to be complete in such a case without a radiograph of the thorax. Amongst the exceptions were these cases in which the nerve had become implicated in enlarged lymphatic glands or in a deep-seated new growth, and Dr. Horne referred to a case he had shown to the Society some years ago in illustration of that point.

Dr. BALL (in the Chair) thought the duration also should be taken into account. If one included cases in which a cord had been paralysed for a long time without any symptoms appearing, he did not think that in nine tenths of the cases it would turn out to be aneurysm. A very large proportion of cases which had lasted not more than a year or two turned out to be aneurysm: but he had met with cases in which a vocal cord had been paralysed for an indefinite period, and no one could account for it. It might happen with either cord.

Professor KOENIG (Paris) said that if Professor Vernicker were present he would tell the meeting of a case in his clinique aged forty or forty-five, whom he showed frequently for several years, who had paralysis of both posticus muscles. They moved only very slightly from the middle line. The patient breathed fairly well, and no aneurysm was found, nor anything to explain the condition. It was probably a case of neuritis.

Dr. WATSON WILLIAMS said that, having seen many similar cases as a general physician, his experience certainly bore out Dr. Permewan's remarks that where there were no other symptoms or physical signs of other lesions, nine tenths of the cases of paralysis of the left vocal cord were due to aneurysm. On that assumption he had several times had the diagnosis confirmed.

Dr. DUNDAS GRANT said that, while agreeing in the main with what had been said with regard to paralysis of the left vocal cord, there had been two curious cases in his experience. One seemed to be attributable to alcoholic poisoning, which got well when the patient corrected his habits. The other was a case which he saw seven or eight years ago,

in a comparatively young woman, who had fixation of the left vocal cord, but there was nothing discoverable to account for it. She was delicate, but he could find no evidence of tuberculosis. He heard a day or two ago that she died very recently of pulmonary tuberculosis. He believed the left recurrent nerve was involved in a tuberculous gland.

Dr. SMURTHWAITE said he had seen three *post mortems* in which the patients suffered from paresis of vocal cord, in two cases of the left cord and in one of the right. In one there were no symptoms of aneurysm, and no glands could be felt at the triangles. *Post mortem* a small gland was found, in which the recurrent laryngeal nerve was tightly embedded. In one case the patient had hæmatemesis and hæmoptysis, and it could not be discovered whether she had carcinoma of the stomach or phthisis. *Post mortem* it was found that a small old gland had ulcerated into the trachea and œsophagus, involving at the same time the recurrent laryngeal nerve. The third case—paresis of the right cord—was thought to have aneurysm in the region of the subclavian. At the *post mortem* the aneurysm was not pulling on the right subclavian, but there were adhesions where the nerve recurred around the subclavian and passed up on to the trachea. The nerve was embedded in old adhesions.

Dr. PERMEWAN said, in further explanation, that he was familiar with right cord paralysis; but in cases of paralysis of the left cord, lasting a considerable time, where there was no local disease in the larynx itself, and without any cause which one could be sure of, the vast majority would be found to be due to aortic aneurysm.

Dr. DAVIS, in reply, said that there was no tracheal tugging and no physical signs in the heart. The first part of the arch was certainly not affected; he thought that the aneurysm had been deep-seated and had now reached the surface of the chest; it could not be a mediastinal new growth, as the swelling was expansile on pulsation.

CASE 1. EPITHELIOMA OF EPIGLOTTIS AND BASE OF TONGUE REMOVED BY SUB-HYOID PHARYNGOTOMY.

Shown by Dr. LAMBERT LACK. Previously exhibited to the Society in January, 1904. The patient first came under his care in May, 1903, suffering from epithelioma of the epiglottis, the glosso-epiglottic fossa, and adjacent part of the tongue. There were enlarged glands in both anterior triangles of the neck, especially hard and fixed on the left side.

The skin incisions extended from near the tip of the mastoid on either side of the neck along the anterior border of the sterno-mastoid muscle to the level of the cricoid cartilage. Both anterior triangles were completely dissected, all glands, fat and fascia being removed, and the large vessels fully exposed. The lateral incisions were then united by a transverse one passing across the front of the neck immediately below the hyoid bone. Laryngotomy was performed and the pharynx opened by a transverse incision through the thyro-hyoid membrane immediately above the upper border of the thyroid cartilage. The epiglottis was thus cut through well

below the disease. It was drawn out of the wound, and thus the growth was brought into full view and removed freely. The stump of the tongue was then sutured to the thyroid cartilage and the remains of the epiglottis. The opening in the pharynx was closed by a series of closely set, fine, interrupted sutures passing through mucous membrane only. The over-lying fascia, muscles, etc. were then very carefully sutured to strengthen the union. Finally the larger muscles were sutured and the skin incision closed. Drainage tubes were inserted in both sides of the neck.

The patient made an uninterrupted but slow recovery. There was some suppuration of both sides of the wound, and for three weeks the patient was unable to swallow without coughing. During this time he was fed through a tube.

He regarded the complete closure of the wound in the pharynx with several layers of interrupted sutures the most important part of the operation.

Now (nearly two years later) the patient remained well, free from recurrence, and in excellent health. He was able to swallow well and speak well. Microscopical examination showed typical squamous epithelioma.

Case 2. Epithelioma of Right Arytenoid and Adjacent Parts, Removed by Lateral Pharyngotomy.

Shown by Dr. Lambert Lack. The patient, a man aged fifty-six, was seen in association with Mr. Peake and Dr. Watson Williams, both of whom kindly assisted at the operation.

The glands in the neck were first noticed in January, 1904. On February 18 there was œdema and ulceration of the right arytenoid. Iodide of potassium, 60 grains a day, was given for a month without improvement. On March 18 the disease was obviously malignant, and the case was referred to me. At this time there was an irregular œdematous swelling of the right arytenoid, complete fixation of the right side of the larynx, and no enlarged glands could be felt in the right anterior triangle of the neck. Although the growth was attached to the posterior surface of the arytenoid, Dr. Lack advised its removal, believing it to be strictly circumscribed, and both his colleagues agreeing, operation was performed on April 3.

A skin incision was made in the median line from the hyoid bone to within a finger's breadth of the sternum, and a second curved incision was made from the upper end of this cut outwards

along the lower border of the hyoid bone to the anterior border of the sterno-mastoid, and upwards to end just below the mastoid process. The large triangular flap thus marked out was dissected up and turned outwards. The object of this incision was to render it possible to remove half the larynx, or even the whole larynx, if it should be found impossible to excise the growth otherwise. The anterior triangle was first cleared out, one large and several small glands being removed. Then the trachea was opened and a Hahn's cannula inserted. The pharynx was opened by a vertical incision just behind the posterior border of the thyroid cartilage. This incision was found to be just beyond the growth, which was exposed and clipped out with scissors together with a half-inch margin of surrounding healthy mucous membrane. The excised parts consisted of the whole of the right arytenoid, the right aryepiglottic fold, and a small portion of the pharyngeal wall. The opening in the pharynx was then closed by three layers of closely applied sutures. The first layer united the mucous membrane of the arytenoid and of the interior of the larynx to that of the lateral pharyngeal wall. The skin wound was then stitched up and a drainage-tube inserted. The Hahn's cannula was retained for about a week, and the patient during this time was fed with a tube, although he was able to swallow a little. He made an uninterrupted recovery, and was quite well in a month.

At the present time he was in good health and free from all signs of recurrence. He could swallow naturally, but his voice was rather hoarse and weak. The left cord swung across the middle line in phonation to meet the right.

These two cases were exhibited to draw attention to the fact that growths in the pharynx, even growths affecting both pharynx and larynx, the most unfavourable situation of all, could be removed if seen early enough, without in any way impairing any important function, and with fair prospect of complete success. Too many of such cases were considered to be inoperable merely because the parts affected by these growths were considered inaccessible to the surgeon.

Dr. Herbert Tilley congratulated Dr. Lack on the excellence of the results which he had obtained in these cases which had been considered inoperable. He had had the pleasure of seeing Dr. Lack operate upon some of these extensive cases and thought the level of excellence obtained in these cases was equal to that which had been reported from other countries.

Dr. Watson Williams remarked that Dr. Lack's second case had

come under his (Dr. Williams') care, and considering the patient's age and the extent of the disease, he thought it was not a favourable case for operation. However, he had the pleasure of assisting Dr. Lack at the operation, and the result he felt sure would call forth the congratulation of members, as it certainly did his own.

Two Cases of Tubercular Laryngitis, healed under Treatment.

Shown by Mr. H. Barwell. C. R——, a man aged thirty-three, came under Mr. Barwell's care on November 17, 1904, suffering from hoarseness and dysphagia of moderate severity for seven months. There were signs of early phthisis at both apices; both testicles had been removed for tuberculosis a year before; the general health was fairly good.

On examination, both arytenoids were much swollen, the left especially; there were interarytenoid granulations; the left ventricular band was enlarged, and the left cord thickened, red, and granular.

Altogether eleven large pieces were removed from the arytenoid region with Lake's punch-forceps, and applications of a solution of lactic acid, formalin, and carbolic acid used daily.

Treatment was discontinued on January 31, 1905, and the condition had not changed. There were now no laryngeal symptoms present, but some enlargement of the false cord remained and a little thickening on the anterior aspect of the arytenoid region, but the parts were entirely covered with sound epithelium.

A microscope slide from one of the pieces removed was shown, and the section was typical of tuberculosis.

A. W——, a woman aged thirty-one, came under Mr. Barwell's care in November, 1903, having suffered from hoarseness and almost constant aphonia for three years. There was consolidation at the left apex.

The larynx showed diffuse red infiltration of the left cord, with an ulcer at its centre and numerous small interarytenoid granulations. She was treated as an out-patient throughout, with weekly frictions of the lactic acid, formalin, and phenol solution. In June, 1904, the ulcer was healed, but the infiltration of the cord remained as also the interarytenoid outgrowths, and aphonia persisted. In August the voice returned and became steadily stronger; and in October the left cord was only slightly thickened in front, and the interarytenoid outgrowths had disappeared, leaving a slight uniform thickening; phonation was good. Treatment was then discontinued, and at the present time the larynx remained soundly healed.

Case of Cerebro-spinal Rhinorrhœa which had apparently Recovered Spontaneously.

Shown by Dr. Watson Williams. S. C——, female. aged forty-three. She was shown in the Laryngological Section at the Annual Meeting of the British Medical Association at Cheltenham in 1901, and the case was reported in the *British Medical Journal* for 1901, vol. ii, in association with Dr. Stocker. She had been in good health till March, 1901, when she had a febrile attack resembling influenza, but with the constant dripping of cerebro-spinal fluid from the right nostril. She lost a pint of fluid daily during the waking hours and a good deal more which ran down the throat posteriorly during the night. The tests applied to identify the escaping fluid were described in the original report. Professor Osler had then suggested the desirability of trying continuous lumbar puncture, and in this way Dr. Stocker had endeavoured to give relief, but without avail. The escape of fluid persisted without alternation till about three months ago, when it began to lessen, and after decreasing steadily it ceased to flow a month ago. She was subject to very severe frontal headaches about once every month or six weeks, but these were not different in character or frequency to the headaches from which she had suffered for many years, nor were they appreciably modified during the four years she had the nasal flow. The patient seemed now fairly normal, and nothing abnormal has ever been detected in her nasal passages except the flow of fluid.

Case of Sphenoidal and Posterior Ethmoidal Sinusitis, Cured.

Shown by Dr. Watson Williams. This patient, a male, had for fourteen years complained of a bad taste in the mouth, with symptoms of gastric catarrh. He had had treatment for the gastric symptoms, and finally daily washing out of the stomach without any marked or permanent benefit. Since coming under Dr. Watson Williams' care, the posterior ethmoidal cells and sphenoidal sinus on the right side had been laid open, and the cessation of nasal purulent discharge had been followed by very marked relief to the gastric symptoms, while the patient's general health and weight had shown marked advance. Inspection through the nose anteriorly allowed a view of the opened sphenoidal sinus.

A fine collection of naked-eye and microscopical preparations, selected and arranged by Dr. Pegler, Curator to the Society, were on view during the day. The following is a list of the catalogued exhibits:

Section A. NAKED-EYE SPECIMENS.

I. Larynx.

1. Inflammatory Œdema of the Larynx ceasing below at the ventricular bands. University College Hospital Museum.
2. Pachydermia of the Larynx. Guy's Hospital Museum.
3. Pachydermia of the Larynx in a man æt. 34. Glottis much stenosed and completely closed in one situation. Mr. R. LAKE. Royal College of Surgeons' Museum.
4. Diffuse Pachydermia of the Larynx in a case of suspected syphilis. St. Bartholomew's Hospital Museum.

4A. Lymphoma of the Larynx, involving the Epiglottis, Ventricular Band, and Arytenoid Cartilage, etc., of the left side. 'Lancet,' Oct. 15th, 1887. Dr. CLIFFORD BEALE. Great Northern Hospital Museum.

5. Papilloma of the Larynx. St. George's Hospital Museum.
6. Diffuse Papilloma of the Larynx in a child two years old. Aditus completely filled by a densely papillomatous growth. St. Bartholomew's Hospital Museum.
7. Simple Tumour of the Larynx. A papillated cauliflower excrescence attached to each vocal cord and below anteriorly in the middle line; young woman æt. 17. (Death from suffocation.) University College Hospital Museum.
8. Large lobulated Lipoma of the Larynx growing from the right aryepiglottic fold; removed from a man æt. 24, who could eject it into the mouth at will. St. Thomas's Hospital Museum.
9. Fibro-lipoma of the Larynx. The growth could be protruded into the mouth. (Death from suffocation.) Westminster Hospital Museum.
10. Tuberculosis of the Larynx. Deep ulcer of the left vocal cord causing longitudinal fission in a man æt. 49. Brompton Hospital Museum.
11. Tuberculosis of the Larynx. Both vocal cords are split, and the arytenoid cartilages laid bare by ulceration. Brompton Hospital Museum.
12. Leprosy of the Larynx. Swelling and ulceration. St. George's Hospital Museum.
13. Leprosy of the Larynx; later stage; cicatricial contraction. From Leper Asylum, Trinidad. St. George's Hospital Museum.
14. Glanders of the Larynx affecting the epiglottideal region. St. George's Hospital Museum.

15. Laryngeal Ulcer with necrosis of Cricoid and one Arytenoid Cartilage in Typhoid. St. Bartholomew's Hospital Museum.

16. Diphtheria of the Larynx and Trachea in a case of Tuberculosis of the Lung. St. George's Hospital Museum.

17. Foreign Body in the Larynx. Aditus completely obstructed by a piece of meat. 'Proc. Laryng. Soc. of London,' vol. iii. St. Bartholomew's Hospital Museum

18. Artificial dilatation of the Pyriform Fossa of the Larynx into a Pouch: produced by Indian native for secreting rupees; also leaden disc used for the purpose. St. Bartholomew's Hospital Museum.

19. Larynx from a case of Aortic Aneurysm which complicated the left recurrent Laryngeal Nerve. Atrophy of the left crico-arytenoideus posticus, and crico-arytenoideus lateralis. St. Thomas's Hospital Museum.

20. Fasciculated Sarcoma of the Larynx (spindle-cell sarcoma). St. George's Hospital Museum.

21. Carcinoma of the Larynx in a Woman æt. 35. Papillomata had been removed intra-laryngeally from the glottis four years before death. Squamous-cell epithelioma. Sir FELIX SEMON. Royal College of Surgeons' Museum.

22. Carcinoma of the Larynx (squamous cell). Sagittal section through tongue, larynx, trachea, pharynx, and œsophagus, man æt. 42 'Proc. Laryng. Soc. of London,' vol. iii. St. Bartholomew's Hospital Museum.

23. Carcinoma of the Larynx. Complete extirpation. Mr. CHARTERS SYMONDS. Guy's Hospital Museum.

24. Carcinoma of the Larynx. Partial excision for squamous-cell carcinoma of the ventricle of Morgagni (the case of the late Mr. Montague Williams). Sir FELIX SEMON. St. Thomas's Hospital Museum.

25. Carcinoma of the Larynx. Partial excision of the true and false vocal cords for carcinoma on the under surface of the vocal cord in a gentleman æt. 50. Mr. BUTLIN. St. Bartholomew's Hospital Museum

II. Nose and Accessory Cavities.

26. Fragments of deviated Septum Nasi with spur removed by complete submucous resection, 'Proc. Laryng. Soc. of London, vol. xi. Dr. STCLAIR THOMSON.

27. Papilloma of the Septum Nasi, removed from a man æt. 89; no recurrence. Mr. P. DE SANTI. Westminster Hospital Museum.

28. Large polypi attached to the inferior and middle turbinals; a smaller polypus seen in the frontal sinus. St. Bartholomew's Hospital Museum.

29. Right side of a child's head in which the nasal passages are blocked by a fibrous lobulated polypoid growth from the mucous membrane. Rapid growth; death from suffocation. St. Bartholomew's Hospital Museum.

30. Carcinoma of the Antrum (spheroidal-cell). A large firm growth extending upwards from the antrum into the orbit, and inwards filling the nostril on the right side. Woman æt. 64. Death from epistaxis. St. Bartholomew's Hospital Museum.

III. **Naso-Pharynx.**

31. Naso-pharyngeal fibroma attached to the base of the skull and internal pterygoid plate in a boy æt. 12. Removed through the nares. Dr. DUNDAS GRANT.

32. Two halves of a large naso-pharyngeal polypus removed from a man æt. 17, by splitting the palate and removal of the upper jaw. Angeio-fibroma. St. Bartholomew's Hospital Museum.

33. Two large Polypoid Masses removed by operation from the Naso-pharynx of a boy æt. 14. Angeio-fibroma.
St. Bartholomew's Hospital Museum.

34. Right Superior Maxilla removed from this case.

35. Large Naso-pharyngeal Polypus attached to the base of the skull in a boy æt. 14; removed through an opening in the roof of the mouth. St. Bartholomew's Hospital Museum.

IV. **Pharynx and Œsophagus.**

36. Pharyngeal tumour, commencing from left tonsil, extending upwards to the naso-pharynx, and ultimately protruding through the left external auditory meatus.
University College Hospital Museum.

37. An Œsophageal Diverticulum removed by operation from a gentleman æt. 50. Mr. BUTLIN.
St. Bartholomew's Hospital Museum.

38. An Œsophageal Pressure Pouch which opened from the junction of the Pharynx and Œsophagus. Removed from a lady æt. 50. Mr. BUTLIN. St. Bartholomew's Hospital Museum.

39. Epithelioma of the Œsophagus. Specimen showing an epitheliomatous stricture, with a Symonds' tube *in situ*. Mr. CHARTERS SYMONDS. Guy's Hospital Museum.

40. An Œsophageal Pouch, the size of a pigeon's egg, projecting from the anterior wall on a level with the bifurcation of the trachea.
Guy's Hospital Museum.

The thanks of the Society are due to the Curators and Museum Authorities of the respective Hospitals who have kindly lent the above Specimens for this occasion.

Section B. MICROSCOPICAL PREPARATIONS.

I. **Larynx.**

1. Section of Epithelioma of the Right Vocal Cord from a case of Thyrotomy; gentleman æt. 50. 'Proc. Laryng. Soc.,' vol. xii, p. 41. Sir FELIX SEMON.

A collection of nineteen other microscopical preparations (by Mr. S. G. Shattock), of malignant disease operated on by thyrotomy or partial extirpation by Sir Felix Semon, is also exhibited.

2. Section of Endothelioma of the Larynx in a Case of Tertiary Syphilis; woman æt. 50. 'Proc. Laryng. Soc.,' vol. xi. Dr. LAMBERT LACK.

3. Section of Sarcoma of Interior of Larynx and Thyroid Gland. 'Proc. Laryng. Soc.,' vol. vii. (Specimen shown.) Dr. DUNDAS GRANT.

4. Section of Soft Fibroma from the Aryepiglottic Fold; young woman æt. 17. 'Proc. Laryng. Soc.' vol. xii. (Specimen shown.) Dr. DUNDAS GRANT.

II. Nose and Accessory Cavities.

5. Section of Polypoid Growth of Septum showing Localised Psorospermosis. Also a description of the new organism "*Rhinosporidium Kinealyi*" by Prof. Minchin, and a drawing from life. 'Proc. Laryng. Soc.,' vol. x. Major F. O'KINEALY, I.M.S.

6. Section of Papilloma of the Septum from a specimen measuring six and a half inches in circumference. 'Proc. Laryng. Soc.,' vol. iv. Mr. LOGAN TURNER.

7. Section from a case of Rhino-scleroma; woman æt. 26. 'Proc. Laryng. Soc., vol. vii. Dr. DUNDAS GRANT.

(Drawings of other cases will be shown, kindly lent by Mr. Shattock, Royal College of Surgeons.)

8. Section of Bleeding Polypus of the Septum. Type of granuloma; a recrudescence after six weeks; woman æt. 38. 'Proc. Laryng. Soc.,' vol. xi. (Drawings shown.) Dr. SCANES SPICER.

9. Section of Bleeding Polypus of the Septum. Type of granuloma exhibiting fibromatous and cavernomatous development; woman æt. 33 (a coloured drawing also shown). 'Proc. Laryng. Soc.,' vol. x. Mr. HUNTER TOD.

10. Section of Bleeding Polypus of the Septum. Type of fibroma with marked endothelial proliferation; man æt. 29 (a coloured drawing shown). 'Laryng. Soc. of Lond.,' vol. iii. Dr. STCLAIR THOMSON.

11. Section of Bleeding Polypus of the Septum. Type of telangiectoma. 'Proc. Laryng. Soc.,' vol x.; (a drawing also shown.) Dr. A. BROWN KELLY.

12. Section of bilateral lymphoid tumour of Septum (lymphoid tissue rich in follicles) growing from close to the posterior choanæ; man æt. 19. 'Proc. Laryng. Soc.,' vol. v. Dr. PEGLER.

13. Section of Cystic Tumour depending from roof of Left Nasal Cavity; man æt. 29. 'Proc. Laryng. Soc.,' vol. ix (with drawing). Dr. PEGLER.

14. Section of large Fibroma of Nasal Septum which extended into the naso-pharynx and formed a rounded hollow in the base of the skull (drawing and specimen shown). 'Proc. Laryng. Soc.,' vol. iii. Mr. W. R. H. STEWART.

15. Section of Papillary Columnar-cell Carcinoma of nasal cavity removed by radical operation; man æt. 24. 'Proc. Laryng. Soc.,' vol. xi. Sir FELIX SEMON.

16. Section of œdematous Angeio-fibroma from the maxillary antrum occluding left nostril; woman æt. 60. 'Proc. Laryng. Soc.,' vol. xi. Dr. ADOLPH BRONNER.

17. Section of Granulomatous New Growth from the Antrum and Ethmoidal Cells. 'Proc. Laryng. Soc.,' vol. xi. Dr. SCANES SPICER.

18. Section of Endothelioma of the Antrum; man æt. 50. 'Proc. Laryng. Soc.,' vol. xi. Dr. LAMBERT LACK.

III. **Naso-pharynx.**

19. Section of Angeio-fibroma (of hard consistence) of naso-pharynx with additional attachments to the Ethmoidal and Antral Cavities. 'Proc. Laryng. Soc.,' vol. x (specimen shown). Dr. HERBERT TILLEY.

20. Section of Œdematous Angeio-fibroma (of soft consistence) of naso-pharynx and nasal cavities, attached to the Base of the Sphenoid. 'Proc. Laryng. Soc.,' vol. vii. Dr. PEGLER.

IV. **Pharynx.**

21. Section of Polypoid Growth of lymphoid character springing from the right supra-tonsillar fossa. 'Proc. Laryng Soc.,' vol. vi. (with coloured drawing). Mr. ARTHUR CHEATLE.

22. Section of Tonsil showing colonies of Actinomycosis, girl æt. 16. 'Proc. Laryng. Soc.,' vol. xii, p. 65. Mr. ARTHUR CHEATLE and Dr. EMERY.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

NINETY-SEVENTH ORDINARY MEETING, *April* 7, 1905.

CHARTERS J. SYMONDS, F.R.C.S., President, in the Chair.

PHILIP R. W. DE SANTI, F.R.C.S.
HENRY J. DAVIS, M.B., M.R.C.P. } Secretaries.

Present—30 members and 1 visitor.

The minutes of the preceding meeting were read and confirmed.

WILLIAM DOUGLAS HARMER, M.C.Cantab., F.R.C.S., London, was nominated for election at the next meeting.

The following cases, photographs, and specimens were then shown:

The PRESIDENT announced that Professor Onodi, of Buda-Pesth, had presented to the Society a number of valuable plates illustrating the anatomy of the frontal and other sinuses. Professor Onodi attended the Oxford meeting and exhibited these plates. He had written a letter specially thanking the Society for its courtesy. The drawings would be placed in the library, where they could be accessible to members. The Secretary had been requested by the Council to acknowledge the gift, conveying the best thanks of the Society to Professor Onodi.

The PRESIDENT, on behalf of the Secretaries, requested members to alter the shorthand reporter's notes as little as possible. In some instances the alterations were so extensive as to change the complexion of what had been said at the time, and even to alter the sequence of the debate. The editorial work was greatly increased on this account, and he would therefore request the members to confine their alterations to the verbal changes necessary to make the matter clear, and in all instances to return the numbered notes of the reporter.

TRAUMATIC (?) PERFORATION OF THE SEPTUM IN A BOY AGED SEVENTEEN.

Shown by Dr. H. J. DAVIS. The patient was engaged in the flour mills of a saccharine manufactory, and was working in a very dusty atmosphere. He first attended the West London Hospital two months ago for attacks of epistaxis. A perforation of the septal cartilage was plainly visible, and at its upper border there was a small blood-clot of recent formation. When this was disturbed hæmorrhage returned. The boy seemed in excellent health, but he stated that he was perpetually "scratching his nose, as it was always itching when he was at work." Ulceration had evidently resulted, with consequent perforation of the septum and hæmorrhage. He was advised to find other occupation, was treated with quinine and iron, ordered to sniff hydrogen peroxide into the nostrils, and to syringe the nose with a solution of tannic acid (gr. x, ad ℥j). The perforation was now in the process of repair, and had diminished considerably in size during treatment. He (Dr. Davis) would like to know if there was any possibility of the perforation closing, and whether members had ever seen a case where a similar perforation of the septum had become totally occluded.

Mr. ROBINSON, in answer to Dr. Davis' question, expressed the opinion that the perforation would never close up.

Dr. BALL also thought the perforation would not close up, but perhaps Dr. Davis meant would the edge heal?

Dr. DAVIS explained that he meant to ask whether it would completely close. It was now about half the size it was two months previously.

Dr. BALL said that such perforations were not uncommon, but his experience was that in some cases it was very difficult even to get the edges to heal; they would continue to form crusts month after month, and unless cauterisation and curetting were performed, they would not heal. He gathered that Dr. Davis attributed the condition to the boy's occupation. One would scarcely accept that idea unless one knew that people in that occupation were specially subject to the complaint, and he did not know whether that was the case. Probably dust had something to do with it, but others were exposed to the effects of dust. Had they not all seen erosions on one or other side of the septum, sometimes on both sides, and been unable to get them to heal? yet they went on for months or even years without perforating. He did not know exactly what happened when they perforated, but the process was rapid when it occurred.

Dr. WAGGETT thought the most important element in the treatment of that kind of case was to make the patient go to bed with a thick pair of woollen gloves on the hands in order to prevent the unconscious use of the finger-nails.

Dr. WESTMACOTT remarked that the perforation was over a spot in

the cartilaginous part of the septum where there was a poor blood supply (Zuckerkandel's area). If the artery passing over it became injured, ulceration occurred on the one side and necrosis followed sooner or later, leaving a perforation, circular, with regular border and limited to cartilage. Probably, as Dr. Davis suggested, dust caused crusts to form after the first hæmorrhage, and those being removed by the finger from time to time caused the perforation. He considered that the perforation was healed at the edges, with the exception of a small spot on the posterior lower edge, at which there was a little brown incrustation, and under which healing had perhaps not occurred. He thought the perforation was best left alone.

Dr. DUNDAS GRANT said it was not merely a dusty occupation which brought about the condition, but the character of the dust had some bearing on the point. The dust might be either a chemical irritant, such as the bichromates, or a mechanical one, such as irregular particles from breaking stones. But another necessary condition seemed to be a septum so shaped that there was a receptacle for the dust to lodge in. In the present patient there was a concavity in the left side of the septum in the innermost part of which the dust appeared to be caught. In cases in which a perforation of traumatic origin was not so evident there might be some loss of nutrition from probable thrombosis of the artery, which he believed was named after Kieselbach (?). There was then a wasting of the very thin tissue between the two layers of the mucous membrane followed by a tissue necrosis.

Dr. VINNACE suggested that the primary treatment in such a case should be directed towards the patient's general health. He believed the perforation was due to some constitutional cause; either it was tubercular, or due to some extreme debility brought on by a previous illness, such as typhoid, or one of the zymotic diseases. To him it was very unlikely that in a patient of anything like normal health the mere irritation of flour, aided by picking the nose, would cause a perforation through the septum. He had never seen such a case.

A PIECE OF BLUE CHALK HALF AN INCH IN LENGTH IMPACTED FOR THREE WEEKS IN THE RESPIRATORY PASSAGES OF A BOY AGED TEN.

Shown by Dr. H. J. DAVIS. Dyspnœa and bronchitis supervened. The chalk was eventually dislodged and swallowed during a laryngoscopic examination. It was subsequently passed *per rectum*. The boy was at school when the accident happened; "he was sucking at the chalk, when he was abruptly spoken to by the teacher, and it slipped into his throat. He could not bring it up or swallow it. He then began to cough and made a noise in breathing."

Dr. DAVIS said that he had been asked by Dr. Law whether he would not have expected to find some indications of the action of the digestive juices on the surface of the chalk. This point had, however, occurred to him also, and he had immersed the chalk into a test-tube containing saliva. Although the chalk had been exposed to the influence of the

juice for four days, yet no alteration in the surface was apparent, and the saliva was not even discoloured. He thought that the foreign body had lodged between the tongue and epiglottis, or in one of the fossæ, and that when the tongue was drawn out for laryngoscopy and a mirror inserted, the chalk was dislodged and had slipped down the gullet. The boy stated that he had swallowed it. His mothor gave him a dose of castor oil, and the chalk was passed intact through the bowel. From that time the symptoms of dyspnœa ceased.

A Case of Carcinoma of the Larynx.

Shown by Dr. Jobson Horne. The patient, a smith, aged fifty-eight, had experienced discomfort in the left half of the larynx since Christmas, 1904, and throat symptoms for some time previously. Syphilis was contracted some forty years ago. The left half of the larynx was involved; the right half appeared to be free. Dr. Horne said that he had definitely stated to the patient that the disease was cancer and could be removed by an operation. Dr. Horne trusted that no member would be prejudiced by that expression of opinion.

Mr. de Santi said the case was undoubtedly one of malignant disease, and he thought it was a fairly suitable case for the operation of extirpation in the hands of a competent surgeon. It must, however, be done by a man who was accustomed to do big operations, as it was by no means a niggling procedure.

The President said the case seemed to him to be largely epiglottic as a primary disease, extending down the ary-epiglottic fold. The right vocal cord and arytenoid seemed to him to be free from disease, sufficiently free and sufficiently far away to raise the question of the possibility of relieving that portion of the larynx in any operative interference. The glands were not extensively enlarged, but there was one on the left side. He agreed with Mr. de Santi that the man's prospects were much better with operation than without.

Dr. Dundas Grant said that the doubtful point seemed to be as to whether the disease had not extended to the side of the pharynx, and it seemed difficult to decide that merely by laryngoscopic examination. Possibly by palpation under an anæsthetic that might be made out. If that were so it would, of course, greatly alter the prognosis in reference to operation. On the other hand, the comparatively insignificant enlargement of the glands would suggest that it was rather approaching the intrinsic than the extrinsic form of cancer.

Sir Felix Semon thought that it was a case for suprahyoid pharyngotomy. The parts would be easily accessible, and should the disease prove to be more extensive than now appeared laryngoscopically, it would not interfere with the prospects of total laryngectomy.

The President asked whether Dr. Horne had examined the parts with the finger. He had not himself done so, but suggested that in this

way a fair estimate of the amount of the pharynx involved could be ascertained.

Dr. JOBSON HORNE, in reply, said he had not palpated the parts. He thanked those who had spoken for the opinions they had expressed, and which had coincided with his own and the operative measures he contemplated carrying out.

A CASE OF LINGUAL GROWTH IN A MAN AGED SIXTY.

Shown by Dr. KELSON. The patient complained of dryness in the throat and difficulty in swallowing of four months' duration. On examination, a rounded swelling was observed about the size of a cherry on the dorsum of the tongue in the region of the foramen cæcum; it felt elastic and was pedunculated. It was thought probably to be connected with the remains of the thyro-lingual duct. Opinions were requested as to its nature and treatment.

Dr. DAVIS considered it was a thyro-lingual cyst, and if pricked that it would probably collapse; if not it could be removed with a snare.

Mr. ROBINSON thought it looked rather solid. It had a pedicle, and its appearance suggested a relation to the little papillomatous growths seen in the supra-tonsillar fossa. It was growing from the margin of the foramen cæcum in relation with the lymphoid structures in the neighbourhood of the circumvallate papillæ.

Mr. DE SANTI remarked that the growth had a pedicle, and he believed that if ligatured and cut off it would be got rid of entirely.

The PRESIDENT suggested that perhaps Dr. Kelson would report on the case later, after operative procedures had been carried out. This Dr. Kelson agreed to do, and to exhibit the specimen.

CASE OF HIGH-ARCHED PALATE AND CROWDING OF TEETH DUE TO NASAL OBSTRUCTION, SHOWING THE FACTORS PRODUCING THE DEFORMITY.

Shown by Dr. LAMBERT LACK. The patient, a boy, aged twelve and a half, attended the London Hospital for nasal obstruction. He had had left-sided facial paralysis since two years of age. The mouth was drawn over to the right side, the tension of the tissues on the right side of the mouth was much greater than on the left. The eyes closed almost equally well; the right side of the face was normal.

The palate was seen to be highly arched, and the teeth on the right side were irregular. He was indebted to Mr. J. G. Turner for pointing out the exact deformities of the teeth, and for making the casts of the jaws which were now exhibited.

The right central incisor was rotated so that its posterior surface looked inwards; its axis also sloped inwards. The right lateral incisor was on a posterior plane to the central teeth; that is, it retained its fœtal position. The right canine was a temporary tooth, the permanent canine not having yet erupted. The arch on the left side was slightly flattened, owing to the loss of a second bicuspid, but not nearly so much so as on the right side, and the teeth were regular. The lower jaw showed the same deformity in less degree. On the sound side there was flattening of the dental arch from the canine back to the second molar (exclusive of the latter). On the other, the paralysed side, there was pushing in of the dental arch from the central incisor to the first molar (exclusive of the latter) due to the same cause as in the case of the maxillary dental arch of that side, *i.e.* loss of a bicuspid, which allowed tissue-tension to contract the arch (J. G. Turner).

Most observers were probably agreed that the nasal obstruction, and the consequent mouth-breathing, was the primary cause of this deformity of the jaws and teeth, but various views were held as to the factors by which these developmental irregularities were produced. He had always accepted the theory which ascribed the chief influence to the tension of the soft parts of the cheeks. These tissues were put on the stretch when the mouth was kept open, and caused a lateral flattening of the jaws, more especially of the upper jaw. The most common deformity—lateral approximation of the alveolar borders with high-arched palate and V-shaped alveolus—was exactly what one would expect to be produced by this lateral compression of the cheeks. This case went far to prove this view. On one side (the paralysed) the tissues of the cheeks were flaccid, and there was little or no deformity of the jaws; on the other side, the normal one, the tissues were tense and the deformity was well marked. The differences in the tension on the two sides was well shown in the photograph handed to the meeting, and might be tested by applying the finger to the corner of the boy's mouth. Of course, one case was insufficient to prove a theory, the more so that unilateral deformity was occasionally found; still, the coincidence, if it be one, was very striking.

Dr. Ball thought the case an extremely interesting one. He had never had much belief in the theory of the pressure of the cheek from the open month, though he, among others, had mentioned it. In the present case there was certainly a difference between the two sides, and here, at any rate, the pressure of the cheek on one side had an effect which was not seen on the other. Dr. Lack would no doubt admit that in the development of high palate and narrow alveolar arch, the pressure of the

cheek was not the only factor. Of course there were plenty of adenoid cases with open mouths which did not develop a high narrow arch, so that there was some other element, such as undue softness of bones. It was curious that this high and narrow arch was peculiar to a certain type of head and face, which in its turn was almost always associated with adenoids, and undoubtedly heredity played a great part in the production of the deformity.

Mr. Robinson thought it could scarcely be said that facial paralysis was present, therefore that could be dismissed from the case. If that were put out of court, would not a defective bite lead to that condition of jaw?

Mr. Westmacott thought the case illustrated very well the effect of even such a slight pressure as that induced by the muscles of the cheek on any alteration in the shape of the teeth and the conformation of the arch. There was certainly some change on that side. But what he was not satisfied about in the case, and in all others of so-called high-arched palate, was that there was any increase in the height of the arch. With Mr. Campion, a dentist in Manchester, he had examined many skulls and the models and mouths of a large number of children at the Children's Hospital, with a very ingenious instrument which Mr. Campion devised for measuring the height of the palate; and the result was that very little increase in the height was discovered. Apparently the two alveoli were pressed closely together, and there was no great increase in height. In all the cases in which he had taken measurements inside the nose he found that the floor of the nasal space was not higher than it would be in a normal case—*i. e.* that in the arching of the palate there was no corresponding convexity in the floor of the nose, that the floor was perfectly flat. Seven years ago he read a paper in which he tried to show that there was some arrest of development in the nasal septum, owing to intra-nasal pressure, with an arrest of blood-flow down the nasal septal arteries, and a corresponding venous and lymphatic congestion, and in the result the nasal septum, and more especially the vertical plate of the ethmoid, did not get sufficiently nourished to keep pace with the growth of the facial bones. However, in view of the later experiments, he had come more round to the theory that there was some actual pressure of the buccinators on the alveolar arch.

The President said he understood Dr. Lack to call special attention to the bulging of the alveolar margin towards the median line. If that was a point in the case, he would like to refer to an instance in a man with complete congenital atresia stenosis of both choanæ. The peculiarity of his mouth was, that both alveolar arches were enormously thickened, and were almost in contact in the middle line. There was merely a cleft with vertical sides running antero-posteriorly along the middle line. His own explanation at the time was, that it was due to the absence of any respiration through the nose; but the anterior part of the nose was fully developed, and was quite capacious, a point against this view. Possibly the case might help to support the view held by Dr. Lack.

Sir Felix Semon said he had seen and described a case of bilateral congenital stenosis of both nostrils. It was described many years ago, in the German edition of Morell Mackenzie's book, 1884, vol. ii. He was certain that in that case there was no abnormality of the palate.

Dr. Kelson remarked that if the irregularity was due to pressure on one side by the buccinator and not on the other, why was it that in the lower jaw the same irregularity was not seen? Of course the lower jaw

was more mobile than the upper, but it was held in position by powerful muscles, such as the masseters and pterygoids, and on the hypothesis which had been advanced one would expect irregularity in the lower jaw as well as in the upper.

Dr. LAMBERT LACK, in reply, said that there was deformity in the lower jaw, which Mr. Turner would be willing to describe. In answer to Dr. Ball, he thought the deformity of the upper jaw could not be expected unless nasal obstruction persisted for many years during childhood. He admitted there were a few inexplicable cases, like that quoted by Sir Felix Semon, in which complete nasal obstruction had given rise to no deformity of the jaw. Such cases were extremely rare, and the one related by the President was a much more typical case. In answer to Mr. Robinson he said there could be no possible doubt about the facial paralysis. The lower part of the face was chiefly affected. Dr. Lack was very interested in Mr. Westmacott's remarks. He considered that in many cases there was one reason for supposing the roof of the palate was raised, namely, its frequent association with deflection of the septum. This pointed to the fact that the floor of the nose was raised, so that there was no room for the vertical development of the septum. The facial paralysis dated from two years old.

Mr. J. G. TURNER (visitor) said the lower jaw showed flattening on the affected side from the region of the canine back to the second molar. On the other side there was an arch from the region of the first incisor to the second molar. On that side from the region of the canine it went straight back. That was produced by the same tension of constantly using the mouth, which flattened the maxilla. In the ordinary adenoid case the lower jaw, *pari passu* with the upper jaw, became flattened and moulded forward. One always looked for a deformity of the lower as well as upper jaw, and it made one think they both owned a common cause. The tension of the tissues in the mouth-breather seemed to be the one common cause. Another cause, as far as the upper jaw was concerned, he would take to be a more pronounced want of growth than was found in other parts of the body.

CASE OF BROADENING AND DISFIGUREMENT OF THE EXTERNAL NOSE CAUSED BY TENSE, BILATERAL, NON-VASCULAR SWELLINGS ATTACHED TO THE ANTERIOR THIRD OF THE CARTILAGINOUS SEPTUM. NASAL OBSTRUCTION COMPLETE.

Shown by Dr. L. F. PEGLER. The patient, a man aged fifty-seven, had been attending Dr. Pegler's clinic about three weeks and was at present taking potassium iodide with a view to the swellings being gummatous. No operation had yet been undertaken. The tension was already diminished and the swelling on the left side of the growths had subsided a little, but the great thickening of the external nasal walls was not so far affected by the iodide. The man denied syphilis, but a transverse cicatricial band along the junction of the hand with the soft palate, favoured this diagnosis.

Mr. ROBINSON thought it was an abscess of the septum of some dura-

tion, and that the insertion of a scalpel would let out pus. But the nose would not be so beautiful afterwards, as a depression would be left.

Dr. DUNDAS GRANT supported Dr. Pegler's idea that the swellings were gummata, which would subside under well-carried-out antisyphilitic treatment. Probably the man had been a little casual about it.

Dr. JOBSON HORNE said he gathered that there was a history of traumatism, and he would regard it as a hæmatoma which had not cleared up.

Mr. DE SANTI concluded that it was a bilateral hæmatoma. The general condition of the nose outside, the swelling, and so forth, was unlike a gummatous deposit. The appearance was much more suggestive of double suppurative hæmatoma, and he thought a scalpel should be put into each swelling and the case would then probably clear up. If it proved to be gummatous, the use of the scalpel would do no harm.

Dr. DAVIS said he also thought it was hæmatoma.

The PRESIDENT said the hæmatoma view was interesting, and he would like to elicit from those who mentioned it whether they meant that blood actually existed at present, or that it consisted of blood which had undergone some change. He was familiar with permanent thickening of the septum after injury, in which a hæmatoma left a permanent thickening of the character of a perichondritis.

Dr. PEGLER, in reply, said he had suspected the case to be syphilitic from the condition of the pharynx, to which perhaps he had not drawn sufficient attention. There was no history of an injury to favour a diagnosis of hæmatoma; on the other hand, the appearance recalled to his mind an extensive gummatous tumour of the septum of which he had shown sections to the Society in June, 1903. Photographs of this case had been taken, since which the effects of the iodide were very noticeable. The man gave no intelligible history of his condition, but said the swellings were considerably greater at one time than another. Dr. Pegler proposed to deal surgically with the case and report the result.

CASE OF OBSTINATE HEADACHE ACCOMPANIED BY CRUSTING AND MUCO-PUS FORMATION IN A MAN AGED FORTY IN WHICH THE MAXILLARY, SPHENOIDAL, AND FRONTAL SINUSES HAD BEEN EXPLORED WITHOUT TANGIBLE RESULTS; FOR DIAGNOSIS.

Shown by Dr. L. H. PEGLER. The man was an engine-tender who pursued his occupation in South Africa, but periodically visited his home in Sunderland, whence he had been sent to him by Dr. Rowstron.

On admission the walls of the naso- and oro-pharynx were crusted with sticky muco-pus which seemed to escape chiefly from the left sphenoidal opening and, to a less extent, from the right. The walls of both nasal cavities were smeared with the same adhesive material; the middle turbinals were spongy, red, and vascular, but there was no general atrophic condition of the mucosa nor fœtor. Persistent headache, causing insomnia, was complained of, chiefly at the root of the nose. After removal of the crusts the pharyngeal

mucosa was intensely red and beefy. Both middle turbinals were removed under chloroform soon after admission, and the stumps were now satisfactorily healed over. After this both sphenoidal sinuses were explored, the openings being easily reached, but with negative results. Later, Dr. Tilley, who kindly expressed a wish to see the case, confirmed this observation, and the sphenoidal sinuses were again explored and washed out. The right antrum was explored at the same time and two or three flakes of coagulated non-fœtid pus removed by the syringe. The left maxillary antrum was washed through by an alveolar opening but contained nothing; the frontal sinuses were easily entered by a sound from the nose, but no pus escaped. The case was still under treatment, but the headaches were so far but little relieved.

Dr. WAGGETT thought the work in the case was only just beginning. Dr. Pegler now had to gain access to some of the posterior ethmoidal cells, and on the left side the bulla ethmoidalis was suppurating. On the right side the posterior attachment of the middle turbinated was not yet completely removed, and there was pus coming from its neighbourhood. A couple of months' hard work yet remained to be done on the case.

Mr. WESTMACOTT thought it was the bulla that was seen on the right side. The middle turbinal seemed to have been removed. It would be interesting to have a bacteriological examination of the discharge. There seemed to be such a general affection of the whole of the nasal cavity that it hardly seemed to come from any particular sinus; it was apparently more of a general disease than the manifestation of a local empyema.

Sir FELIX SEMON thought it would be a pity if the discussion on that very interesting case were curtailed, because he was convinced that everything was not yet known about nasal suppuration. There were some cases in which, without any tangible lesion of any of the accessory cavities, there was a general tendency to the formation of crusts. He had, by chance, at present two such cases under his care, and he had been unable to find evidence of disease of any of the accessory cavities. For years, without the usual symptoms of accessory sinus disease, there had been a muco-purulent secretion in the naso-pharynx of a troublesome nature. He had not found out what was the real cause, but from a therapeutic point of view—and he was a great sceptic on therapeutics in such a connection—very decided effects were produced by applications of fluid vaseline by means of an atoniser, with a suitable receptacle, which he first saw in the practice of Dr. Goldstein at St. Louis. He had found it very useful to make daily applications to the interior of the nose similar to placing a liniment on an exterior surface, though he could not yet speak of a "cure."

Dr. HERBERT TILLEY said his experience of such cases as shown by Dr. Pegler was practically identical with that mentioned by Sir Felix Semon. He had the advantage of seeing the present case with Dr. Pegler some weeks ago, and on transillumination it was found that the right antrum was darker than the left. The right antrum was washed out, and what came away was not the ordinary purulent discharge which one

expected in an ordinary case of empyema, but purulent *débris*, which might have been pus at one time, but had since become disorganised and desiccated. The frontal sinuses were carefully explored, and both sphenoidal sinuses were washed out, the ethmoidal cells were likewise investigated, but he was bound to say that at the conclusion of the examination he was in doubt as to what was the causal condition underlying the symptoms. These cases were unlike the ordinary empyemata of the accessory cavities, in which one found liquid yellow pus, which reappeared shortly after it was removed from any one sinus opening. He was reminded by Dr. Pegler's case of one recently shown by Dr. Bennett, of Leicester, which exhibited an identical condition of things, but in which the whole inside of the nose was covered by a thin veneer of what looked more like dry muco-pus than pus, and the mucous membrane was in a thin red-glazed condition. He felt certain that no curetting of the ethmoidal cells or any radical operation upon this patient would produce a good result, and he thought some method of treating the mucous membrane rather than accessory cavities should be adopted.

Dr. StClair Thomson agreed with Dr. Pegler's diagnosis, viz. that he had eliminated all the accessory sinuses except the posterior ethmoidal cells. He saw the patient before the meeting, when pus was exuding from what must have been posterior ethmoidal cells. In those cases of purulent rhinitis where the pus did not come out of the large accessory cavities there was much difficulty. He sent a case for inspection to Dr. Tilley's clinique six months ago, in which he had located the posterior ethmoidal cells. That patient suffered so much from headache, as well as from the crusts, that he (Dr. Thomson) did his best to open up the cells. He confessed that though she was greatly relieved of her headaches, and though he had gone in as far as it was safe to go, she still had a great deal of the secretion. He thought the pictures of Dr. Onodi would show how large the posterior ethmoidal cells could be; some could be as large as the sphenoidal sinus, and would admit the end of his little finger. He gave Dr. Pegler credit for saying he had removed the middle turbinals, but he thought the muco-pus on the left was coming from a posterior ethmoidal cell.

Dr. Dundas Grant said an appliance had recently been published which might help the diagnosis, and perhaps also the treatment, of such cases. One wanted to relieve the patient of his uncomfortable symptoms and to ease his mind, as well as to radically open the sinus. The present patient did not seem to have an immense amount of discharge, and many people would not complain if their trouble was no greater than his appeared to be. The appliance he referred to was a suction apparatus invented by Dr. Sondermann. There was one form for use in the nose and another for the ear. It was like a miniature anæsthetist's face-piece, fitting over the nose, with pneumatic cushions to make it fit tightly. Attached to it was a compressible india-rubber bottle, which acted only in the direction of suction. When in position the patient uttered the sound *e*, which shut off the naso-pharynx by means of the soft palate. By the suction a little mucus might be drawn from the frontal or any of the ethmoidal sinuses, and relief given in that way. He had seen relief produced by that instrument where there seemed to be little more than a slight catarrh of the frontal sinus. In the present case the suction might help the diagnosis by bringing out the fluid and enabling one to judge where it came from. He had found it give relief in the ear when there seemed to be pus or muco-pus lying in the deeper accessory cavities of

the tympanum. He would be happy to bring the instrument to the next meeting, but Messrs. Meyer and Meltzer had procured it on his recommendation.

Dr. PEGLER said he was much obliged for the valuable opinions that had been offered in relation to this case. In reply to Mr. Waggett, he thought he had removed both middle turbinals sufficiently, but was aware that the anterior lip of the meatus (formed by the uncinate process) still projected a little on the right side. He, however, quite agreed with the suggestion to open the ethmoidal cells and carry the treatment further in that direction. He attached great importance to the point alluded to by Dr. Tilley, viz. the absence of fluidity and creaminess in the discharge, the sticky irritating character of which, as Dr. Tilley said, visibly affected the lining membrane everywhere, including the walls of the septum. This fact suggested relationship to those cases of crusting often associated with atrophic conditions, which had been a bone of contention amongst rhinologists, and which Grünwald maintained depended upon accessory sinus suppuration. The idea of a bacteriological examination of the material had occurred to him, but he did not hope for any tangible assistance towards treatment in this direction.

[The patient left the hospital the day after this consultation with view to returning to South Africa, as his leave of absence had expired but he hoped to come back later.]

SOFT FIBROMA ON LEFT VOCAL CORD.

Shown by Mr. H. BETHAM ROBINSON. The patient, a man aged sixty-five, came to St. Thomas's for stuffiness in the nose, and in a routine examination the tumour was detected on the vocal cord. He had no laryngeal symptoms except slight huskiness at times. On the left vocal cord, at the junction of its anterior with the middle thirds, was a small tumour the size of a split-pea, involving only the mucous and submucous layers: on phonation it fitted into a depression on the opposite cord. Its surface was rather vascular, from impact only, and there was no sign of any loss of tissue. It was an undoubted soft fibroma, but from the appearance on its surface it was just a question whether it should be considered an angiofibroma.

Dr. JOBSON HORNE said he had had the opportunity of seeing a precisely similar growth, and also of removing it and afterwards of observing it under the microscope. It did not contain much angiomatous tissue. He believed the present growth to be more fibrous than angiomatous.

Dr. STCLAIR THOMSON thought the word "angio" was unnecessary. Though such cases looked red and purplish in the mirror, when removed and placed under the microscope they were found to be vascular fibromata.

Mr. ROBINSON, in reply, said he thought it was only a soft fibroma.

ANGIOMA OF LARYNX.

Shown by the PRESIDENT. Mr. R—, aged thirty, consulted Mr. Symonds in November, 1904. He stated that he suffered from recur-

rent colds followed by hoarseness. With the present attack he had, for the first time, a sensation as of a lump in the larynx, and on the right side. Ten years before he had syphilis and to this the hoarseness had been attributed. He took iodide of potassium himself and got better. The appearance presented was that of a purple vascular, though hard, lobulated swelling on the right side. It overhung but did not seem to involve the cord. The ventricular band was lost in the swelling. The anterior end of the vocal cord was just visible on phonation and the movement was free. The appearances suggested the existence of a growth for some time—a growth not in any way syphilitic—and that, for the most part giving rise to no trouble, it swelled under the effect of a simple catarrh and gave rise to symptoms. Seen on several occasions, no material change was observed except that at times the cord was lost to view The voice returned to what he considered its normal condition and to what his friends recognised as natural to him, but the swelling remained unaltered.

The opinion he had formed of the case was that there had been an angioma in existence for some years—probably from birth and that the increased hoarseness and the recent sensation of swelling are due to aggravation of the catarrhal affection. At the present time (March 31st, 1905) the whole of the vocal cord can be seen; the movements are good. The growth was divided into two parts by a deep falcus, the lower division projected as a somewhat lobulated mass above the cord, and of a somewhat purple colour. The upper and smaller part is distinctly vascular and is at times blue as from enlarged veins.

Sir Felix Semon said he had now seen the patient three times, and he was certain the President's diagnosis of genuine angioma was correct. The tumour varied so much in size and appearance that nothing short of a real blood tumour could explain those variations. It was an extremely rare condition, and he did not remember having seen anything exactly like it. As it did not cause much trouble to the man he counselled leaving it alone for the present.

Dr. StClair Thomson said he would show the members some day a beautiful colour drawing (made by a lady artist) of an angioma in a patient who had been frequenting Golden Square, off and on, for between 20 and 30 years. The patient had been seen by Morel Mackenzie, and later by Dr. Walfenden, and Dr. Bond had also seen him. Others had made attempts to treat him by the galvano-cautery, but with unfortunate results. The man appeared to suffer from no hæmorrhage or trouble, except when he was treated! Though Mr. Symonds' case was not so typical, yet there was a blueish infiltration under the ventricular band which was characteristic.

Mr. Atwood Thorne asked whether the President would have a colour drawing made of the condition and publish it in the *Transactions*.

Dr. PEGLER said this exceedingly interesting case would seem from the appearance of the growth to be one of genuine capillary or cavernous angeioma of the larynx, such as Bland-Sutton described in his work on tumours as occurring, though very rarely, in that region. He remarked that he had no microscopical preparation in the Society's collection that corresponded to this; on the other hand, of "fibro-angeiomas" he had several. These were more or less related to the case Mr. Robinson was showing that day as a probable angeio-fibroma, and were actually granulomata with some dilated capillaries, and more or less admixture of fibrous tissue.

Dr. SPICER said his idea was that it was a venous telangiectasis, such as Dr. Pegler described, rather than angioma in the histological sense of that term.

The PRESIDENT, in reply, said he would be glad to have a drawing of the case made for the *Transactions*. He had intended doing so, but was in a difficulty as to the artist. He would ask Dr. StClair Thomson to advise him on this point. He was glad his diagnosis had been confirmed, as it would enable him to assure the patient he could safely undertake the journey round the world which he had projected.

SUBGLOTTIC HYPERPLASIA, PRODUCING TRACHEAL STENOSIS, PROBABLY OF SYPHILITIC ORIGIN.

Shown by Dr. HERBERT TILLEY. Patient was a female, aged thirty-one, who sought advice for difficulty in breathing, which became very marked if she hurried or exerted herself in any way. She stated that eight years ago she suffered from a bad attack of "laryngitis and bronchitis" which caused such difficulty in breathing that it was thought probable a tube would have to be inserted into the trachea. This was followed in a few days by a rash on the chest and limbs like measles. Shortly afterwards the bridge of the nose began to sink in, and some five or six months later she had another attack of difficulty in breathing, coupled with some pain in the nose and jaw, and accompanied by a temperature of 103°. Six years ago complete loss of voice ensued, and she went to reside in the South of England, where during a six months' stay the voice gradually returned. During this period she often coughed up "crusts and matter." Laryngoscopic examination revealed marked subglottic hyperplasia and imperfect mobility of the cords, the latter being much thickened. There was no crust formation nor signs of active ulceration. The patient had been taking iodide of potash and mercury internally for five weeks, and externally using mercurial inunctions, but up to the present without beneficial effects.

Mr. ROBINSON said he had a woman under care at the present time with subglottic hyperplasia, and she had tracheotomy done three months

ago, but it had not diminished the trouble. At the same time she had been under anti-syphilitic treatment.

Dr. HERBERT TILLEY explained that towards the end of the sitting the patient became more tolerant of examination, and several members had obtained a view of the larynx. He wished to ask members if they had ever found that the performance of tracheotomy, thus inducing rest of the larynx for, say, a couple of months, had had any effect in removing these subglottic hyperplastic conditions.

UNILATERAL RIGHT ABDUCTOR PARALYSIS ASSOCIATED WITH PARALYSES OF RIGHT HALF OF SOFT PALATE AND PHARYNX, RIGHT STERNO-MASTOID, UPPER FIBRES OF RIGHT TRAPEZIUS, PTOSES OF RIGHT UPPER EYELID AND CONTRACTED PUPIL.

Shown by Dr. TILLEY. Patient was a man of sixty-one, who sought advice for difficulty in swallowing and slight hoarseness. The symptoms developed some two months ago after an attack of "spasm of breathing" associated with temporary loss of consciousness, ascribed by his medical man to a "minor attack of epilepsy."

In addition to the above symptoms, largngoscopic examination revealed a large collection of saliva in the right pyriform sinus. A full-size œsophageal bougie could be passed quite easily into the stomach. Beneath the right mandible was a hard, well-defined swelling as large as a pigeon's egg, and situated in the position of the submaxillary gland. This swelling could easily be felt through the right floor of the mouth, and it was freely movable. Behind the right ascending ramus of jaw, between it and the anterior border of the sterno-mastoid and extending upwards to the base of the skull, a distinct but ill-defined thickening could be felt, and it was a question whether the lesions indicated were not due to some involvement of the nerve-trunks in this situation as they emerged from the base of the skull. There was no history of syphilis, neither were any clinical evidences of the disease to be found in other parts of the body:

Dr. DUNDAS GRANT said the case seemed to be of a complicated nature. It was difficult to see how the swelling in the submaxillary region could compress at the same time the sympathetic there and the pneumogastric at the part where the pharyngeal branch came off, because he took it that that was where the innervation of the half of the palate was derived. He thought the lesion which caused that hemi-paresis of the palate, as well as the paralysis of the left vocal cord, must be situated at a considerable height, perhaps close up to the foramen lacerum posterius. The relation of the growth in the neighbourhood of the submaxillary gland to the nervous lesion was very doubtful. He thought there must be some change close to the foramen to account for this, especially as the tumour behind the maxilla had apparently lasted many

years, whereas he believed the other lesion was not of very long duration.

Mr. Robinson thought that whatever the cause of the nerve lesion was one must put out of court the submaxillary swelling, as he did not think it had any relation to the other part. It suggested a mixed tumour of the submaxillary gland, or possibly an old calculus.

The President said he thought Dr. Tilley pointed out that above the old swelling, behind the jaw, there was another gland, and the question was whether that did not throw some light on the cause of the paralysis; there might be some primary growth at the base of the skull. The old swelling seemed to resemble a calcareous formation. Possibly it was some caseation followed by calcification in an old tuberculous mass.

Dr. Herbert Tilley, in reply, said he saw the case three weeks ago, and thought the gland under the jaw had nothing to do with the paralysis. There was distinct thickening behind the ramus of the jaw, which was possibly the cause of the lesions, and very likely of a syphilitic nature. He wished to ask Sir Felix Semon whether he had ever seen a case of this type—which was not very uncommon—benefited by any form of treatment.

Sir Felix Semon answered Dr. Tilley's question in the negative. Even in cases where there was a syphilitic history he had not seen improvement. He had not meant to speak to the case, but in reference to Dr. Dundas Grant's observation, he was strongly of opinion that its cause was peripheral, not central.

The President agreed with Sir Felix Semon's view, and hoped an opportunity would be afforded of seeing it later.

Case of Double Frontal Sinus Suppuration, in Young Man, cured by Radical Operation.

Shown by Mr. Waggett. There were two points of interest in the case. (1) The external operation enabled the operator to examine the right frontal sinus, the lower supra-orbital portion of which had been completely cured by syringing through the nasal route, carried out by the patient himself for some months. It was interesting to observe that the mucous membrane was thin, and perfectly healthy in appearance, although there was no doubt that some months previously large quantities of pus were daily washed out of this portion of the sinus by the use of the cannula. The upper mesial portion, partly separated from the rest of the sinus by an incomplete partition, remained in a state of suppuration owing to the presence of a pathological perforation (carious edges) of the septum between the two sinuses. This portion discharged into the left sinus. (2) On the left side a modified Killian's operation was performed, a considerable portion of the roof and inner wall of the orbit being removed, a bridge being left as usual. On the right side the orbital roof and inner wall were left, intact for the reason that the lower part of the sinus and the frontal ethmoidal

cells had already been successfully dealt with through the nasal route.

Now, five months after complete healing of the wound, there was no noticeable deformity upon either side; that is to say, the removal of the orbital wall had, at all events in this case, in no way affected the cosmetic result, which was equally good upon the two sides of the head. On both sides the inner angles of the stem wound were kept open for a fortnight, granulation taking place around small drainage-tubes, two directed upwards and one downwards on each side.

The PRESIDENT thought all would agree that it was a very satisfactory result.

PAPILLOMA OF THE LARYNX.

Shown by the PRESIDENT. A man, aged thirty-seven, came into Guy's Hospital for hoarseness of twelve months' duration. On examination, there was to be seen attached to the left vocal chord in its anterior part a lobulated purple movable swelling. Its upper surface was grey in patches, a condition probably due to injury during mobility, for the swelling moved freely in phonation. The movement of the left cord, though not quite so rapid as that of the right, was sufficiently so to practically exclude infiltration. The anterior attachment of the growth was difficult to see. He submitted it as an example of a simple papilloma of the left vocal cord.

Dr. DUNDAS GRANT said the most remarkable point about the case seemed to be the absence of symptoms arising from so considerable a growth.

A CASE SEVEN YEARS AFTER COMPLETE EXTIRPATION OF THE LARYNX.

Shown by the PRESIDENT. The patient, a lady, was now aged sixty-four. When she came under his care, a tracheotomy tube had been worn since the summer of 1895. There was complete laryngeal obstruction; the interior could be seen filled with a soft pale growth. The larynx was somewhat broadened; no glands could be felt. The larynx was removed in January, 1898. The trachea was attached to the skin just above the sternum, and the pharynx sutured. Glands were found under both lobes of the thyroid gland. The entire thyroid gland was removed, together with the lymphatics. The recovery was slow, owing to incomplete closure of the pharynx. The piece of growth removed before operation showed typical carcinoma. Traumatic myxœdema

occurred, but was relieved by thyroid extract and it was still necessary to take this remedy.

He attributed the absence of recurrence in the case to the free removal of the thyroid gland, and underlying glands and lymphatics.

The patient could make herself understood fairly well, and had been able to superintend the management of a hotel.

Note.—The tracheotomy referred to was performed by Sir Felix Semon in 1895, under whose care the patient was at that time. Sir Felix had been good enough to give him the early notes in writing, and permission to add them to this report, thus making the record complete.

The following are Sir Felix Semon's notes on the case:

"In compliance with my promise, I have looked up my notes of Mrs. G—. She was sent to me in June, 1895. I found great narrowing of the glottis, the left vocal cord was almost invisible, the right only slightly moved outwards. Both cords were swollen, and the rest of the larynx was congested and relaxed. In the narrow slit remaining between the cords a whitish projection was seen. More than this could not be made out.

"I was not certain about the nature of the whitish growth, and, whilst naturally thinking of malignancy, was doubtful on this point on account of the very long duration of the symptoms. She had suffered from aphonia for a period *of more than ten years*; there was no broadening of the larynx, and no enlargement of cervical lymphatic glands in the neck, nor was there any evidence of perichondritis. After the performance of tracheotomy, which was necessitated by the dyspnœa, I found on October 8 of the same year very considerable improvement generally and locally. The condition of the larynx had considerably changed, the front part of the vocal cords was better visible, and although they appeared to be somewhat adherent in front, and still much swollen and congested, the glottis opening was larger than it had been. It could then be seen that the anterior part of the cricoid cartilage was enormously swollen. I recommended continuation of her wearing the tube, and the administration of iodide of potassium from time to time."

The PRESIDENT said that Sir Felix Semon had found it necessary to perform tracheotomy one and a half years before he (Mr. Symonds) removed the larynx. That fact would indicate the severity of the obstruction. When he saw her there was a large growth filling the whole upper opening of the larynx, so that a large piece was easily removed for ex-

amination. He had the larynx, and would try to complete the case some day by showing it.

Sir FELIX SEMON heartily congratulated the President on the result; it was the most happy-looking case of total extirpation of the larynx he had ever seen.

Mr. ATWOOD THORNE asked whether it was not most unusual after such an operation for the voice to be as good as the present patient's, and wished to know if Mr. Symonds could in any way account for the excellent voice in this case.

The PRESIDENT replied that it was a question of practice on the part of the patient. It was seven years since the operation, and she managed the kitchen in a hotel. He also exhibited the case to show the effect of total removal of the thyroid gland. She had been kept well by thyroid extract.

Dr. STCLAIR THOMSON asked whether the patient was able to make exertions. It was said that those who had gone through that operation were handicapped, that they could not strain at stool, and that they could not earn their own living, especially when there were weights to lift, etc. The voice, in the present case, was the most remarkable he had himself heard after laryngectomy; and it would be important to know whether she could lead a free and vigorous life and keep free from tracheitis and bronchitis.

Dr. VINRACE asked for what disease the larynx was removed.

The PRESIDENT, in further reply, said he would inquire as to the points raised by Dr. StClair Thomson. She was an active woman, but was not called upon to make any great effort. The larynx was removed for extensive carcinoma, and there were secondary glands under both lobes of the thyroid gland. He had microscopical sections.

MAN AGED THIRTY-NINE WITH LATERAL ULCERATION OF THE LARYNX: HOARSENESS ABOUT TWO MONTHS.

Shown by Dr. DONELAN for diagnosis.

Dr. DAVIS was of opinion that the case was one of syphilis.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

NINETY-EIGHTH ORDINARY MEETING, *May* 5, 1905.

CHARTERS J. SYMONDS, F.R.C.S., President, in the Chair.

PHILIP R. W. DE SANTI, F.R.C.S.
HENRY J. DAVIS, M.B., M.R.C.P. } Secretaries.

Present—23 members and 3 visitors.

The minutes of the preceding meeting were read and confirmed.

ELECTION OF ORDINARY MEMBER.

The ballot was taken for—

WILLIAM DOUGLAS HARMER, F.R.C.S., M.C.Cantab.,

who was elected a Member of the Society.

The following cases, specimens, and apparatus were then shown:

A CASE OF ALMOST COMPLETE BONY OCCLUSION OF THE LEFT NOSTRIL, THE RESULT OF TRAUMA AND SEPTAL DEFORMITY IN A MAN AGED TWENTY-FIVE.

Shown by Dr. DONELAN.

Mr. WAGGETT thought it would be well to deal with the case by resection, making use of the chisel.

Dr. HERBERT TILLEY agreed with Mr. Waggett that it would be an admirable case for resection of the deviated septum. Dr. Donelan, during the speaker's inspection of the patient, suggested that difficulty would arise on account of adherence of the septum to the anterior end of the inferior turbinal by cicatricial adhesions originating from some former traumatism. But if one occluded the patient's right nostril he could blow down the left, and bubbles of mucus could be seen issuing from the whole length of the cleft between the deviation and the anterior end of the turbinal, and hence he thought it was probably only an apparent junction of the two. Even if there was a real adhesion it would still be an excellent case for resection of the deviation.

The PRESIDENT referred to a recent case of his own, in which there was real bony fusion between the septum and the outer wall, but the

appearances were different from those in the present case, which looked more like a simple deviation, with perhaps some adhesion, such as might result from the attrition of two mucous surfaces. In his own case he was obliged to saw through the attachment, and by submucous section to remove a considerable portion of the bony septum. But that scarcely applied to the case under present discussion.

Dr. DUNDAS GRANT said that although this was not an ideal case for submucous resection, yet he thought the operation feasible. Even if it did not eventuate in an ideal way, and a perforation resulted, the condition of the patient would be much better than at present. He recommended that procedure.

Dr. PEGLER said he had recently operated in private upon an extreme deviation in which the septal curvature was such that it created considerable external deformity by pushing outwards the superior lateral cartilage, causing the patient to seek advice on that account, quite disregarding the complete unilateral obstruction. If Dr. Donelan did not care to do a "fenster resection" in the present case, he assured him that if he tried a modified Moure's operation he would be very pleased with the result. By this means he had had an excellent result, both as regards the deformity and the obstruction, in the case to which he referred. If the incisions were made sufficiently freely above and below, ample room would be obtained for breathing, and even if an absolutely straight-looking septum were not obtained, the obstruction would be sufficiently cured and the nasal functions restored. Two incisions would suffice, though it might be advisable afterwards to shave off some of the redundant cartilage in order to reduce the convexity.

Dr. SCANES SPICER doubted if complete relief would be given in this case by submucous resection. He thought it would be necessary to operate with the saw and straighten, and of the two evils, incomplete relief or perforation, he would not bother much about the probability of perforation.

Dr. DONELAN, in reply, pointed out that he did not suggest that obstruction was complete, and in reply to Dr. Tilley he stated that the patient had been under chloroform, and considerable force had been used in endeavouring to separate the adhesions. He had attempted to force a flat director with a stout handle through the obstruction, but without success, and through an incision which he made he had examined with a probe, and altogether he thought the union must be bony. He thanked members for their suggestions.

LARYNGEAL CASE FOR DIAGNOSIS.

Shown by Mr. DE SANTI. The patient, a female aged fifty-six, came to Mr. de Santi's clinic complaining of cough, hoarseness, and pain in the throat of four months' duration. Examination revealed paralysis of the right vocal cord and thickening of the right crico-arytenoid joint; there was also some limitation of movement in the left vocal cord. There were no glands or swelling in the neck, no history of syphilis, nothing in the chest showing intra-thoracic pressure or disease of the lungs; there was evidence

of organic heart disease. The case was brought forward for diagnosis.

Dr. Scanes Spicer asked whether the thorax had been examined with X-rays. He had at present under treatment a case which appeared exactly similar, and in which the X-rays revealed a marked aneurysm. In another apparently similar case he could not find anything wrong with the chest. In the absence of pressure in the chest he should regard Mr. de Santi's as probably due to an intrinsic nerve condition.

Sir Felix Semon was not so sure whether there was paralysis or mechanical fixation. There was considerable thickening about the base of the right arytenoid cartilage. Possibly the immobility of the right vocal cord might be due to congenital ankylosis, or ankylosis acquired a long time ago, to which attention had been only directed by accident in consequence of some intercurrent acute laryngeal affection. The difference between the two arytenoids was very striking, and the mechanical possibility as the cause should be kept in view.

Dr. Dundas Grant recalled the attention of members to a case in which he was led into error—and, he thought, justifiable error—where the appearances were somewhat similar to those in the present one. The woman was about forty years of age, and had fixation of the right vocal cord. There was slightly more infiltration than in the present instance, and he was disposed to attribute it to syphlitic perichondritis. Mr. Symonds suggested at the time that an œsophageal bougie should be passed. When that was done some obstruction was found, and there was soon some sprouting in the pyriform fossa, the case eventuating as one of epithelioma. The appearances in this case when it was exhibited before the Society were somewhat similar to those in Mr. de Santi's, although there seemed more activity. There was, in the present case, a gland in the neighbourhood on that side, enlarged and hardened.

Dr. Jobson Horne thought the appearances in the larynx were sufficient to account for the fixation, although, as Sir Felix Semon had suggested, it might be of longer standing than was known. He gathered that there was a history of tuberculosis in the family, if not in the patient herself, and he thought that before taking any other view, a very thorough examination of the chest should be made, and a radiograph obtained, with the idea of excluding any pleural adhesions and enlarged glands which would account for the fixation of the cord.

Mr. Atwood Thorne remarked that no one had referred to the swelling on the left side, above the left vocal cord. He did not know what its exact nature was, but it suggested that the disease was intrinsic rather than extrinsic.

Dr. Robert Woods said the left vocal cord was distinctly limited with regard to its movement. And there was not much difference in the two sides. He believed the affection to be local, and not due to any intrathoracic involvement.

Mr. Barwell said the left vocal cord was not only swollen, but it showed the longitudinal groove which was sometimes described as cleft cord. He regarded the case as one of fixation rather than of paralysis, because of the local lesions in the larynx, and the base of the arytenoid was decidedly swollen. On phonation, the right arytenoid was not seen to be pushed away by the left. He regarded it as a case of ankylosis.

Mr. de Santi, in reply, said he had been interested in the various diagnoses advanced. The first time he saw the woman he noticed a con-

dition very similar to that mentioned by Dr. Woods on the opposite side. He observed this two or three times, and found subsequently that there was more movement on the left side. He believed there was still limitation there; he did not regard the case as malignant. In answer to Dr. Horne, he mentioned in describing the case that the chest had been carefully examined by a physician, but nothing had been found except some dilatation of the right ventricle and mitral regurgitation. There was nothing wrong with the lungs or sputum, though the latter was examined as a routine procedure, as the patient had a cough. He had seen three or four cases of paralysis of the same kind in which the diagnosis had been cleared up by the radiograph showing an aneurysm. He did not think much could be done for the patient, but he would watch the case.

Bleeding Polypus of Septum in a Boy aged nine.

Shown by Mr. Waggett. Each of the anterior nares was blocked by a growth resembling a raspberry in colour and appearance. Each lobulated growth was attached by a broad base to the septum, just within the muco-cutaneous boundary line, and posteriorly it shaded off into the normal mucous membrane. Bleeding was frequent. The growth on the right side was noticed two years ago, while the left nostril was believed to be quite clear a year ago. Some interstitial corneal opacity was to be seen. There was no evidence of past or present ulceration of the septum.

Dr. Pegler remarked that if this were a fibro-angioma (bleeding polypus) of the septum, it was in the youngest patient but one on record. The youngest previously was exhibited by Norval H. Pearce, who described two cases, one was a patient aged fifteen, and the other aged five. The growth seemed to be absolutely sessile, and he did not think one could decide positively as to its true nature until it had been removed and examined microscopically. Although it was lobulated on the surface, yet it did not appear to be very vascular. There was also a smaller growth on the opposite side, but a bilateral "bleeding polypus," or one making its way through the cartilage of the septum had not yet been described. The nearest approach to this was the case described by Verneuil, in which a pulsating erectile angioma appeared first on one side of the septum, then disappeared, an exactly similar one appearing on the opposite side. There were true angiomata elsewhere on the patient's body, including the palate, as in Dr. Lack's case.

Dr. Dundas Grant thought there were grounds for suspecting it to be tuberculous.

Mr. de Santi asked whether Mr. Waggett had found any evidence of perforation in the septum, and whether the condition seen might not be excessive granulation tissue in connection with perforation through the septum. That might go with the history of interstitial keratitis and congenital syphilis, but as Mr. Waggett had examined the case thoroughly he could inform them as to that point.

Dr. Woods said he had operated upon two cases which, clinically, were similar in appearance to the present one. They both turned out to

be tuberculosis of the septum. There was no tubercle anywhere else in the body.

Dr. JOBSON HORNE thought the growth was absolutely innocent. He had seen a good many such growths, and had occasion to examine them, and to follow out the subsequent history. In the majority of cases they were thought to be sarcoma, but they generally proved to be innocent growths, and after they were thoroughly removed nothing further was heard of them. With regard to the diagnosis of tubercle in those cases, it was as well to resort to animal experiment; the histological structure was at times misleading. After the removal of the growth, a portion might be reserved for the inoculation of a guinea-pig, and the remainder placed in a preservative fluid for microscopic examination. He asked Dr. Woods whether, in his cases, the diagnosis of tubercle was made on the presence of bacilli, or merely upon the presence of giant-cells, because the latter were not in themselves conclusive evidence of tubercle.

Dr. WOODS, in reply to Dr. Horne, said the diagnosis in his cases was made from the general microscopic appearance. Tubercle bacilli were not found.

Dr. PEGLER said further that he joined with those members who were inclined to regard the case as one of lupus of the septum.

Mr. WAGGETT, in reply, thought the history was against it being tubercle or lupus. It had been stationary on the right side for two years, while it had been present on the left side one year. He thought it was an ordinary vascular soft fibroma, which had very likely pierced the septum. There was no perforation, and the upper inner edge of the growths shaded off into the mucous membrane. He would report the progress of the case later.

ATOMIZER FOR SPRAYING MEDICATED FLUID VASELINE.

Sir FELIX SEMON showed an atomizer for the application of fluid vaseline to the mucous membranes of the upper respiratory tract. The application consists in the interpolation of a cylindrical nickel-plated metal tube, about 1½ inches in height and a little more than 2 inches in diameter, with a removable lid, into the air-conducting tube of a De Vilbiss atomizer. After screwing off the lid a small quantity of vaseline is put into the tube, which may be medicated by the addition of thymol, cinnamic aldehyde, etc., dissolved in paroleine or adepsine. The lid is screwed on again, and the tube heated over an ordinary spirit lamp until the vaseline becomes fluid, when the solution may be sprayed on to the mucous membranes in the ordinary way by a hand-ball, or from a compressed air cylinder. The parts are thus covered with a thin film of medicated fluid vaseline, which is very effectual in preventing the formation of crusts in atrophic conditions of the mucous membrane and gives the patient considerable relief. As to the curative effects of this application, the demonstrator did not wish to express as yet any opinion.

Dr. DONELAN thought the apparatus would be greatly improved if it had a pistol handle, as it seemed difficult to hold it when it was hot.

A NEW INHALER DESIGNED BY DR. HERYNG, OF WARSAW.

Exhibited by Dr. PINKUS. Dr. Pinkus, in the absence of Dr. Heryng, gave an interesting demonstration on the principles and working of a new inhaler, which he claimed was capable of spraying medicated vapours, in which the molecules were reduced to such a minute state of subdivision that, when inhaled, the drugs or ingredients employed penetrated into the smallest interstices of the lung.

He exhibited drawings of the lung of a cat, in which *post-mortem* section, after only thirty inspirations, showed staining of the entire lung from apex to base.

The ingredient employed in the inhaler for the experiment had been a solution of methylene blue, 1 in 1000.

THE PRESIDENT thought the members would accord a vote of thanks to Dr. Pinkus for exhibiting the apparatus at great trouble to himself. It seemed to fulfil all the conditions claimed for it.

Dr. PINKUS (Warsaw) explained that the spray really represented a mixture of fully saturated and partially over-saturated vapours or atomised fluid. They were bubbles containing terebene, or turpentine, or thymol, or creasote. There was full saturation with different localised points of condensation, represented by droplets of $\frac{1}{200}$ mm. in diameter. Such a fine spray, no doubt, penetrated into the lungs. He exhibited drawings of the lung of a cat which was killed immediately after 30 inhalations of a solution of methylene blue 1 in 1000. On dissection the lung showed staining commencing at the apex. Sodium iodide inhaled in that way would appear in the urine fifteen minutes later, whereas if taken by the mouth it would not be found in the urine in less than two or three hours. On the other hand, its appearance in the urine lasted much longer—some twenty hours. Dr. Heryng would come over in the winter and speak on the matter himself. When pyramidon, 1 gramme, was inhaled, the patient's temperature being 39° R., it fell to 37·5°, and remained so for sixteen hours. Administration by the mouth lowered the temperature only by $\frac{1}{2}$° for a shorter time. He regretted that he had not been able to demonstrate another apparatus for a cold spray, which was similar to a Richardson's atomiser, with a pear-shaped bulb.

A CASE OF ATROPHIC RHINITIS AND PHARYNGITIS WITH VISIBLE PULSATION OF THE CAROTIDS IN A MAN AGED THIRTY-SIX.

Shown by Dr. DONELAN.

Case of Angioma of the Palate.

Shown by Dr. Lambert Lack. The patient was a girl aged twenty-one. For about a year she had noticed a red discoloured patch on the soft palate; this had gradually increased in size during the last two months. For the last three weeks it had bled frequently. The slightest touch, even the passage of food, brought on the bleeding, and the patient complained that all her food tasted of blood.

On examination, a swelling about the circumference of a shilling was seen on the left side of the soft palate, extending outwards almost to the cheek, and upwards to the hard palate. It was soft and but slightly raised, the surface was covered with dilated venules which bled readily when touched. At one part near the lower edge the surface seemed slightly harder and inclined to be papillary.

The case was considered to be one of angioma. It had been suggested that because of its rapid growth, it might have undergone a malignant transformation, and might prove to be a sarcoma.

The case was shown on account of its rarity, and to elicit opinions as to diagnosis and treatment.

The President remarked that, from the history, it did not appear to be congenital. He thought the question was rather whether it was sarcoma, and what method of treatment would be best.

Mr. de Santi thought, from the appearance of the swelling and its history—though such cases were very rare—that it had a sarcomatous element in it. The case should not be left, but should be subjected to some form of treatment. He did not see why, under ordinary care, a piece should not be cut out and subjected to microscopical examination. Of course, it would bleed freely, but with adrenalin and the usual appliances for checking hæmorrhage, such as Paquelin's cautery, it was justifiable to remove a piece and deal with the disease accordingly. Sections could be cut at the time of the operation, and then the operation proceeded with. He thought it should not be left, as there was rapid growth, and the age of the patient and the appearance of the tumour were very suggestive of malignant disease.

Mr. Waggett thought the diagnosis of sarcoma made from inspection of hastily prepared microscopical specimens in the operating theatre was not very reliable. He thought it would be unwise to cut out a portion for diagnostic purposes, but considered it would be better to remove the whole growth by an operation, planned on a liberal scale.

The President said he at first thought, from the description, that it was congenital, but obviously it was not. Nævi in that position did give trouble, but the operation was not insuperable. He was struck with its great solidity, and agreed it would be best to excise it. He did not think very much hæmorrhage would result if one kept free from the tissue itself. That was the great principle in operating upon nævi. The hæmorrhage was very small if one kept well beyond the disease. He

thought that the tumour could be excised with very little risk indeed. The bleeding on handling was chiefly from the surface; it was probably a papillomatous growth, which might have a sarcomatous basis.

Case of Pharyngeal Diverticulum opening into the Pyriform Fossa in a Woman aged fifty-one.

Shown by Dr. Dundas Grant. The patient was a sparely built woman of small stature, aged fifty-one, who for about a year had been conscious of a slight difficulty in swallowing. On examination, the right pyriform fossa was seen to be filled with a frothy fluid; the larynx was otherwise normal. An œsophageal bougie passed without any difficulty. At first, suspicions were entertained that it might be a case of commencing epithelioma in the pyriform fossa, but after careful mopping no signs of epithelial sprouting were found. To the right side of the thyroid cartilage was an elongated swelling resembling a mass of enlarged lymphatic glands lying on the carotid artery from which it received a communicated pulsation. When this swelling was compressed the fluid in the pyriform fossa exuded in increased quantity. On inquiry, it was elicited that small particles of food returned at intervals of several hours after swallowing, and the condition was then believed to be a diverticulum of the pharynx. Attempts were made to introduce a curved probe into the cavity, but without success. Röntgen ray photographs were taken by Dr. Mackenzie Davidson before and after the swallowing of bismuth by the patient; in the latter the bismuth emulsion was seen to collect like ink at the level of the swelling, and in the subsequent photograph there could be seen an elongated area of opacity in the same region, which was not visible in the previous one, and which could only be accounted for by the bismuth (opaque to the Röntgen rays) having collected in the sac. This appeared to confirm the diagnosis, and it was proposed to remove the sac by an external operation.

Mr. de Santi said he thought there seemed to be a swelling on the other side and that it was a bilateral swelling, larger on the right than on the left side. Did Dr. Grant think the swelling on the left side something separate?

Mr. Waggett asked whether Dr. Grant thought he could get a more complete knowledge of its anatomy by means of the short Killian's tube.

Dr. Dundas Grant, in reply, said he had tried to insert a bent probe into the orifice, but had not succeeded with such force as he felt justified in using without damaging the tissues. He did not think anything remained but removal. The patient said she could not get any "satisfactory" food down; she could only take milk and slops, and very soft

solids; she could not eat meat with any comfort. He could not say she was wasting to any extent, but she was suffering.

Case of Left Facial Paralysis (one week); Ulceration of Oro- and Naso-Pharynx (five weeks) in a Man aged forty-seven.

Shown by Dr. H. J. Davis. The patient attended the West London Hospital two days before the meeting complaining of a sore throat and inability to close the left eye. He stated that the throat had been sore for about five weeks, but that the trouble in the eye had only originated seven days ago. "It did not inconvenience him much, but, as he was a football referee, he found it difficult to blow his whistle properly," and this impeded him in the exercise of his duties on the field. He thought, but was not sure, that the face trouble came on very gradually after a night journey to Plymouth. There was complete facial palsy on the left side, and tears were running down the cheek, but the muscles still responded to faradism, though feebly. There was also well-marked ulceration at the back of the pharynx, more plainly visible when the palate was raised. Examination by the finger detected extension of the ulceration high up into the naso-pharynx chiefly on the right side; no glands were found enlarged, and there was a vague history of specific disease about twenty-five years ago. There was no nasal disease. He (Dr. Davis) thought that the ulceration was undoubtedly specific; that the facial paralysis was a true Bell's palsy, and the association of the two diseases in this patient a mere coincidence. But he would like the opinions of members on the case, which he thought a very interesting one.

Dr. H. J. Davis explained that he showed the case to ascertain whether members thought the facial paralysis was specific, or whether it was simply a coincidence in the case. The only reason that he had for thinking that it was not a pure facial palsy was that the onset was gradual. As a rule, peripheral neuritis due to cold came on abruptly. The patient stated that the lower eyelid gradually drooped, and that he could not breathe properly through the left nostril unless he drew his cheek to one side, and this was evidently due to paralysis and collapse of the muscles around the nostril as a result of the palsy. He believed it to be purely Bell's palsy, associated with a gumma of the palate; but he could not state that there was not some pressure in the bony canal where the facial nerve emerged. At the hospital there was difference of opinion as to the condition and the proper treatment to adopt, and he would like the opinion of members as to diagnosis.

Sir Felix Semon though no one could answer the question which Dr. Davis desired, but considering that gummata were so frequently multiple, he thought before believing in a mere coincidence, which was one of the

well-known refuges, he would give iodide of potassium and mercurial inunctions, and see what the result would be. The palsy also might be the better thereby. He himself considered it more likely that the paralysis was of syphilitic origin.

Dr. DUNDAS GRANT asked if there was any defect of taste, and on being answered by Dr. Davis in the negative, said that it looked as if the cause were peripheral rather than in the part of the facial nerve above its junction with the chorda tympani, and below where the great superficial petrosal came off. He suggested it would be more helpful for diagnosis to avoid for a time giving antisyphilitic remedies, as Bell's paralysis sometimes passed off quickly; there was a so-called "rheumatic" facial paralysis which resulted from exposure to cold, and was sometimes very rapid in its departure. He only mentioned that in regard to diagnosis, as, of course, in the patient's interest, iodide of potassium was required.

Dr. DAVIS, in reply, said he believed that the lesion could not be above the nucleus, because, if so, only the lower part of the face would be affected. The orbicularis was evidently paralysed, and the patient could not raise or depress his eyebrows. If the lesion were in the cortex, or in the nuclear fibres, the lower part of the face would only be affected, and the upper part would escape, but this was not the case. The paresis certainly involved the whole trunk of the nerve, and, therefore, he thought it must be of peripheral origin, and very unlikely, therefore, to be due to tertiary syphilis.

CASE OF EXCAVATED ULCER OF THE PHARYNX PRESENTING THE PUNCHED-OUT APPEARANCE OF A TERTIARY LESION, BUT WITH A DEGREE OF INDURATION CHARACTERISTIC OF EPITHELIOMA, IN A MALE SUBJECT AGED SIXTY.

Shown by Dr. DUNDAS GRANT. The disease was of three months' duration, and there was remarkable absence of pain or of enlargement of lymphatic glands.

Dr. DUNDAS GRANT remarked that it looked like syphilis, and felt like carcinoma.

Sir FELIX SEMON said he would go further and say it did not look like syphilis. Although the ulcer itself looked very clean, as if it were a broken-down gumma, he thought the margins of it, particularly in its lower aspect, were much too big for a mere syphilitic ulcer. There was distinct new growth in this; it was not merely ulcer. Surely it was a case in which removal of a small piece for microscopical examination would be justified.

The PRESIDENT said he took the opportunity of feeling the growth, and it had all the characters of malignancy, especially in its lower part.

Mr. DE SANTI said the growth looked malignant, and was so; probably there were some enlarged retro-pharyngeal glands, which could not be felt. Of course it was inoperable.

Dr. DUNDAS GRANT, in reply, said his own opinion was that it was malignant, but in view of the possibility of doubt he had given iodide of potassium and mercury. He only saw the patient on the preceding day, and therefore had no opportunity of observing the course of the complaint.

Subacute Osteomyelitis of Frontal Bone with Empyema of Right Frontal Sinus.

Dr. Scanes Spicer showed Henry W. H—, aged thirty-five, a shop-assistant, who had been referred to him at St. Mary's Hospital on January 10, 1905, by Dr. Campbell Pope for empyema of frontal sinus.

The patient first noticed aching over the right eyebrow and swelling of the eyelid on January 6. The next day the pain became a severe neuralgia, the eyelid œdematous and closed over the right eye, which was painful and injected.

This was the condition on January 10, when there was much thickening and tenderness of the supra-orbital ridge and the frontal bone above and below. It conveyed the impression of a greatly distended frontal sinus reaching well to the outer margin of the orbit. On transillumination there was intense blackness of the whole brow when the lamp was placed under inner edge of orbit, as compared with the opposite side. There was no discharge whatever from the nose, but the middle turbinated was enlarged and red, and no probe could be insinuated into the infundibulum. The temperature was normal. The provisional diagnosis was retention of fluid in a distended frontal sinus, with inflammation of the frontal bone supervening. Owing to the brief duration of symptoms it was regarded as an acute inflammatory condition, and ice-bags were applied to the forehead, and hot alkaline nasal washes, and mentholised steam inhalations ordered, a purge of calomel and colocynth and potassium iodide. After four days the condition remaining unchanged, the front end of the middle turbinated was amputated, two polypi were found in subjacent ethmoidal cells. An attempt was made to probe the frontal sinus without success; the same treatment was continued.

After another week with no alteration, it was decided to explore the sinus from the outside. On the removal of the crown of bone, at the junction of the supra-orbital ridge with the median line, red cancellous tissue was seen filled with marrow-like substance. The cells were lined with thin white delicate membrane, and exuded sanguineous fluid. Quite an inch of this was gone through before reaching a small cavity downwards and inwards, the size of a small almond, filled with glairy yellow pus. On enlarging the passage from frontal sinus into nose, small polypoid-looking masses were brought away. The same red cancellous

tissue with no trace of pus extended outwards over the orbital plate and was freely curetted away. The operation was completed in the usual way, and uninterrupted recovery ensued.

The points of interest appeared to be the extensive affection of the frontal bone, and the small size of the cavity representing the frontal sinus, in spite of the very marked and extensive opacity on transillumination and the absence of nasal discharge. Syphilis was denied, but there had been tonsillar and pharyngeal trouble in the past, and chronic eczema, which did not present specific characters. No evidence of tuberculosis. The term "osteomyelitis" is applied to the case because the inflammation of the marrow of the cancellous tissue appeared to be the most prominent feature, though there was also periostitis and osteitis of the outer table, as well as an empyema of the small frontal sinus.

Dr. JOBSON HORNE asked whether any examination of the material removed had been carried out, with the view of ascertaining the nature of the disease.

Mr. CHICHELE NOURSE asked whether there was any traumatism. Two years ago he operated upon a case of chronic frontal sinusitis, in which he noticed beforehand that there was considerable bulging of the bone over the site of the sinus. During the operation he found that it was due to the thickening of the bone, which was reddened and softened over the frontal sinus, but this was not so marked as in Dr. Spicer's case. The disease had come on slowly, and the degree of osteitis was not advanced.

The PRESIDENT said it was a rare case, and it led him to a case he was called upon to handle three or four years ago at Guy's Hospital. A man came with signs of cerebral abscess, but he had never been operated upon. There was a purulent discharge from the nose and osteomyelitis of the whole frontal bone, extending back and involving the temporal bone. On removing the bone a quantity of pus was found lying over the dura mater. The patient practically died from encephalitis. Dr. Scanes Spicer had his case in an early stage and removed the disease. In support of that gentleman's view, he had found in operating on the mastoid of little children aged fourteen months a distinct osteomyelitis, while the mastoid antrum was quite healthy, and there was softening of the bone for some distance backwards, covering over the lateral sinus.

Dr. H. J. DAVIS asked whether the osteomyelitis extended beyond the cavity, or whether it was simply limited to the shell of bone surrounding the frontal sinus.

Dr. SCANES SPICER, in reply, said on lifting the crown of bone of the external table there was spongy cancellous tissue, softer than natural, and the pulp of which was unduly red and engorged with sanguineous serum, a greyish-white membrane lining. The bony cells could be distinguished. One inch of such material was encountered before coming to what he considered the frontal sinus itself, which was the size of a small almond, and filled with pus. He thought the osteomyelitis might have started from the retained frontal sinus empyema.

The PRESIDENT said it might have represented the stage when

suppuration was extending through the bone and was about to perforate in front.

Dr. DUNDAS GRANT suggested that the term osteitis would more correctly describe the condition, as there was no constitutional disturbance such as was present in osteomyelitis. Dr. Spicer said that the lining of the cavity, when he opened it, was perfectly smooth. It was an unusual case, though apparently of longer duration than the three days mentioned in the description.

Dr. SCANES SPICER, in further reply, agreed that possibly osteitis might be a better term than osteomyelitis, because the outer table was involved as well as the cancellous tissue, but the most striking feature of the case was the inflammatory condition of the marrow of the diploë.

[Mr. MAYNARD SMITH, Surgical Registrar to St. Mary's Hospital, has since reported that the material removed from the frontal sinus itself was of myxomatous nature, and similar in every way to the usual structure of the polypi removed in accessory sinus disease. The material removed from the enlarged cancellous spaces in the diploë of the frontal bone, above the frontal sinus, had the naked-eye appearance of granulation tissue. The microscopical examination showed the presence of granulation tissue. No pus was present. No tubercles were present. There were no signs of caseation. Bacteriological examination was not made. He looked upon the condition as one of sub-acute septic osteomyelitis.]

A CASE OF TOTAL EXTIRPATION OF THE LARYNX IN A MAN.

Shown by the PRESIDENT.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

NINETY-NINTH ORDINARY MEETING, *June* 2, 1905.

CHARTERS J. SYMONDS, F.R.C.S., President, in the Chair.

PHILIP R. W. DE SANTI, F.R.C.S.
HENRY J. DAVIS, M.B., M.R.C.P. } Secretaries.

Present—21 members and 2 visitors.

The minutes of the preceding meeting were read and confirmed.

NOMINATION OF ORDINARY MEMBER.

ERNEST PLAYFAIR, M.B., M.R.C.P.Lond., was nominated for election at the next meeting.

The following specimens and cases were shown:

CASE OF NASAL TUBERCULOSIS.

Shown by Mr. H. BARWELL. The patient was a woman, aged twenty-nine and unmarried. She came under Mr. Barwell's care in March, 1905, with signs of phthisis in an early stage. There was an ulcer of characteristic tuberculous appearance on the left anterior part of the septum, with pale "speckly" base, ill-defined edges, and an irregular mass of sprouting granulations; there was occasional slight bleeding from the nose but no pain. A piece removed for examination showed typical giant cells. She did not attend regularly, and by May 18 a smaller ulcer had appeared on the outer wall, as well as a soft granular patch on the left middle turbinal, which bled readily when probed. These cases were rare and not uncommonly primary in the nose. The usual position of the ulcer on the front of the septum pointed to direct infection, with the finger as the cause.

Mr. Barwell said he specially desired the opinions of members on the prognosis of the case. He regarded it as favourable under suitable treatment.

Dr. H. Smurthwaite said he had a case of tuberculosis of the nasal septum, and showed the specimen before the Society a year ago. The septum was perforated, and there had been stenosis for three years. The patient had then no symptom of lung trouble, but he had heard a month ago that she was dying of acute phthisis. Earlier in the case the sputum was examined, with negative results. In reply to the President, he said the nasal condition progressed. He thoroughly scraped it, and reported on the condition at the time.

The President said he supposed the prognosis in the present case would be modified by the presence or absence of phthisis at the moment. In his own cases of tuberculosis of the nasal septum and of the inferior turbinal, the only parts of the nose in which he had seen tuberculosis as a primary affection, the patients had done well and healed. But in the presence of active phthisis the prognosis would not be good.

Mr. Barwell, in reply, said the patient had phthisis now, but only in an early stage, and the physicians regarded it as a suitable case for open-air treatment. He thought many of the cases of nasal tuberculosis were primary. Some years ago Francis Steward collected 100 cases, of which some 58 were found to be primary. Many, he thought, were confused with lupus. In a primary case it was difficult to differentiate lupus in the nose from tuberculosis. Lupus cases might be expected to do well, but the tuberculosis cases were less favourable.

Case of Lupus of the Larynx and Uvula.

Shown by Mr. Barwell. The patient, a girl aged fifteen, came under Mr. Barwell's care last March. She had suffered from hoarseness for six or seven months; there was no aphonia and no pain. The disease was, as usual, most marked on the epiglottis, and extended along the right aryteno-epiglottidean fold; the cords were extensively infiltrated and showed ulceration. The uvula was also affected. He proposed to treat the case with frictions of lactic acid and formalin and excision of part of the epiglottis should this be necessary.

Case of Curious Multiple Growths in the Epiglottic Region in a Man, aged forty-three.

Shown by Dr. G. C. Cathcart for diagnosis.

Dr. H. J. Davis said that he regarded them as growths or hypertrophies from the lingual tonsil. He had examined them with his finger, and he thought that they were undoubtedly connected with the lingual tonsils.

Mr. Atwood Thorne said he agreed with Dr. Davis, and suggested that the growths should be removed and examined.

Dr. Scanes Spicer asked if the opinion of Dr. Davis and Dr. Atwood Thorne were correct, what the central mass was, as there was no tonsil substance in the median line.

The PRESIDENT said he had not been able to obtain a good view of the larynx, largely on account of the condition of the mirror. The case had previously been shown, in January, 1892, and this was important.

A CASE OF NEW GROWTH IN THE RIGHT MAXILLARY ANTRUM IN A BOY, AGED TEN.

Shown by Dr. CATHCART.

Mr. BARWELL remarked that there seemed to be no expansion of the antrum in any direction, except on the facial surface; it did not expand into the nose, nor press down the palate, nor expand upwards into the orbit. The notes did not indicate that it extended back into the naso-pharynx. Those points were against malignant disease of the antrum. It was very hard and firm, and was probably a tumour connected with one of the teeth—a dentigerous cyst, or an odontome in the upper jaw.

The PRESIDENT pointed out that the eye was somewhat raised, but the condition seemed more like bony growths or, as Dr. Barwell suggested, a dentigerous cyst. The question could only be settled by opening the tumour up, which, he considered, would be the best course to adopt.

SLIDES FROM A CASE OF MALIGNANT DISEASE OF THE PHARYNGO-LARYNX.

Shown by Mr. P. DE SANTI. The patient, a woman, had been shown at previous meetings.

The PRESIDENT said the slides certainly showed the disease to be carcinoma.

A SPECIMEN OF A LINGUAL GROWTH.

Shown by Dr. W. H. KELSON. The growth was removed from a man shown at the April meeting; it was the size of a cherry, pedunculated, and proved to be a fibroma.

CASE OF FAUCIAL ERUPTION.

Shown by Dr. W. H. KELSON. A woman, aged forty-seven, with eruption on the fauces, consisting of whitish patches on a red inflamed base affecting the tonsils and palate, and first noticed five months previously.

The case was shown as another of a series of cases shown in 1903 and 1904 (*vide* "Transactions of the Laryngological Society") and having the following characteristics in common:

(1) The affection is more or less symmetrical, and closely resembles in appearance the earliest stage of secondary syphilis of fauces.

(2) Antisyphilitic remedies have no effect, and there is no history or other sign of syphilis to be found after careful search.

(3) The disease runs a chronic course and is of long duration, generally over a year; it is superficial, and leaves no cicatrices. It is never vesicular.

(4) It is accompanied by a good deal of burning pain, and sometimes almost disappears and then relapses.

Dr. F. DE HAVILLAND HALL thought it was probably a herpetic condition. He understood there had been no vesicles. One knew how rapidly vesicles disappeared from the mouth, and he thought the condition might be herpes of the pharynx.

Dr. LAMBERT LACK suggested that before excluding syphilis a much more complete examination should be made than was possible in the adjoining room. The appearance of the fauces was very suggestive of secondary syphilis. The glands in the sub-occipital region were characteristically hard and other glands in the neck were enlarged. It was impossible always to discover how the infection occurred, but this difficulty should not be allowed to exclude the diagnosis.

The PRESIDENT said he did not see the case, but the description seemed to suggest pemphigus.

Dr. KELSON, in reply, said he had always been on the look-out for vesicles. He knew what herpes and pemphigus looked like, but regarded the present case as of a different nature. Certainly it bore a great resemblance to syphilis, and he quite understood Dr. Lack's remark on the point. But in the other cases the condition did not alter for a year, although mercury and iodide of potassium had been used. He thought he could bring a case up which two years ago presented exactly the same appearance, and which alternated a good deal. He showed that case in 1903.

Sir FELIX SEMON said it was very desirable to see the case referred to by Dr. Kelson, together with the one now shown.

The PRESIDENT said the eruptions of herpes and pemphigus closely resembled that of secondary syphilis. He had now two patients under his care, one of them a medical man, in both of whom the fauces were occupied by superficial white patches looking like secondary syphilis. But there was no syphilis in either of them, and the condition lasted for many weeks. He hoped Dr. Kelson would exhibit the case to which he had referred, as it was desirable to clear the matter up.

EPITHELIOMA OF LARYNX IN A MAN AGED FIFTY-ONE.

Shown by Dr. SMURTHWAITE. The patient was sent to Dr. Smurthwaite complaining of cough and hoarseness of some five years' duration—worse the last year. There was no history of syphilis. The patient was temperate in his habits and had not to use his voice much. Examination revealed thickening and irregularity of right vocal cord, which was difficult to differentiate from false cord, the latter being also infiltrated, especially at its anterior part. The left cord at its upper middle third showed

signs of some implication. Three weeks ago Dr. Smurthwaite removed a piece of growth from the right cord and had it examined. The report was squamous epithelioma.

The case was brought before the Society for an expression of opinion as to whether one could have reasonable hope by operative measures of eradicating the disease.

Mr. DE SANTI thought the general appearance that of malignant disease, but as there was some doubt about it he suggested that Dr. Smurthwaite should try the diagnostic methods which had recently been advocated by Dr. Moore, of Liverpool, and of the results of which he (Mr. de Santi) had some experience. Any patient suspected of suffering from malignant disease was given a test meal, consisting of three quarters of a pint of tea, without sugar or milk, and a round of dry toast; then the contents of the stomach were drawn off one and a half to two hours later, and were tested for free hydrochloric acid. The paper appeared in the *Lancet* in April, 1905, and was brought before the Royal Society in March. It described seventeen cases of malignant disease in various parts of the body, including the tongue, cheek, and breast, and in two thirds of the cases there was no trace whatever of free hydrochloric acid in the fluid yielded by the stomach after the giving of the test meal. In the remainder of the cases there was only a very small trace of the free acid, with the exception of one case in which a quantity under one fifth of the normal was found. In over 90 per cent. of the cases of carcinoma of the stomach no free hydrochloric acid was found. The absence of free hydrochloric acid in the stomach in cases of malignant disease was a somewhat recent discovery, but four or five cases had been tested in that way at Westminster Hospital, and in the main corroborated the published results, and it seemed to be a very valuable diagnostic measure. If it were true it would hit the microscopist a good deal, and provide an excellent method of detecting malignant disease.

Mr. DE SANTI, in answer to Dr. Pegler, said his patient had recently been operated on and was not in a condition to have a stomach-tube passed at present or to take a meal such as was necessary for testing purposes.

Sir FELIX SEMON said he would not have had any doubt about the malignancy of the case, but he had a conversation with a distinguished member of the Society who was as astonished at the idea of malignant disease as Sir Felix was that anyone should regard it as other than malignant. He was convinced it was an epithelioma, and, at the same time, probably one of the rare instances of auto-inoculation of the opposite vocal cord, such as Mr. Shattock and he had described years ago before the Pathological Society. He thought the larynx should be opened without delay and the right cord removed; then one would be able to judge whether there was malignant disease in the middle of the left vocal cord, and whether merely that part could be removed with a margin of healthy tissue or whether the whole of the left cord would have to be removed. The sooner that were done the better for the man's life and the chance of preserving some amount of voice.

Dr. STCLAIR THOMSON said he concluded clinically that it was epithelioma of one vocal cord. He had watched the opposite side carefully, and the lesion there seemed to come and go a little, as if there was a good deal of mucus on it. After removing a singer's nodule on one

side, one often saw that the nodule which one expected to have to remove on the opposite side disappeared. In cases where laryngo fissure was advised it had often been mentioned at these meetings that certain things could then be more easily seen. But in some which he had done the direct appearance was not so different from that seen reflected in the mirror. He had therefore mentioned to Dr. Smurthwaite the advantage of feeling with the finger the suspicious cord after laryngo-fissure had been performed. This would frequently reveal the extent of the infiltration, and one could tell by touch whether it was a secondary infiltration opposite. The case seemed a most suitable one for operation.

Dr. Lambert Lack said that he had examined the patient carefully, and in his opinion the disease was not malignant. There was a growth on the right vocal cord which fitted into a corresponding depression in the left. There was certainly considerable swelling far back on the left cord, but both cords moved equally and freely, and he thought if the patient were left alone and told to rest his voice he would improve considerably. (Dr. Lack was not present when Dr. Smurthwaite first stated that a portion of the growth had been removed, examined, and reported to be malignant.)

Dr. Smurthwaite, in reply, thanked members who had expressed their opinion on the case, though the different ideas left him in doubt as to what should be done. A good piece had been removed from the right cord, which would account for the depression spoken of by Dr. Lack. The piece had been microscoped, and the report was squamous epithelioma, as he remarked at the commencement of the meeting. Still, even then one sometimes felt uncertain about malignancy. That was why he brought the case up, for a clinical opinion. He would send the slide up to the Society, and he regretted he did not bring it with him. He would be glad of a report by the Morbid Growths Committee.

Dr. StClair Thomson suggested that the Morbid Growths Committee should have a special sitting in reference to this specimen.

Sir Felix Semon, in further remarks, said Dr. Lack spoke of a "depression" on the opposite side. He (Sir Felix) had not seen any depression. Pachydermia was not so remote an idea that one would not think of it, but the part from which Dr. Smurthwaite had removed a projecting piece of growth extended much further forward than one would expect pachydermia to go.

Drawing of Angeioma of Larynx.

Dr. StClair Thomson showed a coloured drawing of a very marked case of angeioma of the larynx. It illustrated, not a local tumour, but a form of telangeiectasis, beneath the mucous membrane, involving the right vallecula, both ventricular bands, the left subglottic region, and the right aryepiglottic fold. He was sorry that he had no further note of the case beyond the fact that the man was aged thirty, and had been under his observation at the Throat Hospital in Golden Square in 1900. Dr. Thomson believed that the man had at other times been under the observation of some of his colleagues, and had even been a patient in the time of

Sir Morell Mackenzie. He believed that the man had not suffered from hæmorrhage.

The PRESIDENT expressed the Society's appreciation of the beautiful drawing, and asked whether it had yet been published.

Dr. PEGLER mentioned, for the information of members who were interested in angeioma of the larynx, that Dr. Percy Kidd had sent him a valuable specimen of telangeiectoma of the larynx, which that gentleman described in the *British Medical Journal* in 1888.

Dr. STCLAIR THOMSON, in reply, said the drawing had not been published. Dr. Bond said the patient was under his care at one time. It was understood he had been shown before the Society, under Dr. Bond's name.

GIRL, AGED SEVENTEEN. COMPLETE PARALYSIS OF THE LEFT VOCAL CORD, ASSOCIATED WITH DILATATION OF THE LEFT PUPIL, MITRAL STENOSIS, AND ENLARGEMENT OF THE LEFT AURICLE.

Shown by Mr. ATWOOD THORNE. D. S——, a dressmaker, aged seventeen, came to the London Throat Hospital on May 13th, 1905, complaining of hoarseness of three or four months' duration. On examination the left vocal cord was found to be in the cadaveric position and immobile. The left pupil was dilated, but responded sluggishly both to light and to accommodation. There was no localised sweating or other sign of involvement of the sympathetic nerve. The upper eyelid did not droop. The radial pulses were apparently synchronous and equal. There was a history of rheumatic fever about four years ago, and there was great dyspnœa on exertion. On examination of the chest there was no indication of aneurysm, but evidence of marked mitral stenosis. He considered that the laryngeal paralysis was probably due to the enlarged left auricle, and remembering a somewhat similar case which was shown some two years ago at the Harveian Society by Dr. Wilfred Harris, he asked him to see the case. He reported as follows:

"In my opinion the palsy of the left vocal cord is due to her heart condition. She has advanced mitral stenosis, with very little presystolic murmur left. There is a marked slapping diastolic shock over the pulmonary artery, with an intensely loud pulmonary second sound and reduplication of the second sound to be heard all down the left side of the sternum. I examined the patient by the screen with the X rays, and there is no sign of any mediastinal growth, but the shadow of the base of the heart is unduly large to the left, no doubt due to the enlarged auricle, as it is faintly pulsatile."

Although Mr. Thorne knew that the condition was a very rare

one, he considered that the paralysis of the cord was due to pressure on the recurrent laryngeal nerve by the enlarged left auricle, and that the dilatation of the left pupil was due to irritation of the sympathetic from the same cause. He would be much obliged if members would give their opinion on the cause of the paralysis.

Dr. DE HAVILLAND HALL said it was a most interesting case, and he had always been on the look-out for the condition, *i. e.*, a sufficient dilatation of the left auricle to involve the recurrent laryngeal. He did not see why such should not occur, but had not seen a case. The girl did not appear to be suffering severely from heart disease, but he understood there were marked physical signs—it was not possible then to examine for them. Failing any other explanation, it was probably due to pressure of the hypertrophied left auricle. Such cases had been described before.

Mr. ATWOOD THORNE, in reply, said the X-rays revealed no evidence of aneurysm.

MICROSCOPIC SECTION OF ANGEIOMA OF PALATE REMOVED FROM A PATIENT SHOWN AT THE LAST MEETING.

Shown by Dr. LAMBERT LACK. The patient was a girl, aged twenty-one, with a tumour on the left side of the soft palate, the size of a shilling. It had grown rapidly during the past three months, and some doubt was expressed at the last meeting as to whether it was not a sarcoma.

Two days after the meeting the growth was excised. Deep incisions were made round the tumour about one quarter of an inch from its margin. The growth was then easily shelled out with the finger. The somewhat free hæmorrhage was arrested by sponge pressure, and one artery which spurted freely was sealed with Paquelin's cautery.

Sections through the piece removed showed that the growth consisted of a simple angeioma, and that a considerable margin of healthy tissue had been removed all round. The deeper portion of the tissue consisted of fat and glands. There was no trace of anything resembling malignant disease. Some of the cavernous sinuses came up close to the surface of the growth, separated only by two or three layers of epithelium. This accounted for the readiness with which the slightest touch caused bleeding.

The PRESIDENT said it seemed to be a very clear and definite case of angeioma.

Dr. PEGLER remarked that this case had maintained its interest to

the last. The microscopic specimen was as interesting and unique as the growth itself. It was not a capillary nævus, but a pure cavernous angeioma.

Specimen of Post-nasal Adenoids removed from a Man, aged fifty-nine.

Shown by Dr. Lambert Lack. The patient, a healthy countryman, complained of deafness, dating from an attack of influenza three months ago. The patient also complained of a dry throat and of nasal obstruction, which had commenced at the same time.

On examination, the deafness was found to be due to Eustachian obstruction; both membranes were indrawn, and the hearing greatly improved on inflation. On examining the post-nasal space, a large mass of adenoids was seen. There was no other cause of nasal obstruction. The adenoids were removed under nitrous oxide anæsthesia, and the hearing greatly improved immediately after the operation, as was usual in adenoid deafness.

The mass removed seemed to be ordinary adenoid tissue, and was of considerable size; on post-rhinoscopic examination it was sufficient to conceal half the septum.

This was the oldest subject with adenoids he had ever seen, the previous oldest case being forty-four years of age. The latter also had typical adenoid symptoms, including Eustachian catarrh, and was of recent origin. Immediate and permanent relief followed operation.

He should be glad to hear if any other members had met with similar cases of apparently recent development of adenoids in old people.

The President said it seemed a very exceptional case. He had not seen such extensive disease in so old a subject. He asked whether the growths were removed by Gottstein's curette, and whether there was any associated disease, such as lymphadenoma.

Mr. de Santi asked whether the microscope showed the mass removed to be the same as ordinary adenoid tissue. It looked more like a new growth—possibly adenoma.

Dr. StClair Thomson said he had had a case of adenoids over fifty. His patient was deaf, and he gave a Politzer inflation, which greatly improved her. When he told her she had adenoids she was most indignant at his suggesting such a childish complaint. He told her she would probably be deaf unless they were removed, but he did not remove them. He met her in society several years later, when she heard perfectly well, but said she had never had her adenoids touched.

Dr. Furniss Potter said he had removed adenoids from a woman, aged forty-seven, who suffered from deafness. Considerable improvement

in hearing resulted. The tissue was examined microscopically and reported to be "adenoid."

Woman, aged forty-five, with Inspiratory Dyspnœa: History of Syphilis, for Diagnosis.

Shown by Mr. de Santi. The patient attended Mr. de Santi's clinic for hoarseness and dry throat of some months' duration. There was a history of syphilis sixteen years previously. Examination revealed some atrophic rhinitis, pharyngitis sicca, chronic laryngitis, and an enlarged thyroid gland. The patient only attended two or three times; later she came under the care of one of the Physicians of the hospital, who found her to be suffering from inspiratory dyspnœa; he reported the breath sounds as being much more feeble on the left than the right side of the chest, and made a provisional diagnosis of stenosis of trachea or left bronchus.

The patient was referred back to Mr. de Santi, who could find no infra-glottic thickening. The question of diagnosis of the inspiratory dyspnœa was the reason for bringing the case before the meeting. In Mr. de Santi's opinion the enlarged thyroid was considered to be the probable cause of the trouble.

The patient had been on iodide of potassium, but was none the better for it.

Dr. de Havilland Hall was of opinion that it was a case of perverted action of the vocal cords. On getting the patient to phonate steadily for some time, the cords became worn out, and then there was a momentary widening of the cords to the full inspiratory position. It reminded him of the first case he saw, when he was indebted to Sir Felix Semon for the diagnosis. Sir Felix told him the trick by which the action of the vocal cords could be overcome, namely, by prolonged phonation. That woman had a good deal of laryngeal catarrh, sticky mucus about the larynx, and he took her into Westminster Hospital, where she was under observation some weeks and the laryngitis was cured, and by various remedies directed to her hysterical condition she got rid of the perverted action. When he first saw her he thought she was suffering from bilateral abductor paralysis, but the prolonged phonation settled the diagnosis, and it was a very valuable means of distinction.

Sir Felix Semon said he believed he was the first to describe the condition to which Dr. Hall had referred and which was present in his case in the German edition of Mackenzie's book, in 1880, under the name of "Perverse Action of the Vocal Cords." He had seen several instances of it in hysterical patients, and accidentally had learned the trick which answered perfectly in Mr. de Santi's case. After prolonged phonation, when there came the necessity for respiration, the cords all of a sudden separated normally. One case he had cured by electricity, and another by an unexpected cold water douche.

Dr. StClair Thomson said the patient had no stenosis of the larynx;

he saw the cords at one moment gaping widely open, so if she had any inspiratory dyspnœa it must be lower down, in the trachea or still lower. The thyroid did not appear to be in the position which generally caused pressure on the trachea. Of course, syphilitic stridor in the trachea or bronchi was difficult to diagnose, and very unsatisfactory to treat; still, in some of those cases which had not improved with iodide of potassium, he found they did well with muscular injections of mercury. So far as the laryngeal condition was concerned, it was functional.

Mr. Atwood Thorne said that mostly during inspiration the cords were close together, and he thought it was double abductor paralysis. He regarded the case as laryngeal.

Dr. Furniss Potter said that he had succeeded in making the patient separate the cords several times in succession, during which she had breathed freely. He had accomplished this by directing her to phonate the word "hay" repeatedly with forcible aspiration. Whilst doing this she appeared to experience no difficulty.

Mr. Atwood Thorne said that perhaps Dr. Potter saw the patient after others had tried the experiment. (Dr. Potter replied that he had.)

Mr. de Santi, in reply, said he would give her a cold douche if he could. The patient had marked inspiratory dyspnœa, but whether that condition could be accounted for by what Sir Felix Semon and Dr. de Havilland Hall had described as perverted action seemed doubtful, Mr. de Santi, having had the opportunity of seeing the patient more than once, was confident there was no abductor paralysis, as he had seen the cords on more than one occasion widely abducted, but the condition of "perverted action" of the cords he had missed altogether.

Intrinsic Laryngeal Neoplasm of Left Vocal Cord in a Man, aged seventy-three.

Shown by Dr. Scanes Spicer. There had been hoarseness of nine months' duration, but the cord moved normally. The mass appeared to have a broad base of attachment and to invade the deeper tissues of the laryngeal wall, and resembled a mass of Iceland spar. It was removed at one cut with Mackenzie's laryngeal forceps, and on examination presented innocent characters only. The voice returned at once. The appearance of the growth and age of the patient suggested malignancy, and the limitation of the growth pointed to its favourable nature for laryngo-fissure, but in face of the definite nature of the histological report, no interference could be recommended and a watching policy was pursued.

Report on the growth by Mr. Maynard Smith.—"The section shows a papilloma (squamous-celled). At one point the tissue lying at the base of the growth is cut through. This has been somewhat damaged in removal, but shows clearly the absence of any invasion with new growth; the tissue is, in fact (apart from some round-celled infiltration), quite normal."

Sir Felix Semon said he would still be suspicious about the growth.

He did not deny that a man aged seventy-three might have an innocent growth, but although under the microscope there might be no evidence of malignancy, he would keep the patient a considerable time under observation. The projections of the growth were very sharply pointed, which he did not like to see.

Ulceration of Tonsil and Palate in a Man, aged forty-five.

Shown by Dr. Kelson. The patient had a large ulcer on the left tonsil and palate, with warty indurated edges. It was said to be of four months' duration. The lymphatic glands in the corresponding sub-maxillary region were enlarged, and the disease was believed to be cancer.

Mr. de Santi said there could be no question about it being epithelioma; there was a large mass of fixed glands.

The President asked whether it was the general opinion that anything could be done for him. It would be very difficult to remove. He had operated upon a man who had malignant disease involving the whole of the left side of the lower jaw, the pharynx, and part of the tongue, etc. There was no particular trouble about it, but he thought he had invasion of the opposite side, in the glands and lymphatics. It was of no use operating unless the jaw were removed. The present patient was not a very good subject, but it was possible to operate, as the disease did not reach the aryepiglottic fold, and therefore one could not decline.

Case of Extensive Infiltration of the Pharynx, with slight Ulceration; for Diagnosis.

Shown by Mr. Charles Parker. The patient, a man, aged thirty-seven, had suffered from sore throat and mouth, and a sensation of something rising in the throat for three months. He was otherwise in good health, and was able to carry on his work as a gardener. On examination of the pharynx great swelling of the tonsils, posterior pillars of the fauces, and the lateral bands of the pharynx were seen, more marked on the left side. Studded over the swollen parts were small yellow deposits about the size of a split millet-seed. These also extended along the free border of the soft palate and on to the uvula. At the junction of the soft and hard palate there was distinct superficial ulceration. On examination of the larynx there was seen to be very considerable œdema of the left arytenoid and slight œdema of the right. On the anterior surface of the right one a small tag of mucous membrane or granulation tissue could with difficulty be observed. The patient also suffered from deafness of a month's duration. The teeth were carious and in a filthy condition. There was a possi-

bility of syphilitic infection nine months previously, but the history given and the results of examination were too indefinite to draw any conclusions from them.

Dr. PEGLER suggested it was a case of tuberculosis.

Dr. SCANES SPICER thought the condition was syphilitic.

Dr. SMURTHWAITE thought from the general appearance that it was syphilitic. If it were tuberculous, he thought there would be redness of the cords, whereas the cords appeared to be white, except at the base. If it had been tuberculosis in the pharynx, one would have expected the patient to be worse than he was at present, and there would have been pain on swallowing. He advocated putting the patient upon a course of antisyphilitic treatment first.

Sir FELIX SEMON said that if the patient had come to him privately he would not have committed himself to a definite opinion after one single examination.

Mr. BARWELL said it was difficult to believe it was tuberculosis. That disease was not only very uncommon in the pharynx and fauces, but it usually only occurred at a late stage of phthisis. No report of the condition of the chest had been mentioned. The patient was usually very ill, and dysphagia was severe; therefore it seemed improbable that the ulceration of the fauces could be tuberculous. The œdema of the arytenoids was asymmetrical, and a very translucent bluish-red, the remainder of the larynx being unaffected. It did not give him the impression of tubercular laryngitis, but of an inflammation of the posterior surface, which he regarded as probably syphilitic.

Dr. STCLAIR THOMSON said he did not think Mr. Parker suggested it was tubercular, but that the diagnosis lay between chronic infection of the pharynx and syphilis. One had never seen a tuberculous pharynx like that without much more local and general reaction. The pseudo-œdema of the arytenoids in this case was more characteristic of syphilis than of tubercle. Recently he saw a case in his clinique in which the arytenoid flapped about and looked as if it were fluid, but when taking hold of it and trying to get it off it was very tough. A similar case was brought to the hospital during his absence, and it was looked upon as œdema of the larynx, because it appeared translucent. *Post-mortem* examination showed it to be an extremely fibrous syphilitic infiltration.

Mr. PARKER said, in reply, that he would have been glad to hear from those who thought it was syphilitic what they considered the exact lesion was. He thought that with such extensive infiltration of the lateral walls of the pharynx it could hardly be of a purely secondary nature, and yet, if it was tertiary, it was very unusual for such extensive gummata in the pharynx to persist for three months without breaking down.

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