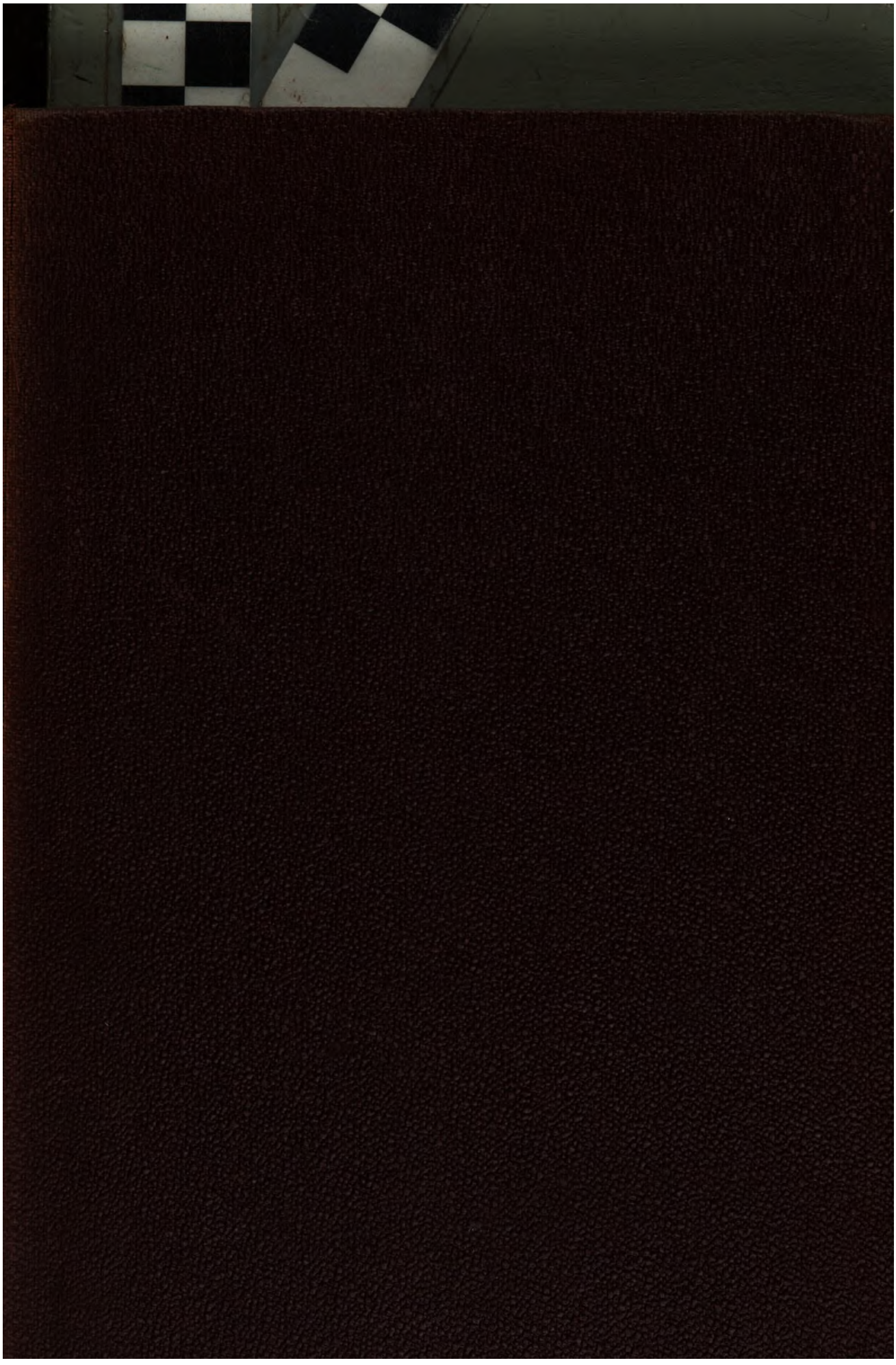
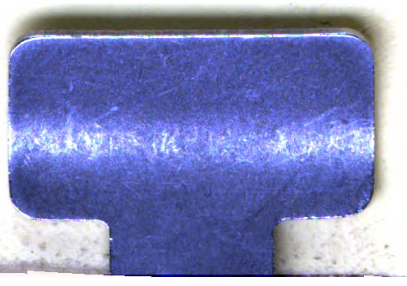
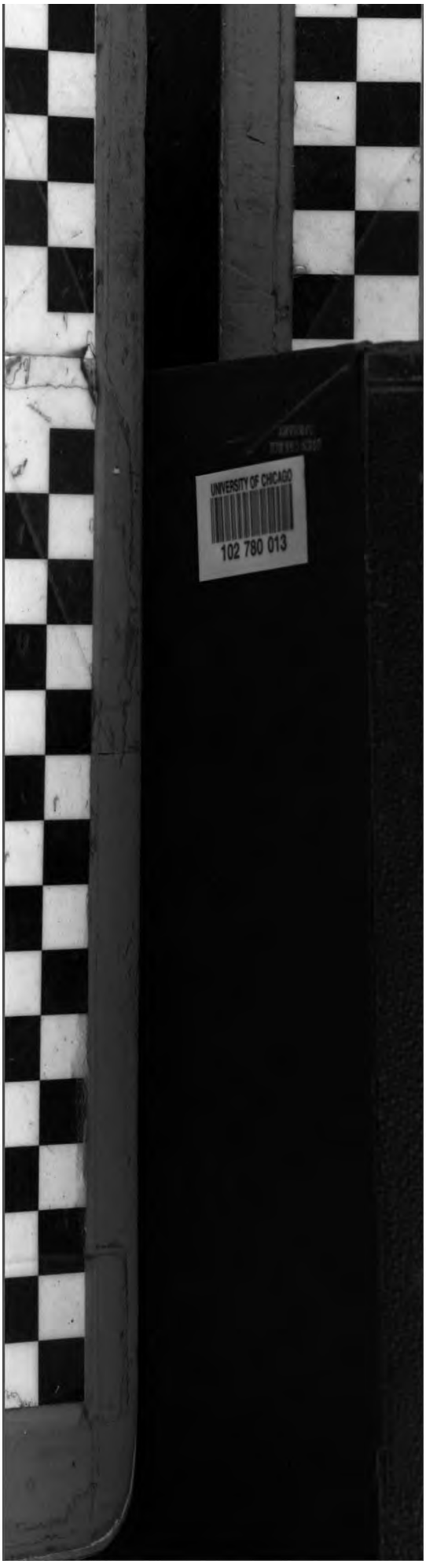
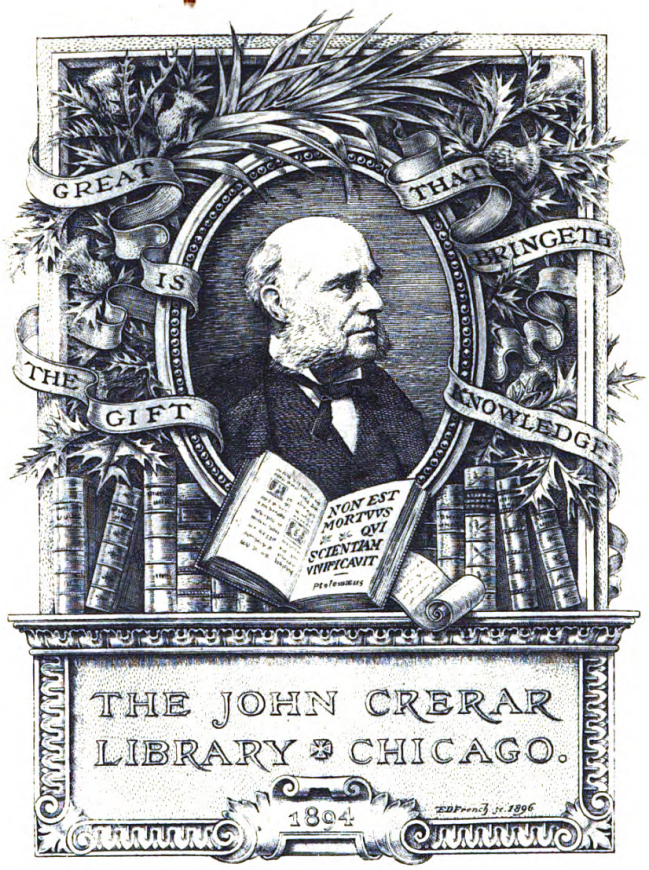





PROCEEDINGS OF LARYNGOLOGICAL SOCIETY.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY

OF

LONDON.

VOL. II.

1894–95.

WITH

LISTS OF OFFICERS, MEMBERS, ETC.

LONDON:
PRINTED BY ADLARD AND SON,
BARTHOLOMEW CLOSE, E.C., AND 20, HANOVER SQUARE, W.

1896.

OFFICERS AND COUNCIL

OF THE

Laryngological Society of London

ELECTED AT

THE ANNUAL GENERAL MEETING,

JANUARY 9TH, 1895.

President.

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

Vice-Presidents.

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Secretaries.

SCANES SPICER, M.D. W. R. H. STEWART, F.R.C.S.

Council.

F. W. BENNETT, M.D. | J. W. BOND, M.D.
A. BRONNER, M.D. | DUNDAS GRANT, M.D.
PERCY KIDD, M.D.

PRESIDENTS OF THE SOCIETY.

(*From its Formation.*)

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

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *October 10th*, 1894.

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

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

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

ADENOMA OF TONGUE.

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

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

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

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

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

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

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

Mr. LAKE mentioned a similar case.

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

IMMOBILITY OF THE LEFT VOCAL CORD.

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

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

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

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

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

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

CYSTIC FIBROMA OF THE LEFT VOCAL CORD.

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

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

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

EPITHELIOMA OF THE EPIGLOTTIS.

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

CASE OF (?) CHRONIC TUBERCULOSIS OF THE LARYNX.

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

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

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

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

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

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

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

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

Dr. Bronner suggested the use of mercurial inunction.

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

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

Tonsillar Mycosis.

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

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

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

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

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

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

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

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

Lupus of the Nose treated by Thyroid Extract.

Mr. Lake also showed the two following cases:

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

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

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

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

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

TONSILLAR NEW GROWTH.

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

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

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

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

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

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

Dr. DUNDAS GRANT suggested that the tumour chould be enucleated

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

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

Dr. SPICER replied.

LARYNGEAL STENOSIS SUPERVENING ON TYPHOID FEVER.

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

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

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *November 14th*, 1894.

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

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

Present—30 Members and 6 Visitors.

The minutes of the previous meeting were read and confirmed.

The following candidates were balloted for and duly elected:

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

The following candidates were proposed for election as ordinary members:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Pachydermia with Perichondritis.

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

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

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

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

CASE OF LYMPHADENOMA WITH OBSTRUCTED BREATHING.

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

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

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

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

PAPILLOMA NASI WITH RODENT ULCER IN AN AGED PATIENT.

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

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

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

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

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

Congenital Fistula of the Neck.

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

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

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

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

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

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

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

Disease of Tongue (for Diagnosis).

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

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

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

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

The patient's *previous history* was good.

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

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

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

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

? Angioma of Vocal Cord.

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

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

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

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

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

Chronic Congestion of Larynx.

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

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

Early Epithelioma? of the Vocal Cord.

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

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

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

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

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

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

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

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

TUBERCULAR DISEASE OF THE LARYNX.

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

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *December 12th*, 1894.

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

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

Present—28 Members and 4 Visitors.
The minutes of the previous meeting were read and confirmed.
The following gentlemen were elected members of the Society:

Charles Cooper Cripps, M.D., London.
A. L. Roper, M.B., Lewisham.
Henry Sharman, M.D., Hampstead.
George Mackern, M.D., Buenos Ayres.
William Jobson Horne, M.B., London.
A. E. Hill-Wilson, London.
Reginald Poulter, London.

The following candidates were proposed for election:

Dr. Barclay J. Baron, Clifton.
Mr. Percy Warner, Woodford.
Dr. J. Walker Downie, Glasgow.

DOUBLE ABDUCTOR PARALYSIS OF UNCERTAIN ORIGIN, ASSOCIATED WITH CYSTIC BRONCHOCELE AND DYSPNŒA; OPERATION; IMPROVEMENT.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr. MACKERN (Buenos Ayres) mentioned a case of double abductor paralysis in a tubercular patient, which recovered completely under iodide of potassium and electricity.

CHRONIC LARYNGITIS.

Mr. BUTLIN showed the case of James D—, æt. 35, regimental bandsman (wind instrument), first seen on Nov. 30th, 1894, suffering from aphonia. The voice, previously strong, had begun to get weak one year and nine months previously, but fifteen months ago it became suddenly aphonic, and had so remained.

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

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

Tracheotomy Tube worn for Eleven Years.

Mr. Richard Lake exhibited a silver tracheotomy tube which had been worn by a patient for eleven consecutive years. The outer tube was much eroded.

Foreign Bodies in the Air- and Food-Passages.

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

1. A piece of holly-wood removed from the nostril of a child of four.
2. A pin removed by forceps from the arytæno-epiglottidean fold of a boy of thirteen, where it had stuck for many months.
3. A counterfeit earring which first was lodged underneath the left vocal cord, and afterwards penetrated into a bronchus on the left side of the chest, whence it was expelled by coughing.
4. A blade from a tooth-forceps removed after tracheotomy from the right main bronchus of a young woman.
5. Two halfpennies removed from the glottis of small children who had swallowed them. (A specimen was also shown illustrating the results of coins remaining undetected in the œsophagus.)
6. A piece of meat, with a long sharp bone attached to it, removed from the œsophagus of an adult.

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

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

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

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

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

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

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

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

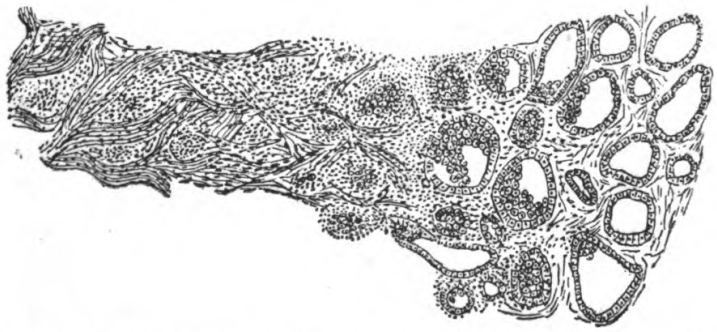
The duration of the affection and the decrease in the size of the thyroid supported the diagnosis of calcification of a formerly enlarged bronchocele.

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ankylosis (?) of the Left Arytænoid Joint.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr. MCBRIDE quoted a case of spontaneous cure, in which the pharynx had been affected with a pale bluish œdema similar to that seen in the larynx in tubercular cases. Lactic acid was applied, but not very regularly, and the swelling disappeared. No bacilli were found in the case.

Mr. CRESSWELL BABER referred to a case of apparently tubercular disease of the epiglottis, and commented on the great variety in the course taken by laryngeal tubercle in different cases.

Mr. SYMONDS pointed out that in his case relief was rapid after the conditions had remained unaltered for six weeks.

The PRESIDENT observed that without the presence of bacilli it was not always possible to be sure of the tubercular nature of some cases.

PACHYDERMIA LARYNGIS.

Mr. C. J. SYMONDS brought forward the patient shown at the last meeting (*vide* 'Proceedings,' vol. ii, p. 17). Some change had taken place since the previous examination, but the condition was still characteristic of pachydermia in the opinion of the PRESIDENT, Dr. KIDD, Dr. MCBRIDE, and Dr. BALL.

Dr. BRONNER and Dr. SPICER advocated the removal of a small piece of the projecting tissue for microscopic examination.

The PRESIDENT thought that the diagnosis was sufficiently clear without the use of the microscope. Changes took place very rapidly in these cases, and the results of microscopic examination were not always positive, but sometimes brought confusion into a simple case.

VENOUS ANGIOMA OF PHARYNX.

Dr. P. MCBRIDE showed a sketch taken from this case. The patient, a young married woman with tendency to varicose veins,

noticed the tumour accidentally one day on looking into her throat. The angioma consisted of tolerably large veins, and occupied the whole palatal margin from the uvula inclusive of the left side. Smaller separate patches were seen on the anterior and posterior pillars of the fauces, while a bluish tinge was communicated to the anterior portion of the soft palate of the corresponding side.

As the tumour produced no symptoms it was not intended to apply any treatment.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ANNUAL GENERAL MEETING, *January 9th*, 1895.

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

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

Present—27 Members and 7 visitors.

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

Dr. W. Law and Dr. George Mackern were appointed as Scrutineers of the ballot for Officers and Council for the ensuing year, 1895.

The Report of the Council for the past year, 1894, was then read, as follows:

During the past year, 1894, the Society has held the full number of meetings, all of which have been well attended. Sixteen new members have joined the Society, and the Council have only to report the loss of one member by the lamented death of Dr. Ernest Jacob of Leeds.

In response to a request from the House Committee of the Royal Medical and Chirurgical Society, the Council have entered into a new and inclusive agreement as to rent, accommodation for the Society's Library, and supply of electric current through the lamps used in the clinical examinations. An inclusive annual rent of £31 10*s.* has been agreed to.

It having been suggested by some of the country members of the Society that a scale of compounding fees should be established in lieu of annual subscriptions, the Council, having carefully considered the matter, have to submit the following propositions for confirmation by the Society:

1. That it is undesirable to establish a compounding fee for town members at present.

2. That country members should be allowed to compound for the sum of ten guineas (£10 10*s.*) on entrance, which sum should include the entrance fee.

3. That country members who have not paid five annual subscriptions should be allowed to compound for the sum of nine guineas (£9 9*s.*).

4. That these fees should entitle the compounding members to

enjoy all the privileges at present accorded to ordinary members of the Society.

It was then proposed, seconded, and carried unanimously—"That the Report be received and adopted, and that the Recommendations with respect to Compounding Fees be approved, and that the Council be empowered to alter Rule 10 of the Society's Rules in accordance therewith."

The Treasurer's Report was then presented as follows:

THE LARYNGOLOGICAL SOCIETY OF LONDON.

BALANCE-SHEET, 1894.

INCOME.

	£	s.	d.
By Balance in hand from 1893	15	13	4
„ Subscriptions—			
49 members at £1 1s.	£51 9 0		
17 members at £2 2s.	35 14 0		
	87	3	0
The 17 subscriptions at £2 2s. include 15 entrance fees and 2 subscriptions for the coming year, 1895.			
Total	£102	16	4

EXPENDITURE.

	£	s.	d.
To Rent, 20, Hanover Square	20	0	0
„ Adlard for Printing and Postage	36	13	10
„ Corbyn and Co., Spirit Lamps, &c.	1	18	0
„ Cheque-book, 4*s.* 2*d.*; collecting two Cheques, 3*d.*	0	4	5
„ Petty Cash—			
Dr. Spicer	£1 18 2		
Dr. Beale	0 15 0		
Attendant	2 0 0		
Waterlow — Diploma of Hon. Membership	0 9 6		
	5	2	8
„ Balance in Treasurer's hands, Jan. 1, 1895	38	17	5
Total	£102	16	4

Expenditure of the year	£102	16	4
	38	17	5
	£63	18	11

Audited and found correct, January 4, 1895. WALTER G. SPENCER. RICHARD LAKE.

The Report was unanimously received and adopted.

The Report of the Librarian was read as follows:

Numerous monographs, pamphlets, periodicals, and a few books have been received during the year. Amongst the latter are 'Medical Essays and Lectures,' and an 'Essay on Asphyxia' by Sir George Johnson, presented by the Author. Additional accommoda-

tion has now been provided in the Library of the Royal Medical and Chirurgical Society for the Society's Library, and negotiations are in progress which, it is hoped, will render the use of the Library more available to the members of the Society.

The Report was unanimously received and adopted.

The President then called attention to the first bound volume of the Society's 'Proceedings,' to which a complete index had been added, and stated that the Society's printers, Messrs. Adlard and Son, 20, Hanover Square, were prepared to bind any sets of 'Proceedings' sent to them by the members, together with the new title-page and index, in the same manner as the specimen volume exhibited.

The Scrutineers then presented the result of the ballot for Officers and Council, as follows:

President.—Dr. Felix Semon, M.D., F.R.C.P.
Vice-Presidents.—Charters J. Symonds, M.S., F.R.C.S.; E. Cresswell Baber, M.B.
Treasurer.—H. T. Butlin, F.R.C.S.
Librarian.—E. Clifford Beale, M.B., F.R.C.P.
Secretaries.—Scanes Spicer, M.D.; W. R. H. Stewart, F.R.C.S.Ed.
Council.—J. Dundas Grant, M.D.; Adolph Bronner, M.D.; Percy Kidd, M.D., F.R.C.P.; J. W. Bond, M.D.; F. W. Bennett, M.D.

The President briefly returned thanks for the election of himself and the other members of the Council.

The following recommendation of the Council was then considered, and after some discussion agreed to:

The Council propose that a Reception should be given to the Foreign and Provincial Laryngologists attending the Annual Meeting of the British Medical Association in London in July, 1895.

They suggest that a Conversazione should be held in the rooms of Messrs. Erard in Marlborough Street at 10 p.m. on the night of July 29th, and that the expenses should be borne by voluntary contributions from the members, the amount of subscription not to be limited.

It was agreed that a small Sub-Committee should be appointed at a later date to make arrangements for the Conversazione.

Ordinary Meeting.

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

The following gentlemen were elected Members of the Society:

Mr. Percy Warner, Woodford.
Dr. Barclay Baron, Clifton.
Dr. J. Walker Downie, Glasgow.

Moriform Growths springing from the Posterior Border of the Nasal Septum.

Dr. William Hill showed this case.—C. H—, æt. 40, presented himself at St. Mary's Hospital in July, 1894, suffering from slight catarrh of the Eustachian tube and tympanum; he had a congenital cleft in the hard and soft palate. On post-rhinoscopic examination two elongated moriform tumours were observed, about the size of broad beans, springing symmetrically from the posterior border of the septum. As these were not large enough to cause obstruction it was decided to watch their growth. Since that date the right one of the two tumours had nearly doubled in size.

Growths in this situation must be comparatively rare, though the exhibitor of this case had removed two such tumours, springing from the *same site*, from a patient whose posterior nares were quite blocked by them; their removal by snare, scissors, and knife had proved by no means easy. As far as Dr. Hill was aware, the only recorded case was the one shown some time since at this Society by Dr. Dundas Grant, in which moriform tumours sprang from the same site.

Ulcerative Disease of the Left Nasal Fossa of Undoubted Tubercular Nature followed by Lupoid Disease of the Left Ala.

Dr. William Hill showed this case.—E. H—, æt. 30, sought advice in May, 1893, for a blocked and ulcerated condition of the left nasal fossa. There was no evidence of syphilis. The patient had been dismissed from the army four years previously for tubercular disease of the lung with hæmorrhage, but there had been no active pulmonary disease for three years.

Granulations and exposed bone were found on the middle fossa in the region of the uncinate body. Dr. Semon saw the case in consultation, and whilst advocating the administration of iodide of potassium he concurred in the view that the disease was probably tubercular, and required energetic local treatment as well. The diagnosis was eventually confirmed by bacteriological examination. The granulations were frequently curetted, and applications of lactic acid, chromic acid, sulphoricinate of phenol, and trichloracetic acid were tried, the last apparently with most benefit; a small sequestrum came

away, and after this the ulceration was found to be practically healed at the end of two months, though the patient was recommended to continue to medicate the nose daily with an alkaline douche.

When seen again on December 15th, 1894, there was an abundant purulent discharge from the nostril and ulcers on the floor and on the outer wall of the middle meatus, together with excoriation and swelling of the upper lip near the anterior naris, and evidently extending by continuity from the vestibule; in spite of appropriate treatment the disease had extended to the ala, which at the present time. presented a tuberculated appearance, and looked just like lupus. The patient had recently been under the care of Mr. Stanford Morton for purulent ophthalmia, probably caused by the irritating nasal discharge having been conveyed accidentally to the eye. The case was of interest, inasmuch as an undoubted tubercular disease of the nasal mucosa had been followed after nearly two years by extension to the cutaneous covering of the ala, and this more recent lesion would have been unhesitatingly diagnosed as ordinary lupus had not the course of the disease and the continuity of the lesion been known. Ichthyol ointment was now being applied locally, but it was proposed to scrape the affected skin.

Dr. Eddowes thought that the disease was probably lupus. He suggested getting rid of infection by means of mercurial plasters and ointment, and then attacking the diseased surface by the cautery, using great care to keep the wound aseptic.

Dr. Hill still regarded the case as tubercular.

Dr. Alexander Hodgkinson (Manchester) exhibited—

1. A throat mirror for laryngoscopic purposes in which quartz was substituted for the glass of the ordinary mirror. It was thus rendered far more durable.

2. A magnifying laryngoscope. This consisted of a magnifying throat mirror and an ordinary frontal reflector to which were adapted magnifying lenses. The throat mirror consisted of a plano-convex lens mounted in the usual way, and having the convex surface silvered so as to constitute a concave reflector when seen through the plane face. The magnifying power was varied by having two such mirrors with focal lengths of eight and eleven inches respectively. The frontal mirror, of the ordinary size and form, was fitted with four double convex lenses, two for each eye, and capable of being used separately

or together, so as to allow of further varying the amplifying power. The focal length of each of these lenses was twenty inches. When properly constructed for varying width of eyes it was easy to use, and gave excellent results.

Laryngeal Stenosis; Polypoid Growth from Left Vocal Cord, (?) Syphilitic.

This case was shown by Dr. Percy Kidd.—William I—, æt. 44, polisher, admitted into the Brompton Hospital December 15th, 1894, on account of dyspnœa.

Patient had syphilis sixteen years ago, followed by a rash, and was treated at the Middlesex Hospital for eighteen months. His tongue has been cracked and covered with whitish patches for thirteen or fourteen years. Hoarseness began three years ago, and he ultimately lost his voice. For the last four months he had suffered from gradually increasing dyspnœa with cough and slight expectoration, which he found much difficulty in expelling. Slight hæmoptysis (one teaspoonful) occurred a fortnight ago. He stated that he had lost much flesh.

On admission marked stridor and dyspnœa, mainly inspiratory. Nutrition of body poor. Chest slightly hyperresonant; breath-sounds weak generally. Tongue showed leucoplakia and some scarring. Larynx moderately congested. Glottis represented by a mere chink bounded by two motionless fleshy bands, which showed a kind of fusiform swelling at their middle two thirds. Just below the posterior third of the left band a pale pink, irregularly rounded, polypoid outgrowth projected inwards, and almost touched the opposite side of the larynx. The posterior wall was marked with numerous coarse nodular elevations; no definite ulceration. Sputum examined for tubercle bacilli with negative result.

The case was regarded as one of laryngeal syphilis, and was treated with large doses of iodide and mercury.

The stridor and dyspnœa had diminished slightly, but there had been no change in the larynx beyond a slight decrease in the nodular appearance of the posterior wall.

The case resembled somewhat that of C. H—, shown at the March meeting of the Society in 1894, which proved to be syphilitic.

Mr. W. G. SPENCER thought that thyrotomy should be performed, as the larynx was very narrow.

Dr. HALL considered that the disease was undoubtedly syphilitic, and that it would be best to perform tracheotomy, and to attack the larynx with the forceps at a later stage.

The PRESIDENT thought that the possibility of malignant disease should not be disregarded. There seemed to be an excessive outgrowth for a simply syphilitic condition, but antisyphilitic treatment should be tried.

Dr. KIDD, in reply, stated that no attempts had yet been made to remove the growths with the forceps. He had, at first, thought that the disease was tubercular, but now regarded it as syphilitic. He proposed to treat the case by tracheotomy, and subsequently to try removal of the outgrowths with the forceps.

ŒDEMATOUS SWELLINGS OF THE PALATE AND PHARYNX.

Dr. EDWARD LAW showed a patient, Mrs. S. B—, aged 62, widow, first seen on November 20th, 1894, on account of the sudden occurrence of great difficulty in respiration and deglutition, associated with much discomfort and swelling at the back of the throat. The patient had been under the care of Dr. Alfred Eddowes for nine months suffering from so-called Quincke's disease or acute circumscribed œdema, a malady which had been also described as urticaria tuberosa, nodosa, or gigans.

During childhood she was said to have suffered from one attack of nettle-rash, and her father is reported to have been very gouty.

The patient had always enjoyed fairly good health with the exception of occasional dyspepsia. Three years ago she lost her husband, and suffered from severe and lasting shock, but it was not until eighteen months later that the disease began from which she now suffered. Before the rash appeared she took chillies for indigestion, but neither Dr. Eddowes nor the patient had been able to ascertain that the ingestion of any particular condiment or food had any influence in the causation of the eruption.

The patient was now practically never free from the disease. She described the lesions as coming on with little hard isolated lumps under the skin, which were about the size of a pea or bean and very irritable. The redness and œdema appeared later, and were apparently accompanied by a feeling of heat, tension, and smarting rather than of true itching. No factitious urticaria could be produced by scratching,

although a little excessive congestion followed the irritation of the nail, but no distinct urticarial wheals had been observed in her case, either from the disease or from artificial excitement.

The appearance of a patch when the œdema was well established and the redness at its height was somewhat similar to erythema nodosum, but it differed from that affection in the history of the case and in many other respects.

The size and shape of the patches varied greatly, sometimes involving nearly the whole of a limb. They caused most distress when they affected the mouth, throat, or face. Occasionally the eyelids had been so swollen as to be completely closed for one or two days.

She had had previous attacks of a less urgent character in the throat and mouth, with and without swelling of the lips and tongue.

The patient gave the following history on the occasion when first seen by Dr. Law. She woke up suddenly in the early morning with the feeling of a lump at the back of the throat, which she was unable to dislodge by coughing or swallowing. There was great discomfort and uneasiness, but little or no pain. She noticed, by means of a looking-glass, that her throat was so much swollen that the uvula was in contact with the two sides of her mouth. The difficulty in swallowing greatly increased, and the sense of suffocation became so oppressive that the patient was very nervous and alarmed through the fear of impending death. This critical condition lasted for two or three hours, when the symptoms gradually subsided and the swelling rapidly disappeared.

On examination a few hours later an œdematous swelling of the uvula was found with slight serous infiltration of the left half of the palate and of the left aryepiglottic fold. The left ventricular band appeared to be more prominent and congested than the one on the opposite side. The neighbouring parts of the pharynx were only slightly hyperæmic, and a few enlarged follicles were visible upon the posterior pharyngeal wall. There was increased redness of the epiglottis and laryngeal mucous membrane, but the vocal cords moved freely, and, with the exception of streaky redness, were normal in appearance.

No active treatment was called for, as the urgent throat symptoms had evidently already passed away. Dr. Eddowes stated that the following internal and local remedies had been employed with only questionable advantage:—arsenic, quinine, ichthyol, colchi-

cum, iron, citrate and chlorate of potash, bromide of potassium, creoline, tincture of iodine, and solution of alum.

Brocq, Riehl, Unna, Crocker, Pringle, and others had reported similar cases in which the tongue or mucous surfaces of the eye, throat, or stomach were affected by the disease. Strübing had also probably described the same disease as an angioneurotic œdema.

The PRESIDENT observed that these cases were excessively rare. He had been watching a case for some time, but had never been able to see it while the local swellings were visible. In that case the swellings came on without warning on the soft palate, and lasted for a few minutes or sometimes for an hour. The condition had been well described by Strübing as angioneurotic œdema.

Dr. HALL suggested that 10 or 20 per cent. solution of cocaine might afford temporary relief if applied to the swellings directly they appeared.

Mr. BUTLIN objected to the term "Quincke's disease" as being altogether unknown. These temporary œdematous swellings, when causing obstruction to the respiration, might very well be overcome by means of intubation.

Mr. ROPER mentioned a case in which œdematous swellings of the lips, tongue, soft palate, arms and back occurred to an old lady of seventy-five without any warning. The swellings were of short duration, and seemed to call for no treatment.

Dr. LAW, in reply, had not been able to find any reference to "Quincke's disease" as such in any text-book, but a case was reported in the 'Archiv für Laryngologie.'

LUPUS OF PHARYNX AND LARYNX.

The PRESIDENT showed the little girl affected with lupus of the pharynx and larynx whom he had demonstrated at the April meeting 1894 ('Proceedings,' p. 103). The treatment then proposed, viz. curetting and application of lactic acid locally with the internal administration of cod-liver oil and arsenic, had been carried out methodically in such a way that the local applications had been limited to the pharynx, and the larynx had not been treated at all locally. Nevertheless a very general improvement had taken place, also in the condition of the larynx. The patches of lupus from the gums, palate, and pharynx had entirely disappeared; the larynx was much less ulcerated, though still swollen, and the previously aphonic voice was now loud and strong. The case offered a fresh illustration of the fact that certain cases of lupus will get better or even temporarily well under almost any medication.

Dr. Hennig's Oil Studies of Laryngeal and Nasal Disease.

The President also demonstrated Dr. Arthur Hennig's (of Königsberg) admirable studies in oil for teaching purposes of normal and diseased conditions of the upper air-passages. These studies represented forty illustrations very considerably enlarged from nature. It was mentioned that the artist greatly wished that these paintings should be reproduced for teaching purposes, but that the great cost of such reproductions stood in the way, and that it would only be possible to take the matter into serious consideration if a large number, at least 300 subscribers were found.

Dr. Scanes Spicer proposed a vote of thanks to Dr. Arthur Hennig for the trouble he had taken to bring the pictures to the notice of the Society, and expressed the opinion that they should be reproduced if possible for teaching purposes.

Mr. Cresswell Baber seconded the resolution, which was carried by acclamation.

At the invitation of the President, several members offered criticisms on the drawings.

Mr. Cresswell Baber, whilst complimenting Dr. Hennig on some of his excellent paintings, thought that the representations of the nasal cavities as seen from the front were not satisfactory, owing to their not showing the parts in perspective. In the drawings made and published by him some years ago this point was specially attended to, and therefore, in his opinion, they gave a true idea of what was actually seen. Dr. Hennig's drawings also did not show the neck of the middle turbinated body.

Dr. Ball did not think that the reproduction of some of the commoner affections would be worth while, especially as they were by no means typical.

Dr. Hill pointed out that in these pictures, as in many of the text-books, the post-rhinoscopic image was represented in the ideal manner, but not as it was actually seen. The upper turbinal was, as a rule, quite invisible, while the position of the middle turbinal was quite inaccurate.

Dr. Bronner observed that for teaching purposes a good set of typical conditions was required.

The President undertook to convey these criticisms to the artist. The method of reproduction proposed was chromo-lithography, but the cost as at present estimated was almost prohibitive. It was intended by the artist that the pictures should be made useful for teaching purposes by means of pieces of frosted glass which could be laid over the pictures, and variations sketched upon the glass by means of coloured chalks.

Radical Cure of Obstinate Suppuration of the Antrum of Highmore, combined with Intra-nasal and Intra-antral Polypi.

Dr. Scanes Spicer showed F. H—, lawyer's clerk, æt. 30. Sent by Dr. J. Q. Bown in autumn, 1890, for fœtid suppuration in the right nasal cavity. On examination polypi were seen in region of ostium maxillare, and were removed. Suppuration continued, and antral empyema was diagnosed, and confirmed by transillumination. On December 27th, 1890, the antrum was tapped through the socket of a tooth which had been previously removed, and a gold tube fitted to a plate by Mr. Boyd Wallis. Irrigation was practised, and there was temporarily much improvement. After some months the tube caused pain and irritation, and had to be several times altered, and finally removed altogether, and purulent nasal discharge became worse than ever. In May, 1892, patient desired to have something more done, and he was operated on in St. Mary's Hospital by a large opening made with chisel and mallet through the canine fossa into the antrum, and its cavity was well curetted, much thickened granulation tissue being removed. Subsequently drainage apparatus was used, lead spigots, vulcanite plugs, rubber drainage-tubes, and Ellis's tube. All these from time to time caused local pain, and the suppuration, though at first less, finally relapsed to its former condition. In April, 1893, the drainage of the antrum being still deficient, patient was advised to have a further operation, in which an attempt should be made to render drainage better. With this view the opening in the anterior wall was opened up and enlarged, the cavity again curetted, and a large naso-antral opening made from inferior meatus (well behind entrance of nasal duct) into antrum with a Krause's trocar, the index finger being introduced into antrum through anterior opening to act as a guard. The antrum was *flushed* out with boracic lotion, and was then tightly packed with creolin gauze, and especially so as to distend the bucco-antral opening. After forty-eight hours the gauze was removed, and from that time irrigation practised thrice daily. No drainage apparatus was used. The patient was directed to blow frequently from nose through antrum to mouth, and *vice versâ*, so as to move on any secretions tending to loiter in antral recess, and also to force boracic lotion from mouth through antrum into nose. The result of this was that the discharge gradually subsided, and soon ceased entirely. The

patient had now seen no pus for eighteen months, and at the present time the nasal cavity looked healthy, and he could blow air through the antrum from mouth to nose or *vice versâ*.

Dr. Scanes Spicer also showed the *débris* which he had curetted from other cases of chronic maxillary empyema, and which were seen to consist of fungous granulation tissue, mucus polypi, cholesteatomatous cysts, and in one case a portion of necrosed ethmoid.

He advocated the adoption of the double opening into the antrum in chronic cases in which there was reason to suspect the above complications, in which drainage was defective, and in which drainage apparatus caused irritation, or in which there was marked intra-nasal disease, under which category all his cases heretofore had come, for none of them had yielded to the simple method of alveolar puncture and drainage-tube.

Mr. Butlin had had several such cases. He generally scraped the antrum, but called attention to the necessity for making the opening in the floor and not at the side of that cavity in order to ensure perfect drainage.

Dr. Rees doubted whether such operations were necessary in every case. They caused considerable deformity, and many cases could be simply relieved by removal of a tooth. The large openings were often an annoyance to patients who were smokers.

Dr. Dundas Grant had been able to cure a few cases without operation. He thought that the extent of the operation must depend upon the condition of the lining membrane of the antrum. He had obtained good results in patients who possessed a good set of front teeth by the use of Krause's trocar.

Dr. Spicer had not tried dry treatment in these cases. In the present case all simpler methods had already been tried and found unsuccessful.

"Recurrent" Tumour at the Back of the Tongue; Operation, June, 1889.

Mr. Butlin showed this patient, whose case is described in the 'Clinical Transactions' for 1889.

The tumour stood up in front of the epiglottis; it was cut off with a galvano-cautery loop in June, 1889. Its structure was similar to that of the thyroid gland.

At present there was a prominent lump far back in the left half of the tongue.

Hoarseness confined to the Lower Register of the Voice.

Dr. Dundas Grant showed a patient, Miss D—, æt. 30, a school teacher, who had for about three years been the subject of hoarseness characterised by a "bleating" or "croaking" vibration accompanying her ordinary speaking voice and her singing in the lower part of its range. This entirely disappeared above the note  where, when she sang softly, the change of register occurred, and the tones became perfectly clear. On laryngoscopic examination the vocal cords were seen to approximate imperfectly in their posterior thirds during the utterance of the lower notes. (On subsequent more close observation the inner portions of the cords were seen to be thrown into loose visible vibrations.) During the emission of the higher notes the cords appeared to act normally. Dr. Grant attributed the condition to inactivity of a portion of the internal thyro-arytænoid muscle. The chest was normal, and the patient, though spare, was fairly muscular. He had recommended instruction in the use of the breath under Mrs. Emil Behnke.

The President pointed out that the condition was one of diplophonia. So long as all the elastic fibres in the cords were acting they might act unequally, and an imperfect tone was produced; but if only certain bundles of fibres were acting they might, within their own range, produce a clear tone as in Dr. Grant's case. He advised rest to the voice, electric stimulation both inside and outside the larynx, and a course of strychnia.

Fixation of Right Cord.

Dr. Willcocks showed a patient, R. M—, a boatman, who had had a severe blow on nose about thirteen weeks ago, and felt as if his backbone was broken in pieces. Eight weeks after he woke up one night complaining of his throat. On speaking he noticed his voice was hoarse. Since then he had got no better and no worse.

Present condition.—Right cord somewhat oblique and immoveable. Right arytænoid cartilage prominent. No evidence of intra-thoracic tumour. No history of syphilis.

Dr. BRONNER and Mr. STEWART expressed the opinion that the case was one of perichondritis, causing mechanical interference with the movement of the cord.

The Annual Dinner of the Society was held after the meeting at the Café Royale. The President occupied the Chair, and was supported by Sir Russell Reynolds, President of the Royal College of Physicians, the President of the Pathological Society, Sir George Johnson, Señor Manuel Garcia, Sir W. McCormac, Dr. Ord, and a large gathering of members and guests.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *February 13th*, 1895.

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

SCANES SPICER, M.D.,
W. R. H. STEWART, F.R.C.S., } Secretaries.

Present—23 Members and 8 visitors.

The minutes of the previous meeting were read and confirmed.

Before the usual business of the meeting, the President referred in feeling terms to the loss laryngology had sustained by the death of Professor Gottstein of Breslau.

Mr. Arthur Reginald Poulter, M.R.C.S., L.R.C.P., was called to the table, and admitted a member of the Society by the President.

The following candidates were proposed for election:

George C. Cathcart, M.B., C.M., London.
Alec H. Gordon, M.B., B.C., London.
Bruce Hamilton, M.R.C.S., L.R.C.P., London.
Percy Jakins, M.R.C.S., London.
T. E. Foster Macgeagh, M.D., M.R.C.S., London.
G. Calwall Stephen, M.D., L.R.C.P., London.

The following gentlemen were nominated as a committee to carry out the arrangements for the entertainment of the Laryngological Section of the British Medical Association in July:—The President, the Secretaries, Dr. St. Clair Thomson, Dr. Hill.

The President stated that the subject for discussion at the next Ordinary Meeting was the diagnosis and treatment of empyema of the maxillary sinus, and that an invitation would be sent to the members of the Odontological Society, asking them to be present and to join in the discussion.

A Case for Diagnosis, whether Tuberculous, Malignant, or Syphilitic.

The President asked the opinion of the members on the following case. J. F—, æt. 55, a porter, came to the Throat Department of St. Thomas's Hospital on September 28th, 1894, complaining of hoarseness, which commenced fourteen days previously, a slight cough which came on after the hoarseness, with dryness, and a tickling sensation in the throat, causing frequent "hawking;" expectoration scanty; no blood; complains of drawing pain at left apex. Family history good. Past history good. No history of syphilis.

Examination.—Fauces and pharynx congested. Posterior pharyngeal wall granular, with distended veins and adherent secretion. *Larynx:* considerable congestion of larynx, and some swelling of ventricular bands.

November 9th.—Ventricular bands more swollen, some ulceration of both vocal cords. Was put on iodide of potassium, grs. v, three times a day.

December 21st.—More ulceration spreading to interarytænoid commissure. Patient says he feels as if he were going to be choked. Complains of pain on swallowing.

February 8th.—Voice slightly improved; has been taking Pot. Iodidi three months. Cough worse, and has pain in right side in region of hyoid bone on deglutition. *Larynx:* ventricular bands irregularly swollen; ulceration on posterior end on the right side. Vocal cords: posterior end of right side considerably thickened; left side similar, though in a less degree. Movements free both sides. Distinct superficial ulceration in the considerably tumefied interarytænoid fold. *Chest* at first normal, but on February 8th was in the following condition. Resonance slightly impaired, but equal. Breath-sounds, right apex, harsh, with a few râles; left apex, the râles more numerous; breath-sounds almost inaudible over rest of lung. No loss of flesh. No night sweats. No hæmoptysis. *Sputum:* no tubercle bacilli found after repeated examination.

Dr. Cresswell Baber thought it was a case of syphilis, and inquired if large doses of iodide of potassium had been given.

Dr. Dundas Grant thought it was a case of tubercle of the dry warty kind. Had seen a case of this sort, in which there were no

physical chest signs during life, but post mortem pulmonary tubercle had been discovered. He thought there was too much movement for epithelioma. Suggested curetting and lactic acid applications.

Dr. PERCY KIDD had seen two or three cases where the disease was situated in the angle formed by the vocal cords and arytænoids, which had proved to be tubercle.

Mr. CHARTERS SYMONDS had one in which the vocal cords were fringed with growths in a tuberculous case.

Dr. HILL asked if the use of tuberculin was justifiable in such a case for the purpose of diagnosis.

The PRESIDENT, in reply, stated that he had used large doses of iodide of potassium with no result. He had given up the use of tuberculin, but considered it quite justifiable for the purpose of diagnosis, and also the removal of a portion of the growth for microscopic investigation.

PATHOLOGICAL SPECIMEN OF ADENOID GROWTHS AND ONE OF PERFORATION OF THE NASAL SEPTUM.

Dr. KANTHACK showed these specimens, and pointed out that the growths were not in the position usually depicted in books, but were situated on the walls of the naso-pharynx and around Luschka's tonsil.

The PRESIDENT in the name of the Society expressed their indebtedness to Dr. Kanthack for bringing before them such excellent pathological specimens.

Drs. CRESSWELL BABER and DUNDAS GRANT suggested that if Dr. Kanthack was able to obtain another specimen of adenoid growths, the anterior wall should be removed so as to give a view from the front.

Dr. BALL thought the perforation in the nasal septum was a case of simple perforating ulcer, as the voice was not affected.

Dr. DUNDAS GRANT suggested that frequent epistaxis was diagnostic of simple ulcer.

Dr. TILLEY quoted a case where a perforation occurred without local symptoms during an attack of typhoid fever.

Dr. LAW had a case of perforation caused by the removal of a cartilaginous spur by means of the galvano-cautery.

Dr. CRESSWELL BABER frequently removed cartilaginous spurs by the galvano-cautery, and had never seen a perforation follow; he always attacked the apex of the spur.

Dr. SCANES SPICER had never seen perforation follow the application of the galvano-cautery to the spur; he thought Dr. Kanthack's case was one of simple ulcer from the shape.

Case illustrating Various Morbid Conditions of the Nose and Ears.

Dr. E. Law showed this case. A patient, æt. 26, came to the London Throat Hospital complaining of deafness. Had suffered from ear and eye troubles during childhood, and had contracted syphilis four years ago. Examination showed general catarrhal conditions of the upper air-passages—deflected nasal septum—a papillomatous-looking growth from the anterior third of the left inferior turbinate bone, extensive polypoid proliferation of the left middle turbinate, enlarged Luschka's tonsil, sequelæ of otitis media superior (perforation cicatrices, &c.), hyperostosis of external auditory meatus, eczema of both auricles, and various affections of the eyes. Dr. Law asked if the papillomatous-looking growth was a true papilloma, or a simple enlargement of the anterior extremity of the turbinate.

Dr. Pegler considered this a case of papilloma.

Mr. Stewart and Dr. Cresswell Baber thought it was a simple hypertrophic condition.

Mr. Santi, Dr. Hill, and Dr. Scanes Spicer also thought it was not papillomatous.

Dr. Law, in reply, stated that he would remove a portion and have it microscopically examined.

Laryngeal Stenosis, probably Lupus.

Case shown by Mr. Parker. M. D—, a girl æt. 16, first suffered from hoarseness and loss of voice a year and eight months ago, was treated by Dr. Macdonald at the Throat Hospital, Golden Square, and soon got quite well for the time, but has since then lost her voice off and on. Present attack followed influenza eight weeks ago, became steadily worse, causing complete aphonia and much dyspnœa until February 11th. The aphonia and dyspnœa were now very marked, there was loss of flesh and general debility.

Examination.—Distinct scars on the soft palate, and considerable loss of substance of the epiglottis were found; the aryepiglottidean folds were much distorted, and covered by a number of small pale irregular nodules. The arytænoids, seen with great difficulty, were swollen and œdematous. Cords and ventricular bands could not be made out; base

of tongue was covered with small nodules. On account of the scars on soft palate was put on iodide of potassium; has been taking it for one month in gr. v doses, but the condition of the parts has remained unaltered. Family history good. No suggestion of tuberculosis or syphilis, congenital or acquired. Lungs normal.

Mr. SANTI thought the case more like syphilis than lupus.

Mr. MILSOM REES considered it a case of lupus, and very like some cases he had seen treated with tuberculin.

Mr. PARKER, in reply, said he would try lactic acid applications.

The PRESIDENT suggested that arsenic should be given internally.

ANTERIOR NASAL STENOSIS FROM CICATRICIAL CONTRACTION AFTER ULCERATION, WITH CONSECUTIVE CHRONIC LARYNGITIS.

Dr. SCANES SPICER showed a patient, Mrs. I. K—, æt. 52, a monthly nurse, who contracted "blood-poisoning" two years ago while attending a case. She had suffered from glandular enlargements, rash, frontal headaches, and showed scars on arms and legs resembling those left by rupial sores, and ulceration about anterior nares and vestibula narium. These latter had healed, but had been followed by such narrowing as to give rise to subjective distress. Mouth breathing and obstinate laryngitis with thickening of the posterior wall of the larynx. Suggestions were invited as to the treatment of the cicatricial stenosis, which did not appear to the exhibitor to be capable of material improvement.

Mr. STEWART referred to a case he had shown at a previous meeting, where the alæ of the nose were completely drawn in and the throat was secondarily affected; had tried all sorts of forms of dilatation without success, but the patient was kept fairly comfortable by the use of menthol. Thought Dr. Spicer's case was one of syphilis, did not think any operation would be successful.

Dr. MILSOM REES and Mr. SYMONDS thought Dr. Spicer's case was syphilitic, as she had nodes on legs and arms.

The PRESIDENT suggested iodide of potassium and mercurial inunction; he thought an operation might be successful if the stenosis was incised, pyoktanin applied, and the wound stuffed with slips of iodoform gauze. He drew attention to the fact that in cases of syphilis of the upper air-passages it was peculiar that the disease attacked intensely one part and passed quite over another.

In reply, Dr. SCANES SPICER thought that the laryngitis presented no syphilitic characters, but was of that form seen in simple catarrhal conditions.

Paralysis of the Left Vocal Cord.

This was shown by Mr. Charters Symonds. J. C—, æt. 40, a butcher sent to Guy's Hospital by Dr. Dodwell, complaining of alteration in his voice. Up to October, 1894, resided in California; at the commencement of that month, while still there, he "caught a cold" and had a severe "chill," but does not seem to have had any cough or even nasal catarrh. Woke up one morning with altered voice as it is now. Had no previous hoarseness. No joint pains, though says he has had rheumatism. No history of injury or debauch.

Family history excellent. Married with healthy family. Declares he never had a day's illness in his life, and now feels perfectly well. He is a strong-looking, healthy man. Voice exactly the same as when first noticed to be different from the normal. No dysphagia, but he cannot drink large gulps of anything—all his fluid he is obliged to sip. Eyesight good, pupil reflexes normal; knee-jerks normal. Can stand perfectly with eyes shut. Chest normal. No dulness. No dyspnœa. When first seen, on January 25th, mucous membrane of larynx healthy. No swelling anywhere. The left cord fixed and moveable, quite on the middle line. The cord itself appeared quite healthy. The right moved well, and was in all respects normal. The voice is somewhat gruff, but is loud and fairly strong. There is no evidence of perichondritis nor of intra-thoracic disease.

The case seems to be one of paralysis of the cord without a discoverable cause. May it be an early stage of some central disease?

Dr. Milsom Rees thought the case was one of simple rheumatic paralysis from cold.

Dr. Scanes Spicer considered the paralysis due to intra-thoracic trouble, as there was no abnormality in the larynx.

Mr. Symonds, in reply, stated that he had not examined the chest himself, but would do so. It had been examined by his clinical assistant and pronounced normal.

Paralysis of Left Vocal Cord after Injury.

This case was shown by Mr. Symonds. L. H—, æt. 56, came to Guy's Hospital, January 11th, 1895. One week before was looking after a steam elevator, which was above him. As he was speaking to some one below it came down, crushing him severely about the upper

part of the chest. Does not think his neck was hurt. Immediately on recovering he found his voice had disappeared. No hæmorrhage. No pain. No dysphagia. No history of syphilis, phthisis, or rheumatism.

Examination.—Left cord red and fixed on phonation, not quite in middle line, nearer adduction than abduction. The arytænoid did not move at all. Nothing found in chest to account for symptoms. No sign of external injury. Right cord normal. On January 25th the left cord has approached the middle line and occupied a mid-position; is immoveable. Some dysphagia the last ten days.

February 8th.—Larynx remains the same. A full-sized bougie passed is caught at the cricoid, evidently from muscular spasm. The man speaks in a whisper, but can copy a low laryngeal note; the aphonia is presumed to be nervous. No sign of aneurism or malignant disease.

Mr. SYMONDS was disposed to think that the paralysis may have existed before the injury.

The PRESIDENT said it was difficult to say if it was caused by the injury, but as the position of the cord had altered at different times he would say yes. He considered the aphonia to be neurotic.

PACHYDERMIA LARYNGIS.

Mr. SYMONDS again showed the case of Mr. H—. The swelling on the left cord was still present. It has gradually diminished in size; the nodular character has nearly all disappeared. At the present time the swelling is more marked posteriorly, where it is abrupt and elevated while in front it is flatter and smoother. The cord itself is fairly normal, and the opposite side is free. The cord moves freely. The voice is strong and clear for the most part, but at times is gruff. The patient at first took iodide of potassium, but has for some weeks taken mercury. No local treatment beyond rest has been employed.

Drawings illustrating the various stages, which had been made by Dr. Waggett, were shown.

Dr. WARNER said this case had more or less redness of the throat for some time, but this had increased considerably two days ago. Some years ago he suffered from granular pharyngitis.

Dr. WAGGETT suggested absolute silence as treatment, and mentioned a case he had seen in conjunction with the President which under this treatment had greatly improved; Leiter's tubes and iodide

of potassium had also been used. He thought in Dr. Symonds' case the vocal cords had become much redder, and over an increased area.

Pachydermia Laryngis.

This case was shown by Dr. Tilley. Mrs. S—, æt. 52, came to the London Throat Hospital complaining of a feeling of suffocation in the throat, more especially at night, occasional darting pain in left ear, and hoarseness. Complaint came on twenty years ago, six months before a confinement, and some sixteen years after coming to England—was born in Germany. Has been twice married; first husband died of cancer, second husband had suffered for five years from ulcers on the legs. Has drunk beer freely since childhood, and latterly has taken in addition a half quartern of rum when the suffocating feelings come on, which is pretty frequently. Had tonsils removed at Middlesex Hospital two years ago. At London Throat Hospital some varicose veins at the base of the tongue were burnt, and gave great relief for two or three months.

Examination.—Vocal cord congested and thickened; outward movements limited. Shreds of dry adherent mucus in various parts of larynx. In interarytænoid fold is a large and well-marked swelling of somewhat triangular outline; traversing this mass in a direction from above downwards is a fissure. The points of interest are the rarity of the affection in women; the important ætiological factor of alcohol; the position of the disease in the interarytænoid fold; the fissure through the growth, which probably accounted for the pain; and the slight immobility of the vocal cords, probably due to chronic inflammation.

Dr. Waggett had seen the case at the London Throat Hospital, had painted it regularly with perchloride of iron, and the voice was quite recovered for three weeks.

The President said these cases were extremely rare here, but very common in Vienna, and in answer to Dr. Law attributed this frequency to beer-drinking.

Mr. Hill supposed that attrition must be present in pachydermia.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *March 13th*, 1895.

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

SCANES SPICER, M.D.,
W. R. H. STEWART, F.R.C.S., } Secretaries.

Present—19 Members and 10 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were elected members of the Society:

George C. Cathcart, M.B., C.M., London.
Alex. H. Gordon, M.B., B.C., London.
Bruce Hamilton, M.R.C.S., L.R.C.P., London.
Percy Jakins, M.R.C.S., London.
T. E. Foster Macgeagh, M.D., M.R.C.S., London.
G. Calwall Stephen, M.D., L.R.C.P., London.

The following candidate was proposed for election:

Arthur Sandford, M.D., M.Ch., Cork, Ireland.

DISCUSSION ON THE DIAGNOSIS AND TREATMENT OF EMPYEMA OF THE ANTRUM OF HIGHMORE.

The PRESIDENT in the name of the Society offered a cordial welcome to the members of the Odontological Society present, and stated that, although the diagnosis and treatment of empyema of the antrum had of late years been frequently discussed, yet at a recent meeting of the Laryngological Society such a difference of experience with regard to the results of treatment and to the methods employed had become apparent, that the Council of the Society had considered it desirable to choose this subject for general discussion. What was required was not any academic discussion of the whole subject of empyema of the maxillary sinus, but brief and practical statements as to the methods employed by various observers, and as to the final results they had

obtained, together with such points of diagnostic importance as they had found of particular value. He invited remarks to be made in this spirit.

Dr. Adolph Bronner thought that one ought to distinguish between the mild and severe cases. The former were mostly due to nasal disease, and could be cured by treatment through the middle or inferior meatus, as suggested by Mikulicz. If syringing with boric acid did not effect a cure, the insufflation of powder was to be recommended. At first boric acid and iodoform should be used, and then the iodoform should be discontinued and aristol be used. Iodoform often caused abnormal growth of granulation tissue. If a diseased tooth were found, this should be removed, and the antrum opened through the alveolus. The patient could syringe or blow in powder through a small eustachian catheter. In cases where there was a polypus or much granulation tissue the canine fossa should be opened and the finger introduced, and if necessary the antrum scraped with a sharp spoon. It was not always necessary to introduce through and keep a tube in the alveolar process when this was opened. In answer to the President he stated that 40 per cent. of his cases were cured, the length of time taken being under five or six months. In answer to Dr. Spicer, he stated that the deformities caused by a large opening in the canine fossa were a falling in of the face, which thus did not present a symmetrical appearance, and the growth in a wrong direction of the teeth.

Dr. Greville MacDonald maintained that it was the custom to trust for diagnosis too implicitly on the replacement of pus in the middle meatus on bending forward the head. He had seen at least a dozen cases, some of them associated with antrum disease, others not, where suppuration in the frontal sinus produced the same phenomenon. He likened the condition of the latter case to a narrow-necked bottle, which, held in an inverted position, would not allow its contents to escape without ocaasionally being placed on its side to allow the air to enter. As far as treatment was concerned, and his remarks did not refer to cases with co-existent nose disease, he believed that the exploratory opening through the alveolar border, and drainage with the smallest size drainage-tube, were sufficient for the cure of recent cases, *i. e.* of not more than six months' duration. In those of longer existence he had occasionally found it necessary to make the large opening for the insertion of the finger, and after scraping away granulations, &c., he had always secured a cure. But in speaking of cure he would have it undertsood that he did not mean more than the cessation of suppuration, believing that chronic catarrh frequently remained in spite of all endeavours; and he maintained that such a catarrh would often make it desirable that some form of drainage should be permanently secured.

A letter was read from Dr. Cresswell Baber, who stated that in his opinion transillumination was a valuable aid in the diagnosis of empyema of the antrum. He attached special importance to the illumination of the outer half of the infra-orbital region, this being the part least accessible to rays transmitted through the nose and not through the antral cavity. Certainty of diagnosis could

only be arrived at by flushing out the antrum through the socket of a tooth or other opening, or aspirating through the inferior nasal meatus after the method of Moritz Schmidt. With regard to treatment, he always tried the alveolar method, first allowing the patient to syringe out himself with an antiseptic solution through a metallic eustachian catheter attached to a Higginson's syringe; and only when this method failed to arrest discharge did he resort to a larger opening in the same position or though the canine fossa for the purpose of exploration, and if necessary scraping and packing the cavity.

Dr. WILLIAM HILL read part of a letter from his colleague, Mr. Ernest Lane, who had been associated with him in the treatment of several cases of antral disease at St. Mary's Hospital, and who was unavoidably prevented from taking part in the discussion. Mr. Lane wrote, "From the experience gained, and on reviewing our cases, I am led to the conclusion that the most appropriate and rational method of treatment is that of opening the antrum *above* the alveolar process through the canine fossa, and thoroughly clearing out the cavity with Volckmann's spoon or other appropriate instrument. Bearing in mind the fact that in the majority of our cases—six out of seven—the walls of the maxillary antrum were covered with either soft and polypoid granulations or with genuine polypi, in addition to caseous débris, it seems to me to be an essential point in the treatment that the antrum should be thoroughly inspected, digitally explored, and radically treated by an adequate opening at a dependent part of the cavity, through which efficient drainage can afterwards be carried out." Dr. Hill, whilst endorsing Mr. Lane's remarks, explained that in the cases referred to the ordinary method of drainage and syringing, by a hole drilled through the socket of a tooth, had been first carried out for many months, and in one case for two years, with most unsatisfactory results. He felt certain that the morbid contents of the antral cavities in these cases could *never* have been cured by the application of any lotions or powders at present in surgical use. It was as futile to expect such a result in the case of antral polypi and granulomata as in the case of similar disease in the nose and ear. Instrumental removal was the only rational treatment. If a case with obvious antral disease associated with nasal polypi, granulations about the uncinate body, came under his care, and was unrelieved after two months' treatment by the ordinary alveolar method, he would have no hesitation in recommending the thorough exploration of the antrum through a large opening in the canine fossa. He believed an additional opening in the nasal cavity, as recommended by Dr. Spicer, was often useful, especially when the *ostium maxillare* was blocked by an hypertrophied granular condition of the uncinate process. The radical operation he advocated was devoid of danger; he had never seen any deformity result. The œdema and pain in the cheek occasionally observed rarely lasted more than a week or two; certainly in one patient, an early case, the nasal duct had been slightly injured, either by a too vigorous curetting of the nasal wall of the antrum, or else from the counter opening into the nose having been made too far forward.

In answer to a question from the President as to the proportion

of cases in which the canine fossa operation had been resorted to, Dr. Hill admitted that his experience had not been large, but that the seven cases operated on radically had been very marked ones, and due to nasal disease; in three others he had been content with the alveolar method, but inasmuch as they had not long remained under observation he could only say they were relieved. Perhaps it was accidental that he had seen so large a proportion of cases in which the antrum was choked by growths, and which therefore could only be treated by a large opening; but it might be that he had failed to attach much importance, and even failed to diagnose the milder cases which had been described by members of the Society as yielding so readily to applications syringed into the cavity through a small hole.

Mr. WALSHAM said he considered that in empyema of the antrum, as elsewhere, the only absolute sign was the actual detection of pus on exploration. He, however, held that transillumination was of much value, and had practised it as a matter of routine in all cases in which pus in the antrum was suspected. In some cases in which pus had been detected, there had been merely a shadow below the eyelid of the affected side, the rest of the face lighting up. In two or three instances of what turned out subsequently to be empyema of the antrum no pus could be discovered in the nose, the only symptom calling attention to the affection having been intermittent fœtor, and this in one instance was only evident to the patient himself. A marked dulness to percussion on the affected side has been observed in a few cases. He had practised exploration through the inferior meatus, an empty alveolus, and the canine fossa. The first method he considered a useful one in nervous patients, since the puncture could be made under cocaine. As he was accustomed, however, to drain either through an alveolus or canine fossa, he preferred as a rule to puncture at one of these situations under gas, as the one operation then sufficed. Of the two last methods, he only punctured through an alveolus when a tooth was absent or carious. He would on no account remove a sound tooth for the purpose. He generally succeeded by merely washing out, leaving the small spiral tube *in situ* during the intervals. In exceptional cases he had had to make a larger opening through the canine fossa, introduce his finger, and scrape out the cavity. In answer to Dr. Hill, he said the material removed was granulation-like matter. He had not had to remove anything like true polypi from the cavity. He had met with an instance in his own practice where the large opening thus made had not closed, but remained as a discharging sinus, and he had seen another case in which such an opening had been made by a distinguished rhinologist several years previously, which had also remained open and continued to discharge. He wished to know the experience of others on the subject. He had not found patients had been troubled, where the spiral tube had been used either in an alveolus or in the canine fossa, by food passing into the antrum. Dr. Hill said that so far from having to complain of the hole in the canine fossa remaining patent, the difficulty in his experience had been to prevent it healing too soon. Dr. Greville Macdonald, on the other hand, stated that in his experience the wound never healed.

Dr. DUNDAS GRANT agreed with Dr. Greville Macdonald that the presence of muco-pus in the middle meatus was in itself quite insufficient evidence on which to found a diagnosis of empyema of the antrum. He considered transillumination of the greatest value; by its means we could sometimes eliminate antrum empyema absolutely from the presence of translucency, and thus prevent unnecessary operative interference. Opacity was not of equally positive significance. He relied chiefly on the exploratory puncture and irrigation of the antrum by the introduction of Lichtwitz's fine trocar and cannula through the outer wall of the inferior meatus. The revelation of pus by this method was very convincing to the patient, the temporary comfort obtained inducing greater readiness to undergo further remedial treatment. He had not found irrigation through the natural orifice, as Garel had described, at all easy, even when he employed a cannula of Garel's own pattern. He thought it of great importance to diagnose the cause if possible. He attributed the disease to nasal causes in the absence of the characteristic dental fœtor, and of obvious dental disease, especially if the affection appeared to originate in a well-marked coryza, or there were some other intra-nasal cause, such as a frontal sinusitis. (He had a case of frontal sinus suppuration without at first any antral disease. The nasal suppuration persisted in spite of the apparent cure of the frontal condition. On re-investigating the antrum a secondary suppuration of that cavity was detected, which yielded readily to internasal treatment by means of Krause's trocar.) In presence of a diseased tooth in the appropriate position, or with a history of dental pain preceding the nasal dischage, he would ascribe the antral empyema to dental disease. His cases had, as a rule, been treated by the alveolar method, but some by means of a small perforation in the canine fossa. Those cases seemed to have done best in which a tube was carefully fitted by the dentist, and in which peroxide of hydrogen was the antiseptic employed. He thought it possible the alveolar puncture was too exclusively employed, for although the opening was in the lowest position it was not used for drainage, but as an orifice of entrance for the irrigating fluid. It was a possible source of infection of the antrum by some of the numerous bacteria inhabiting the mouth; and in those cases in which pus did not appear at the time of the puncture, but later on, he thought that in some instances at least this process of infection would account for it. Alveolar puncture was not always easy, as the antrum was sometimes very small and situated far inwards, while the alveolar process extended far outwards. Under such circumstances it was easily possible to miss the antrum, and he had seen even in the hands of an experienced operator the puncture so made that the fluid used for irrigation was extravasated into the tissues over the antrum, causing a large painful swelling of the cheek. The great facility with which the patient could practise irrigation for himself was the crowning advantage of the alveolar operation. He had, however, seen several cases in which, after long-continued alveolar irrigation, a degree of improvement was obtained which remained stationary. Rapid advance took place when there

was superadded the method of treatment by means of Krause's trocar, and still more as soon as the alveolar opening was got to close. Dr. Grant had by latter method of treatment effected cures in two cases in a few weeks. The irrigations were practised thrice, then only twice a week. After each irrigation, air was blown in to dry out the cavity, and europhen or iodoform insufflated. He recommended the adoption of this method in cases in which (1) there was no evidence of dental origin or the presence of diseased teeth, (2) when the patient could easily attend for irrigation by skilled hands, or (3) in which the alveolar opening had been maintained for a long time and the disease had reached a stationary stage, before resorting to the more extensive operation through the outer wall of the antrum. In cases where alveolar puncture was badly borne or unsatisfactory the nasal operation was certainly advisable.

Dr. Scanes Spicer said that transillumination was in many cases of decided value and clinched the diagnosis. Relative opacity of one side combined with positive rhinoscopic and symptomatic evidence afforded the strongest presumption of antral empyema, and justified exploratory puncture. Taken alone, however, transillumination was not conclusive, since the bones may not be bilaterally symmetrical in thickness, or the antra in size, shape, and partitioning—circumstances which must affect the transmission of light through the face. He attributed more value to the comparison of the areæ below the lower lids than to the lighting up or not of the pupils, which latter phenomenon appeared to be much less common normally than the former. On the other hand, bilaterally symmetrical opacity of cheek tissues and non-illumination of pupils do not indicate double antral empyema, nor do they exclude empyema of one or both cavities. In a large number of healthy subjects such opacity is found. With reference to the subjective perception of light on transillumination, a dull red glow may be felt on the healthy side to contrast strongly with the absence of such on the side of the empyema. This observation was made for the first time, it is believed, by a former colleague when the latter was transilluminated four years ago for antral empyema. He had not had a single *cure* on treating *chronic* antral empyema by the usual openings through the alveolar ridge. He had, with the co-operation of skilled dentists, for some time made these openings, and had had adapted to them gold tubes fitted to artificial palates, or to small plates attached to adjacent teeth. Such tubes (and plates), in his experience, always caused, sooner or later, irritation, pain, and perpetuated suppuration, The cases went on washing out for many months or years, and were not followed by cure. He had treated all his earlier cases in this way. It is true they were chronic cases, and had well-marked intranasal disease, polypi, granulations, necrosis, or fœtid purulent rhinorrhœa. He had therefore been led to look about for some method of shortening the period of treatment, and that of Dr. Robertson appeared to meet some of the indications, in removing the membrane secreting the pus and in providing freer drainage; but it had the disadvantage of requiring a mechanical drain. He had therefore conceived the idea of adding to the canine fossa opening a large one from the inferior

nasal meatus, well behind nasal duct, opening into the antrum with a Krause's trocar and cannula, so that the patient could keep the antrum clear, after curettement, by blowing air from nose through antrum to mouth and *vice versâ* constantly, and also washing antrum out frequently by forcing antiseptic washes through from mouth. This addition largely diminishes the tendency of the bucco-antral opening to close, though should it do so the passage is easily restored after cocainisation by incision and dilating forceps, and renders abolition of drainage apparatus practicable. After curettement suppuration diminishes *pari passu* with contraction of bucco-antral opening, and often entirely ceases, leaving a small permanent potential bucco-antral nasal fistula which gives rise to no symptoms, and is rather to be treasured as an emergency exit for antral secretions, or safety-valve through which the antrum can be blown out. The objections which had been raised against this operation were its severity, that deformity was caused, that chronic toothache followed, and that smokers could not draw their pipes properly. As to the severity, the temperature frequently never rose at all, and patients need not usually be confined to their room more than a few days. In all the cases in which he had operated by this method (now about twenty) he had never on any occasion found any approach to either of the other objections which had been raised, and he could only regard them as theoretical as applied to the operation he had described. The real objections to the operation lay in the time and patience requisite to effect it thoroughly and without injury to nasal duct, infra-orbital nerve, or dental nerves, and the impossibility of guaranteeing in every case that the bucco-antral opening would not require incision and dilation owing to growing over of soft parts too soon. These appeared to him small inconveniences compared with the positive advantages of measuring the period of cure of antral empyema by weeks instead of by months or years, which was what he claimed for it.

Dr. Ball considered the important practical point was whether any very radical treatment should be employed at the outset, or whether this should be deferred until simple means had failed. His own opinion was that simple means should be tried first. An opening should be made in the alveolar border whenever this was possible; otherwise in the canine fossa, and irrigation of the cavity should be practised in the usual manner. He had followed this plan in sixteen cases. In all these cases the opening was made in the alveolar process. Of these sixteen cases, six had got well after a varying number of months, and had remained well after removal of the tube and closure of the orifice. Of the remaining ten cases, three were abroad, and one had been lost sight of, and he could not say what their condition was. Three declined any further interference, as they were satisfied to keep themselves comfortable by washing out the antrum daily. In three cases he had enlarged the alveolar opening sufficiently to pack the cavity with iodoform gauze, and had kept it packed for a week or two, changing the gauze daily, until the opening had contracted so much that it was no longer easy to pack the cavity. After that the cavity was washed out daily. Two of these cases got

well, the third was not in any way benefited. He therefore quite agreed that there would always be a residuum of cases which would require very radical treatment, and probably in these cases Dr. Spicer's method would prove the most effectual.

Mr. Walter Spencer mentioned three cases of pus in the antrum which differed widely from those upon which the discussion had taken place, since the pus was formed in connection with acute necrosis of the jaw. In one case he removed the alveolar process of the superior maxilla, which had become necrosed, thus taking away the floor of the antrum. The case was shown some time ago at the Clinical Society, when the whole dome of the antrum could be easily seen. Another case had been previously treated by an incision through the cheek, and several attempts had been made to remove portions of the maxilla. When first seen by Mr. Spencer, a most ugly puckering of the cheek had been produced without any relief to the suppuration. A wide alveolar opening was made, and the case soon got well. A third case seen post mortem had died of septicæmia from acute necrosis of the maxilla, and pus was found in the antrum and in the spheno-maxillary fossa. All three cases were considered to be syphilitic in origin.

The President observed that the discussion had clearly shown how widely the experiences and opinions of various members differed in this question, and how impossible it was as yet to draw from it any general lessons. He must range himself decidedly by the side of Dr. Ball in believing that the more heroic measures ought only to be adopted after the failure of the milder means. He may perhaps have been fortunate in his own results, but, having treated in conjunction with Mr. England between twenty and twenty-five cases in private practice during the last few years, in the overwhelming majority of cases the alveolar method, with subsequent insertion of a golden tube and washing out the antrum through that tube by means of a Christopher Heath's apparatus, had answered admirably. He wished, however, to lay particular stress upon the necessity of giving most minute directions to the patients as to the after-treatment which they had to carry out themselves. One always was between the Scylla and Charybdis of their doing either too little, and thereby allowing pus to decompose in the antrum itself, or of their overdoing the washing out, and thereby never allowing the mucous membrane to come to a condition of rest. The rules which he had adopted were as follows:— The operation having been performed, and the tube having been inserted, he saw the patients once again after the operation. On that occasion he prescribed for them a weak solution of some astringent, usually sulphate of zinc, not stronger than ten grains to the ounce, of which solution one teaspoonful was to be added to a tumblerful of tepid water for each injection. The patient was to sit before a mirror, so as to be able to see the fluid come out from his nose. As soon as the patient observed that the fluid returned clean from the nostril, *i. e.* neither being turbid nor having flecks of pus mixed with the water, he was to stop injecting immediately. This proceeding was to be adopted at first twice daily; later on, as soon as the pus diminished, once daily. When, after the lapse of twenty-four hours, hardly any

pus was evacuated on syringing, the washing out was only to be performed on alternate days; on further diminution occurring every third day, and so on, until finally a week's interval was reached. When, after the lapse of a full week, on injection no pus was evacuated, the patient was directed to make an appointment with him (the speaker) a week afterwards, and meanwhile to leave the part quite alone. On the occasion of the interview he (the speaker himself) washed the antrum out, and if then no pus came out, the time had come for removing the tube. In this manner he had not merely succeeded in curing the great majority of his patients, although amongst them cases had been in which the disease had in all probability existed for a great many years, but he had been able to convince himself of the actual fact that the cure had been obtained, and he therefore warmly recommended this method. Should it fail, as no doubt occasionally it must if there were either necrosed bone or formation of granulations or polypi, &c., in the antrum, more energetic measures were of course indicated. But he regretted to say that in the few cases in which he had been compelled to resort to a broad opening through the canine fossa, with scraping out of the cavity and subsequent packing with dry iodoform gauze, &c., his results had not been very satisfactory.

Mr. ENGLAND showed the tube he always made for these cases fitted to a cast of the mouth. It consisted of a plain straight gold tube, attached to a plate which fitted to the alveolus and round the teeth on either side. The mouth of the tube was closed with a split plug, which could be removed easily by the patient.

Erratum.

Dr. PEGLER desires to correct an error appearing under his name in the last report of 'Proceedings' with reference to Dr. Law's case of nasal obstruction. He intended to imply at the time that he disapproved of the term papilloma as applied to anterior hypertrophies of the inferior turbinal, since after making a number of microscopical sections of such growths he had never succeeded in tracing any analogy between that structure and that of a true papilloma.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *April 10th*, 1895.

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

SCANES SPICER, M.D.,
W. R. H. STEWART, F.R.C.S., } Secretaries.

Present—29 members and 4 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentleman was elected a member of the Society:

Arthur Sandford, M.D., M.Ch., Cork, Ireland.

The following candidate was proposed for election:

David Moore Lindsay, L.R.C.P., L.R.C.S.I., Salt Lake City, U.S.A.

Dr. Foster Macgeagh and Dr. A. Knyvett Gordon were called to the table, and having signed the Register were admitted members of the Society by the President.

PAPILLOMA OF THE NOSE.

Mr. CRESSWELL BABER showed this case. Rev. —, æt. 36, first noticed a growth in his left nostril two years ago. In August, 1894, it was removed by another surgeon, and pronounced after microscopic examination to be a papilloma. It grew from the floor of the nose, and was entirely removed, the left ala being slit up for the purpose. Two months after the operation it appeared again as a small papilla on the floor of the nose. Condition when seen on March 7th, 1895, was as follows:—In the left nasal cavity there is a firm mammillated growth, like a small mulberry, projecting into the vestibule, and extending backwards about three quarters of an inch.

It is attached by a broad base to the floor of the nasal cavity and to the septum. Just behind the tumour is a deflection of the septum, through which there is a clear-cut perforation about one eighth of an inch in diameter. Right nasal cavity normal except that it shows the concavity of the deflection and the perforation. By posterior rhinoscopy (with palate hook) the parts are found normal excepting a slight swelling on the left side of the septum, probably unconnected with the growth. There are no enlarged glands. There is no history of syphilis. A small piece from the upper part of the growth was removed for microscopical examination with the cold snare, but it proved so firm that the screw of the snare had to be brought into requisition. The microscopic examination showed only hyperplasia of structure, and no malignant elements. The patient has a flat wart on his head, which he is in the habit of picking, and it has been suggested that the nasal cavity may have been directly inoculated by means of the finger.

Mr. Baber wished to have the opinion of the members with regard to the nature of a further operation.

Mr. Butlin advised the free excision of the growth, and the destruction of the remains with the galvano-cautery. He considered the growth extremely active for an innocent one.

Case of Lupus of the Throat and Nose.

This case was shown by Dr. J. B. Ball. Emma K—, æt. 14, was admitted to the West London Hospital on March 5th, 1895, suffering from hoarseness and laryngeal dyspnœa. She first complained of her throat about eighteen months previously, and had attended at a London hospital for some months, when she was told that she was suffering from lupus of the palate. Has had no treatment during the last nine months. Has suffered from obstruction and crusting in the nose for some months. Two months previous to admission had a sore patch on the left side of the neck. The hoarseness commenced about the end of December, 1894, and for two or three weeks previous to admission the breathing had been noisy, especially at night.

Patient was a fairly healthy-looking girl, though rather thin. No history of phthisis. The voice was husky, and there was well-marked laryngeal stridor and slight cough; no pain or dysphagia. There was some enlargement of the glands under the angles of the jaw, especially

on the right side. On the left side of the neck, a little below the ear, was a patch of lupoid ulceration about the size of a florin, covered with crust. The gums were normal. The whole of the anterior aspect of the soft palate presented a coarsely granular surface, with here and there some fine cicatricial striæ. The granular appearance extended forward on to the hard palate for a little distance. The pillars of the fauces, especially the right, were thickened, and studded with fine granules. Epiglottis appeared to be partially eaten away; it was thickened, and its free edge presented some large pale nodules. The aryepiglottic folds and arytænoids were swollen and pale. The ventricular bands thickened, slightly nodular, especially the left, and the edges of the cords, which were just visible, seemed uneven. On deep respiration the cords were not freely abducted. Both nostrils were blocked with crusts. On removal of these an ulcerated surface was exposed, occupying both sides of the septum nasi, extending from a little above the columna for about three quarters of an inch, and involving the floor of the nose and the fore-part of the inferior turbinated body on each side. About half an inch above the columna there was a small perforation through the septum. Chest normal. Patient has been in the hospital since March 5th, and has taken cod-liver oil and arsenic. The ulcerated patch on the neck has been scraped, and has cicatrised. The nose has also been scraped, and is much improved. The laryngeal dyspnœa has quite disappeared, apparently owing to a diminution of the nodular thickening of the ventricular bands, and there is a freer mobility of the vocal cords. The general condition of the throat is improved.

In view of the apparent improvement, and of good results obtained in a similar case recently exhibited by the President, under the administration of cod-liver oil and arsenic, it is intended for the present not to apply any active local treatment to the throat.

Mr. C. Symonds inquired if thyroid extract had been given, as he had seen cases in which remarkable results had followed its administration.

In reply, Dr. Ball stated that he had not yet used the extract, as the case was doing so well without it.

A Case of Nasal Deformity of Traumatic Origin.

Shown by Dr. J. B. Ball. May M—, æt. 15, a healthy-looking girl, came to the West London Hospital with a view to having an operation done to improve the appearance of her nose. When four and a half years old she had received a violent blow on the nose with the fist. The nose bled very much, the under part was severed from the face, and it was a long time before the parts were healed. At present the nose is broad and flattened, the nasal bones being depressed and spread out. There is a transverse groove across the nose at the line of junction of the nasal bones and lateral cartilages. The plane of the anterior nares is directed somewhat forwards. The anterior part of the septal cartilage is destroyed, as well as a portion of the columna, only a stump of the latter remaining in front and behind. There is a communication running from the anterior part of the floor of the nose into the mouth, between the upper lip and the alveolar process.

The general appearance of the parts rather suggests some destructive disease, such as syphilis, as the cause, but the history of a traumatic origin is very definite, and there is nothing in the family or personal history to indicate syphilis. My colleague, Mr. Keetley, proposes to operate, and the case is shown partly on account of the peculiar deformity of traumatic origin, and partly with a view of eliciting suggestions as to the best means of remedying the deformity.

Mr. Knyvett Gordon showed—

1. A section of a middle turbinate body with polypus formation.

Though there was no dead bone to be seen or felt in the nose, and no operation had been performed n that situation, yet there was, microscopically, well-marked caries of the bone, as shown by the destruction of tissue with well-marked small-celled infiltration and numerous osteoclasts.

Dr. Hill thought the specimen was exactly like that described by Woakes.

Mr. Symonds asked how the specimen differed from normal bone. He could see some change at the edge of the specimen, but none in the bone itself.

Dr. S. Spicer said that clinically this was a case of ordinary polypus; was he to infer that ordinary polypi lead to absorption of bone?

Mr. Gordon, in reply to Dr. William Hill, stated that he was inclined to regard cases such as this as an early stage of Dr. Woakes's "cleavage."

In reply to Mr. Charters Symonds, he said that the presence and position of the osteoclasts with the small-celled infiltration had led him to the diagnosis of caries.

2. Sections of masses curetted from the antrum maxillare in cases of empyema, by Dr. Scanes Spicer.

These showed marked proliferation of the mucous glands in the lining membrane, the epithelium of which was in a state of active secretion. The proliferation was so great as almost to justify him in describing the growth as an adenoma.

Empyema of Antrum entirely cured by Treatment by means of Krause's Trocar.

Shown by Dr. Dundas Grant. Diagnosis was made by means of transillumination and Lichtwitz's exploratory irrigation in June, 1894, while under care of Dr. Wallis Ord for epileptic fits. The nasal discharge and obstruction had existed for some years.

A perforation was made through alveolus on July 9th, when fluid came through the nose, but pain and swelling occurred in the cheek. It was later determined to try intra-nasal treatment only.

Krause's trocar was used in September, and through it the antrum was washed out twice or thrice a week with sanitas lotion. In a few weeks the discharge had completely stopped, and has not since returned. Since the improvement in the condition of his nose the epileptic fits have almost entirely disappeared, though of course he has not left off his regular bromide.

Empyema of the Antrum of Highmore, complicated with Suppuration of (probably) the Frontal Sinus.

Shown by Dr. Dundas Grant. A young Scotchman, who for about two and a half years had a fœtid nasal discharge on the left side, and had suffered a good deal of treatment at various hands, came to me in October last.

Empyema of the antrum was diagnosed by means of transillumination and Lichtwitz's trocar. Krause's trocar treatment was instituted and some relief afforded, but still more when the alveolar perforation

was made and daily irrigation practised. The discharge fluctuated in amount to an unusual degree, and it was observed that after washing out the antrum with apparent completeness a return of discharge occurred within a few minutes. On inspection this could be seen to spring from the upper part of the semilunar hiatus, and more could be washed out by means of Hartmann's frontal sinus tube. Puncture of the bulla ethmoidalis revealed no ethmoidal pus. I have recommended external opening of the left frontal sinus, but the patient is unwilling to submit to it.

Case of Empyema of the Antrum under Treatment by means of Krause's Trocar.

Shown by Dr. Dundas Grant. A young married woman, suffering from nasal suppuration of old standing.

Her antrum was opened through the alveolus of an extracted tooth two years ago, and she practised irrigation with soda solution, followed by the injection of a little peroxide of hydrogen. Irrigation was to be practised twice or thrice a week, and in seven months she seemed well, the condition remaining apparently stationary till five months ago. She returned to me about two months ago.

Krause's trocar was ntroduced about five weeks ago; the antrum was freely washed out and inflated, so as to blow out the remaining moisture, and europhen was insufflated through the cannula.

Great diminution in the amount of discharge has taken place, and she can get on comfortably with much less frequent irrigation, though at present she is unable to go for a week without it.

Case of Empyema of the Antrum greatly benefited by the Use of Krause's Trocar and Cannula, and Closure of the Alveolar Perforation.

Shown by Dr. Dundas Grant. A gentleman æt. 55, who first suffered from nasal discharge about 1884. Numerous polypoid growths were removed from time to time down to 1894.

Antral empyema was diagnosed in February, 1894, and alveolar irrigation was carried on up till the last two months, when no further improvement seemed to accrue.

In October, 1894, Krause's trocar was used, and irrigation followed by drying and insufflation of antiseptic powders (of which europhen was found to be the best) was continued at gradually increasing intervals. Alveolar irrigation was gradually left off, and the discharge diminished. The alveolar opening was allowed to close in February of this year, and still greater improvement took place.

He left town five weeks ago, and omitted all treatment, the nasal condition causing hardly any inconvenience. He has just returned, but on irrigation fetid muco-pus could be evacuated.

Empyema of the Antrum secondary to Suppuration in the Frontal Sinus treated by means of Krause's Trocar with Good Result.

Shown by Dr. Dundas Grant. Referred to him by Dr. Graham Grant in July, 1892, on account of pain in left front region and discharge of fetid pus from the left nostril. Antral disease was excluded by means of transillumination and Lichtwitz's puncture.

A small external opening was made in February, 1893, and pus revealed. Drainage and irrigation were practised with very slight improvement. The anterior part of middle turbinal was removed, but even then the discharge persisted in spite of apparent improvement of the condition of the frontal sinus.

The sinus was widely opened by means of gouge-forceps in June, 1894, and the granulating lining was thoroughly scraped. The nasal discharge continuing, the antrum was again examined, and proved to be the seat of an empyema. In a few weeks the suppuration entirely disappeared under treatment by means of Krause's trocar.

A Case of Tubercular Laryngitis.

Previously shown at an early meeting of the Society by Dr. Dundas Grant. The ulceration was on the former occasion almost entirely confined to the region of the right vocal process, and may be remembered as presenting, on a mass of pale granulations at that point, a white spot where the galvano-cautery had been applied. Since that time the patient has been residing in Jersey, his voice has got more hoarse again, and his cough more frequent. Tubercle

bacilli have been detected (though formerly absent) but no pulmonary lesion can be demonstrated. The granulations in the region specified have become more exuberant, and there has developed a shallow longitudinal fissure just below the edge of the opposite (left) vocal cord.

The laryngeal symptoms are diminishing, and the local signs becoming less marked under almost daily application of pure lactic acid.

The PRESIDENT said he had been asked how long his cases treated by the simple methods lasted. He would say, taking them in the broadest sense, an average of three or four months. He had a letter for Dr. Brady about one case which had gone to Australia, and which had lasted between one and two months.

Dr. HALL suggested that in this case the pure air of the sea voyage had operated beneficially.

Mr. C. SYMONDS said that as it was presumed the good effect in these cases was due to drainage, he did not see that the meatal opening was superior to the alveolar.

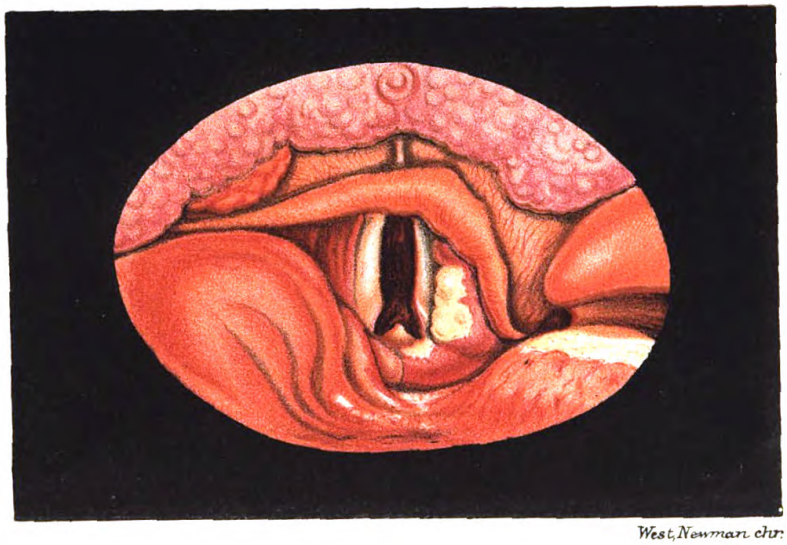
Dr. BALL thought the advantages of Krause's trocar depended on whether it was better to use the dry treatment with powder once a week, or fluid daily.

Dr. LAW asked if europhen was more efficacious than iodoform.

Dr. GRANT, in reply, said he had been led to try the meatal plan on a patient who had a beautiful set of teeth, and would not agree to the alveolar operation. Also many cases operated on by the alveolar method became stationary, and one case improved greatly when the alveolar opening closed. He also thought it was possible for infection to spread through the opening. He would suggest it, too, as an alternative method of treatment. He had not given iodoform such a trial as he had europhen, but it was much better than any of the substitutes for iodoform, and had not the distinctive odour.

A CASE OF MYCOSIS FUNGOIDES.

Shown by Dr. DE HAVILLAND HALL. A man æt. 52, suffering from mycosis fungoides. The disease had existed for about two years and a half. There are numerous tumours all over the body and limbs. In October, 1894, he complained of sore throat, and has had more or less pain in the throat since, but the speech has not been affected. On the posterior and lateral walls of the pharynx there are small oval tumours, and on the left arytænoid cartilage there is a tumour about the size of a hazel-nut; the surface is superficially ulcerated. This is thought to be the first case in which the larynx has been attacked by mycosis fungoides.



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DR. DE HAVILLAND HALL: CASE OF MYCOSIS FUNGOIDES.

(See page 70.)

The PRESIDENT suggested, and it was agreed to by the Society, that as Dr. Hall's case was unique, a drawing of it should be made for insertion in the 'Proceedings,' and Dr. Waggett was asked to make it.

DISEASE OF THE FRONTAL, ETHMOIDAL, AND MAXILLARY SINUSES IN ASSOCIATION WITH NASAL POLYPI.

Dr. WILLIAM HILL showed a patient, A. K—, æt. 34, who recently sought his advice at St. Mary's Hospital for pain in the nose and chronic headache. Nasal polypi had been removed fifteen years before. She suffered from a profuse purulent discharge, and the left nostril was blocked with mucous polypi; these were removed, and pus was then seen issuing from under the anterior extremity of the left middle turbinal, which was enlarged and bulbous; this end of the turbinal was cut off, and an ounce and a half of pus immediately came away, giving the patient instant relief. Granulations could then be seen and diseased bone felt in the neighbourhood of the ethmoidal cells. The left frontal sinus was tender on percussion, and the skin over it was red, and at times puffy; the left maxillary sinus was dark when tested by transillumination.

Whilst the amount of discharge in the neighbourhood of the hiatus semilunaris was not now abundant, a profuse flow of matter was constantly to be seen coming down between the middle turbinal and septum from the superior meatus, presumably from the posterior ethmoidal cells. The middle turbinal was very enlarged, but not cystic, and Dr. Hill thought that nothing short of removal of this bone would relieve the ethmoidal disease which was the prominent factor in the case. He was also prepared to open the frontal sinus by a vertical incision, and the antrum through the canine fossa. He hoped to show the patient again later.

EPITHELIOMA OF THE PHARYNX.

Dr. WILLIAM HILL also showed a man, æt. 44, who consulted him at St. Mary's Hospital a week previously complaining of pain in the throat rendering swallowing difficult, and a shooting pain in the ear. On laryngoscopic examination an ulcer was seen in the right glosso-

epiglottic fossa, extending into the pyriform fossa; the right posterior pillar and the right side of the epiglottis were œdematous, the edges of the ulcer were hard and prominent to the touch; there were some tender and slightly enlarged glands on the right side of the neck at the level of the hyoid bone. There was no history or indication of syphilis. The patient had the day before been digitally examined by students at the College examinations, and the pharynx was much swollen and œdematous in consequence, and less typical in appearance. It was proposed to perform pharyngotomy, and endeavour to remove the growth and the enlarged glands. Mr. Pepper has recommended and offered to carry out this treatment.

Microscopical Specimens illustrating Case of Multiple Papillomata of Larynx.

Shown by Dr. Hunt. C. W—, æt. 12, was operated on by Mr. Paul at the Liverpool Royal Infirmary on September 28th, 1893, when a large growth, which had so completely obstructed the larynx as to demand tracheotomy two months previously, was removed by thyrotomy (see Liverpool 'Med.-Chir. Journal,' January, 1894). This growth was described by Mr. Paul as having "all the microscopic characters which point to the least malignant form of spindle-celled sarcoma, without allowing any question that it is a genuine sarcoma, and not a simple benign growth."

Six months afterwards I made a laryngoscopic examination of the patient, as his breathing was again becoming difficult, and recurrence was feared. I then found the cavity of the larynx filled by two pale warty-looking growths, springing from the left ventricular band, evidently pedunculated, and freely moveable with the breath current. A third growth of a similar character was situated on the posterior surface of the left arytænoid. These growths were easily removed by means of Schroetter's forceps, and on microscopic examination were found to present the characters of simple papilloma.

During the past year I have on many occasions removed similar growths from this patient's larynx, originating from the vocal cords, the ventricular bands, and the aryepiglottic folds, but so far there has been no recurrence of the original growth which sprung from the under surface of the left cord.

The PRESIDENT asked if anyone had seen a similar case in which the usual order of events had been transposed, and papillomata had followed sarcoma.

Mr. BUTLIN had never seen such a case.

Dr. HUNT, in reply, stated that there was no real recurrence, and that the papillomata were situated on a different site though close to the former scar.

LARYNGEAL STENOSIS; POLYPOID GROWTH FROM LEFT VOCAL CORD.

Case shown at the January meeting, 1895, by Dr. PERCY KIDD. After tracheotomy had been performed, the growth on the left side and portions of the fleshy swollen vocal cords were removed with Mackenzie's cutting forceps. Much increase of the glottic space was obtained, the tracheotomy wound was allowed to close, and, for a time, the patient experienced considerable relief.

Microscopical examination of the tumour revealed a well-marked papillomatous structure, with slight, small-celled infiltration of the submucosa, but no appearances of tuberculosis.

Early in March the patient's general condition began to deteriorate, the chief symptoms being progressive weakness, loss of flesh, moderate remittent pyrexia, and pain on swallowing.

The laryngoscope now showed swelling over both arytænoid cartilages, with some ulceration over the right. Examination of the chest gave no constant results. The sputum was examined seven times with a negative result, but a week ago tubercle bacilli were detected on two occasions. The physical signs now indicate infiltration of the apices of both lungs.

Present condition of the larynx:—Epiglottis swollen on right side. Much pale tumefaction over both arytænoid cartilages, with sloughy ulceration of the superior and laryngeal surface of the right. Both vocal cords of pale pink colour, and irregularly thickened. At the posterior end of the right cord is a small sessile reddish outgrowth Vocal cords motionless, lying close together and causing considerable stenosis of the glottis.

Case of Empyema of the Antrum of Highmore.

Dr. Scanes Spicer showed this case.

The President congratulated Dr. Spicer on the improved condition of the patient, he having since the operation fourteen days previously gained 11 lbs. The result of treatment in these cases by the members of the Society was most gratifying.

A Case in which a very Large and Hard Fibro-papilloma of the Larynx has caused Indentation of the Opposite Vocal Cord.

Shown by The President. The patient is a man aged about 40, who two years ago began to suffer from hoarseness, soon followed by dyspnœa and complete loss of voice. The difficulty of breathing became so great that tracheotomy had to be performed. Laryngoscopic examination showed an enormous tumour growing from the left side of the larynx, the exact origin of which could at that time not be made out, and completely filling the vocal organ. A fear was expressed that this might be malignant, and external operation had already been contemplated, when Dr. Johnson Smith, of Greenwich, sent the patient to Dr. Semon. The intra-laryngeal removal and subsequent microscopic examination (Mr. Shattock) of some fragments, however, showed that the tumour was of benign character, and it has in the course of several sittings been reduced to its present size, which is about that of a large bean. The interesting feature of the case is the fact that the right vocal cord is deeply eroded, corresponding to the pressure which the growth in its original size exercised upon it.

Mr. Symonds asked whether the opposing vocal cord in this case was absorbed or eroded.

The President stated that he could not say at present, as the time since the growth was removed was too short. It was quite possible, however, that absorption had taken place.

Suppuration of Frontal Sinus.

Mr. Symonds showed this case. Rev. J. E— consulted me on November 1st, 1892, for a foul discharge from the left nostril of seven years' duration. The left upper first molar had been removed just

after the discharge began. For six years he had been under treatment for what was described to him as "necrosing ethmoiditis," and had been cauterised regularly, but without relief. Three years ago a little discharge appeared on the right side, and this was also cauterised. The case was obviously one of empyema of the antrum, probably bilateral. Through the alveolus the left antrum was perforated, and much thick, foul pus forced through the nose. The nasal opening of the antrum was evidently small, and, on examining the nose, the middle turbinated was adherent to the outer wall, and the whole middle meatus blocked with adhesions, the result of the cautery. After removing the anterior end of the middle turbinated the stream came freely. Granulations still remained in the nose, and some pus escaped. In February, 1893, the right antrum was drained through the incisor fossa; much foul pus was found. In May this side was well, and the tube removed. Though little if any pus came through the nose when the antrum was syringed, pus, sometimes blood-stained, was always visible high up. In December, 1894, bare bone could be felt amongst easily bleeding granulations. These were curetted. The diagnosis now was suppuration in the ethmoidal or frontal sinuses, or both.

January 21st, 1895, he called with swelling in the centre of the forehead, evidently suppuration. A week later (January 28th) I incised in the median line over the centre of the fluctuating area, and let out a good deal of foul pus. A large opening in the frontal bone to the left of the median line led into the frontal sinus. All nasal discharge had ceased while the pus was collecting; a curved probe was easily passed into the nose. A piece of gum-elastic bougie was passed into the nose and retained. Later, a small silver cannula of a length to just enter the sinus was inserted, and through this the bougie was passed. The sinus was daily irrigated with boric acid, and later sanitas.

When shown to the Society rather less than three months from the opening of the abscess the discharge was mucus only, no pus escaped from the nose, no granulations were visible, and the bare bone felt by a probe passed through the nose into the sinus no longer existed. The left antrum for a long time gave no pus, the tube being retained as a precaution only.

Remarks.—The site at which the spontaneous opening formed seems the best at which to open the sinus, *i. e.* just to the left of the median line, and half an inch above the level of the eyebrow. From here a

drain can easily be passed into the nose, and retained by means of a projecting lip. This, covered with a piece of plaster, is by no means disfiguring. I think it much superior to the opening at the inner corner of the eye, through which it is difficult to pass a probe or drain into the nose, and I would suggest this site as the appropriate one for making the external opening. When both sides are involved, a median opening, either a long one or with a flap, will be best. The long period covered by treatment in this case was partly due to the neglect of the irrigation of the left antrum. The rigid tube at first employed gave much pain when introduced, but so soon as the wire one was substituted this inconvenience disappeared, and the antrum rapidly became healthy.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *May 8th*, 1895.

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

SCANES SPICER, M.D.,
W. R. H. STEWART, F.R.C.S., } Secretaries.

Present—31 members and 3 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentleman was elected a member of the Society:

Mr. David Moore Lindsay, L.R.C.P. and L.R.C.S.I., Salt Lake City, U.S.A.

The following candidate was proposed for election:

Mr. George Vincent Fourquemin, London.

Dr. C. Couper Cripps, Dr. G. Caldwell Stephen, and Mr. Bruce Hamilton were called to the table, and having signed the Register, were admitted members of the Society by the President.

OCCLUSION OF RIGHT POSTERIOR NARIS.

Shown by Dr. J. B. BALL. F. H—, æt. 21, has had obstruction of the right nasal passage as long as she can remember. She has always been troubled with frequent discharge of mucus from right nostril. A probe passed through the right nostril is arrested at the region of the posterior cavity by a hard, resisting structure apparently bony. There is no passage whatever for air through the right nostril, either with inspiratory or expiratory effort. By anterior rhinoscopy the right nasal passage is seen to contain a quantity of clear, viscid mucus. There is a slight deviation to the left of the anterior part of the septum near the floor. By posterior rhinoscopy the left choana

appears larger than normal, the distance of the posterior margin of the septum from the left Eustachian tube being greater than from the right tube. The right choana is completely occluded by a smooth reddish structure which joins the septum, not at its posterior margin but a little anterior to this, there being a distinct depression along the line of junction. To the finger the occluding structure feels firm and resisting. This patient was seen by me some six and a half years ago, when the condition and appearances were the same as now. The occlusion is no doubt congenital. Operative treatment was declined on the former occasion, but the patient is now inclined to have something done.

Mr. Cresswell Baber thought this was a case of congenital occlusion like a case he had shown to the Society. He had pushed through the obstruction and dilated under an anæsthetic; no tube was worn afterwards.

Dr. Dundas Grant had a case he had treated by perforating with a trocar and introducing a vulcanite tube, which, in answer to Mr. C. Symonds, he stated the patient had to wear from time to time.

Mr. C. Symonds had a case in which the edge of the septum touched the outer wall. He had sawn out a portion with a Bosworth's saw.

Paralysis of Right Vocal Cord.

Shown by Dr. J. B. Ball. M. A—, æt 18, came under observation at the West London Hospital in October, 1894. He complained of some weakness of the voice which had existed for about three months. On laryngoscopic examination the right vocal cord was found to be fixed in the position of complete paralysis, although there was some slight movement of the right arytænoid on phonation. He had no cough, and repeated examination of the chest at this time failed to discover any definite physical signs, and there was nothing in the case to point to the cause of the paralysis. He was next seen towards the end of December, when he had some cough, and then there was found to be some impairment in the percussion note at the right apex, front and back, and some crackling râles in the same region. His cough has left him for the last two months and he has gained in weight, but the breath-sounds are weak at the right apex and there is some dulness on the right supraspinous fossa together with some crepitant râles in deep inspiration. The diseased process at

the right apex, which is probably tubercular, gives a clue to the cause of the paralysis of the right recurrent laryngeal nerve, but the paralysis of the right vocal cord was in this case the first sign of disease to be discovered.

Dr. Clifford Beale had some doubt whether the paralysis could fairly be put down to the presence of apical disease. Cases of unilateral paralysis of one cord were by no means uncommon where no pleural or pulmonary disease existed, and as no pathological cause could be found for them they were generally classed as "functional." Cases of adhesion of the pleura at the right apex were, on the other hand, exceedingly common, but seldom produced paralysis.

Case of Large Mass of Malignant Glands in the Neck, with Paralysis of the Corresponding Sympathetic Nerve, and Immobility of the same side of the Larynx.

Shown by Mr. Butlin. An engine driver, 56 years old, who four months ago had noticed a lump on the left side of the neck. About the same time he had begun to experience slight difficulty in swallowing.

At the present time he had a large mass of apparently malignant glands in the neck, extending from the clavicle up to the level of the hyoid bone. His voice was very hoarse, and he could only swallow solids with difficulty. The left side of the larynx was completely fixed, but healthy in appearance.

There were typical signs of paralysis of the cervical sympathetic, narrowing of the palpebral fissure, contraction of the pupil, absence of sweating on the corresponding side of the head and face. There was no reddening of the left side of the face and ear, which were a little paler generally than the corresponding parts on the right side.

Mr. Butlin believed the primary affection to be malignant disease of the left side of the œsophagus very high up, and not producing so much stricture as it does when the disease is lower down. He had reported an almost precisely similar case in the 'St. Bartholomew's Hospital Reports,' vol. xxix, p. 103, 1893. In that case there was scarcely any suspicion of malignant disease of the œsophagus until it was found after death. Yet there was a very large mass of glands in the neck, which had produced paralysis of the cervical sympathetic nerve, and immobility of the same side of the larynx.

Mr. C. Symonds stated that he had asked Mr. Butlin whether it was not a case of malignant disease of the thyroid, as there was a large nodule on the right side, and Mr. Butlin had replied that he had a

similar case previously, which he thought had been disease of the thyroid, but that, post-mortem, carcinoma of the œsophagus was found.

Case of Paralysis of the Right Vocal Cord of Uncertain Origin.

Shown by Mr. Butlin. A woman, 28 years of age, a cook, who was suffering from chronic enlargement of the tonsils, and complete paralysis of the right vocal cord, which was in a position midway between adduction and abduction.

In the middle of January of the present year she had been attacked suddenly by a very severe cough. In March the cough ceased, and she lost her voice quite suddenly.

The exhibitor had expected, from the history of the case, to find 'functional aphonia,' and was surprised to discover immobility of the vocal cord. The cause of the condition had been diligently sought for, but thus far without success. There was no history or appearance of catarrh (the larynx was perfectly healthy in appearance). No symptoms of disease of the brain or spinal cord. No tubercular or specific history. No history of injury.

No improvement took place during her stay in the hospital, except that her voice improved, and became almost of normal strength.

Dr. S. Spicer considered that as the paralysis was unilateral, functional paresis was excluded.

Case of Laryngeal Stenosis.

Shown by Dr. Dundas Grant. F. P—, æt. 28, was admitted on the 31st January, 1895, complaining of inability to breathe, except through the tracheotomy tube he was wearing in September, 1894.

He had been sitting up ten days convalescent from typhoid fever, when he complained of a sore throat. Difficulty of breathing set in three or four days later, and tracheotomy was performed.

Condition of the larynx on admission.—Vocal cords considerably obscured by the swelling existing around each *arytænoid* were swollen and red. The *cartilages* were more or less fixed and immobile, the right one completely so. There was a rounded inflammatory swelling at the posterior part of the right vocal cord, merging into the inter-

arytænoid fold, which was much swollen. Perichondritis was provisionally diagnosed. A later examination showed granulations at the posterior extremities of the vocal cords, and evidence of web formation in the anterior commissure.

On the 4th February, after removing some valve-like portions of tissue projecting into the tracheotomy wound, dilatation of the stenosed glottis was attempted by introducing an india-rubber conical dilator through a special tube introduced upwards into the wound.

On February 7th a laminaria tent was introduced from the tracheotomy wound, and left for some hours in the glottis.

By these means the breathing aperture was enlarged, so that by the 11th February some amount of breathing could be performed through it.

On the 11th March, after recovery from an attack of influenza, complicated with pneumonia, the web formation was divided with a Whistler's knife, and the smallest intubation tube passed in. The next day a larger one was used; the breathing was distinctly improved, but the effect was not sufficient to justify the postponement of operation. On the 17th the larynx was opened. The tracheotomy wound was enlarged three inches upwards in the middle line. All the soft parts over the thyroid cartilage were found to be matted together, and the latter was with difficulty exposed. Some granulation tissue was scraped away from the posterior wall of the larynx and bare cartilage was felt, but whether cricoid or left arytænoid was uncertain. The original opening in the trachea was also enlarged, granulations were scraped away, and the finger introduced in both directions found plenty of room. The breathing was much improved. The parts were then transfixed with silver wire and brought together.

A tracheotomy tube with an upward limb was introduced, but the patient could not tolerate it.

On April 8th, the glottic chink was so much more patent that the tube was taken out during the daytime, and the hole plastered over.

May 6th, introduced a dilator. Patient has passed a whole night with wound closed, but still wears tube during a portion of the day.

Case of Syphilitic Perichondritis of the Larynx.

Shown by Dr. William Hill. A female, æt. 34, who had applied at St. Mary's Hospital a week before, suffering from sore throat and loss of voice. There was a clear history of syphilis, and on examination the swollen and congested ventricular bands were seen to meet on the middle line, except for a short distance posteriorly, where a little of the right cord could be observed fixed and ulcerated; the right arytænoid region was swollen, and pus could be seen issuing from an ulcerated surface on the pharyngeal aspect of this region; the larynx was distinctly tender on pressure. Under iodide of potassium the local condition had slightly improved.

Specimen of Pachydermia Syphilitica Diffusa.

Shown by Drs. A. A. Kanthack and W. Jobson Horne. The larynx with portions of tongue and trachea attached was sent by Dr. Engelbach to the Pathological Department at St. Bartholomew's Hospital, with a note that it had been removed from a woman, aged 20 (married—one child—no miscarriage), who kept a brothel, and who for two years and a half had suffered from a very bad throat. In December of 1894 she had extreme dyspnœa, and died suddenly before tracheotomy could be performed.

The glottis was much narrowed. The epiglottis was entirely destroyed. The surface of the root of the tongue and of the interior of the larynx and trachea was studded with closely-set papillomatous-like excrescences.

Vertical sections were made through the anterior end of the right ventricular band, through the posterior parts of the aryepiglottic folds, and horizontal sections were made through the trachea.

Under the microscope there was found no loss of substance, nor destruction of epithelium, but the sections showed a thickening and heaping up of the epithelium together with a metaplasia of the cells from the cylindrical to the squamous variety, even in the trachea. Immediately beneath the epithelium there was an abundant small round cell proliferation, which extended into the deeper parts, and cells were found scattered between the muscle fibres. In places where

the cells were more closely packed, retrogressive changes had commenced.

Dr. CLIFFORD BEALE observed that confusion was likely to arise if such cases were to be indiscriminately classed as "pachydermia," as the lesions both in form and situation differed absolutely from that which was usually described under that name.

Mr. C. SYMONDS thought the case looked more like diffuse syphilitic ulceration rather than pachydermia.

CASE OF TUBERCULAR ULCERATION OF NOSE AND PHARYNX.

Shown by Mr. C. A. PARKER. F. McC— came to the hospital about February 7th, 1894, complaining of stoppage in nose of two to three years' duration, and was found to have hypertrophy of his inferior turbinate bone, which was removed on the right side with the cold snare.

Two or three days afterwards there was some epistaxis. About two weeks after the operation, ulceration was found to be present over the turbinate bone. This was at first treated by simple means, but it spread steadily and made its appearance on the pharynx.

Some little time later it was curetted, and painted with lactic acid frequently, and was improving rapidly towards the end of the year, at which time—in October—he went into the country. After his return, he attended at the Brompton Hospital for Diseases of the Chest.

In March, 1895, his *weight* was 8 st. 8½ lbs.; on May 7th, 8 st. 3 lbs.

Examination of Chest.—In April, 1894, marked flattening of left apex anteriorly with diminished movement and impaired percussion note. Vocal resonance and fremitus were both +. Bronchial breathing with numerous moist crepitations.

Night sweats occurred, but not much expectoration.

May 4th, 1895, examined again. But slight impairment of note. Respiration jerky; expiration prolonged, with tendency to hollowness. No crepitations could be heard. Vocal resonance and fremitus slightly +.

Dr. CLIFFORD BEALE commented on the comparative rarity of tubercular lesions in the nose and the importance of their early recognition and treatment by lactic acid. The corresponding lesions on the tongue and soft palate were more often recognised in their early stages, and were quite amenable to such treatment.

Microscopical Sections Illustrating the Histology of Turbinal Hyperplasias.

Shown by Dr. Pegler. The sections largely corroborated the views put forth by Wingrave, in a paper read before the last meeting of the British Medical Association at Bristol. Dr. Pegler had, however, been led to take a somewhat simpler view of the morbid changes, so far as his observation had gone, since, in every specimen examined, he had found mucoid degeneration in greater or less degree, and in no instance a true hypertrophic condition of the sinus walls. This applied to growths taken from any point along the free border of the inferior turbinate, from the middle turbinate, and from the septum. Special attention was directed in section (1)—(normal inferior turbinate)—to the walls of the sinuses, constituted by strands of visceral muscle-fibre crossing in all directions, and interlaced with bands of the wavy areolar tissue of the part. No. 2 was taken from a typical "anterior hypertrophy" of the inferior turbinate, the external contour of which was deeply convoluted, showing long finger-like processes in the section. This character was probably answerable for the fact of "papilloma" being commonly applied to such growths, but instead of a dense coating of stratified epithelium (altered by irritation?) with a thin line of vessels included, we had here a primary vascular outgrowth in a mucoid matrix, put forth apparently from the main body, and bordered by delicate ciliated epithelium. Attention was next called to the mucoid degeneration of areolar tissue, conspicuous in the lymphoid and general submucous area of the growth. Comparing carefully with the normal, it would be seen that this change had conspicuously attacked the walls of the venous sinuses, the mucoid thinning out of the areolar element throwing into prominence the muscular constituent, and creating an appearance of actual muscular hypertrophy. Sections 3 and 4 showed what were probably later stages of the pathological process (apparently progressive in character), the muscular trabeculæ themselves disappearing, till a mere rim surrounding some of the spaces remained. Wingrave believed that dilatation followed this atrophic stage, and proposed the term *turbinal varix* to designate it, but he also recognised a hypertrophic condition of the sinus walls in other cases. The remaining sections were from polypoid hypertrophies of the middle

turbinate, and wall of the septum. The septal growths were mucoid, and œdematous in the dependent portions, but contained numerous glands and sinuses towards the pedicle. This was evidently the structure of most septal proliferations, true papillomata being quite rare.

Mr. Charters Symonds had not sufficient experience in these cases to criticise.

Dr. Bronner considered them most interesting.

Dr. S. Spicer thought we ought to get rid of the name hypertrophic rhinitis, and call the condition by some more suitable one.

Dr. Pegler in reply stated that his observations were strictly limited to the sections he had shown, and though he had not as yet met with what appeared to him to constitute true tissue proliferation or hypertrophy of the sinus walls, he did not deny the existence of those conditions. He might have to alter his views; there were many sources of fallacy, and much still remained to be worked out.

Case of Fistula in the Neck.

Shown by Mr. W. R. H. Stewart. C. G—, æt. 19, was shown at the January meeting of the Society. He had been operated on several times, and when shown the sinus was nearly healed. It was quite healed a few days afterwards. Owing to adverse criticism as to whether an operation in this case was justifiable, Mr. Stewart brought the case again forward to show that it was possible to cure these cases by operation. In answer to Dr. Hill, Mr. Stewart stated that the dissection was carried back to the foramen cæcum.

Specimens of Polypi from the Antrum.

Mr. Symonds showed several polypoid masses, some of them three-quarters and half inch long, which he had removed from the right maxillary sinus. The patient, a woman æt. 25, had the right second bicuspid extracted for pain. There was no discharge from the nose. Soon after this a swelling projected through the socket, and was removed; a second soon followed. When first seen by Mr. Symonds, two pear-shaped gelatinous masses projected from the socket formerly occupied by the tooth. That these were not connected with the gum was shown by the fact that a probe could be passed all round them, and entered the antrum. The anterior wall of the

antrum was removed, and the polypi which were attached to the inner and posterior wall were removed by a sharp spoon. The largest measured about seven eighths of an inch in length. They were all attached about the same site and projected downwards. The aperture in the alveolus was much enlarged, and the polypi which projected through the opening were paler in colour and had a denser covering.

Large Nasal Polypus from a patient aged eighty-seven.

Shown by Mr. C. Symonds. This was a large mass with a portion of the middle turbinated, that had been removed by the cold snare. It is composed of many pendulous masses, and when removed was in outline as large as the palm of the hand. The walls of the nasal cavity had been much absorbed.

A Post-nasal Sarcoma.

Shown by Mr. C. Symonds.

Case of Pachydermia Laryngis.

Shown by Mr. C. Symonds. This case was that of Mr. H—, exhibited on several previous occasions.

The mass had nearly disappeared, so that the original view of the case has been confirmed. For three weeks the patient has resumed his duties as a schoolmaster, and during this time the greatest change has taken place for the better.

Case of Laryngeal Disease.

Shown by Dr. Herbert Tilley. S. E—, male æt. 49. "Complains of hoarseness and sore throat." Patient had syphilis about ten years ago, and was treated for it. About eighteen months after contracting the disease, he began to complain of his throat. It has been getting worse and worse, and he applied to the hospital early in February last, when he was at once put on anti-syphilitic treatment.

At first he improved, complained of less pain and easier breathing, but recently he has remained *in statu quo*.

There is no history of phthisis in family. There is a history of hæmoptysis when he was eighteen years of age. Recently he has been getting weaker. Altogether the history of phthisis is very indefinite, and the only physical signs in the lungs are those pointing to slight consolidation in the left apex.

There is a prominent granulation in the arytænoid space on left side. Left processus vocalis swollen. Over position of right vocal cord is a swollen mass of tissue which looks something like a large granulation. There is no fixation of the vocal processes beyond that due to inflammatory thickening. There is considerable laryngeal stenosis.

Dr. TILLEY was inclined to consider it a case of syphilis.

Dr. SPICER and Mr. STEWART considered it a case of tubercle.

Dr. BRUNNER thought it was syphilitic, and recommended mercurial inunctions.

Dr. TILLEY stated that Mr. Butlin had suggested that it might possibly be malignant.

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PRINTED BY ADLARD AND SON,
BARTHOLOMEW CLOSE, E.C., AND 20, HANOVER SQUARE, W.