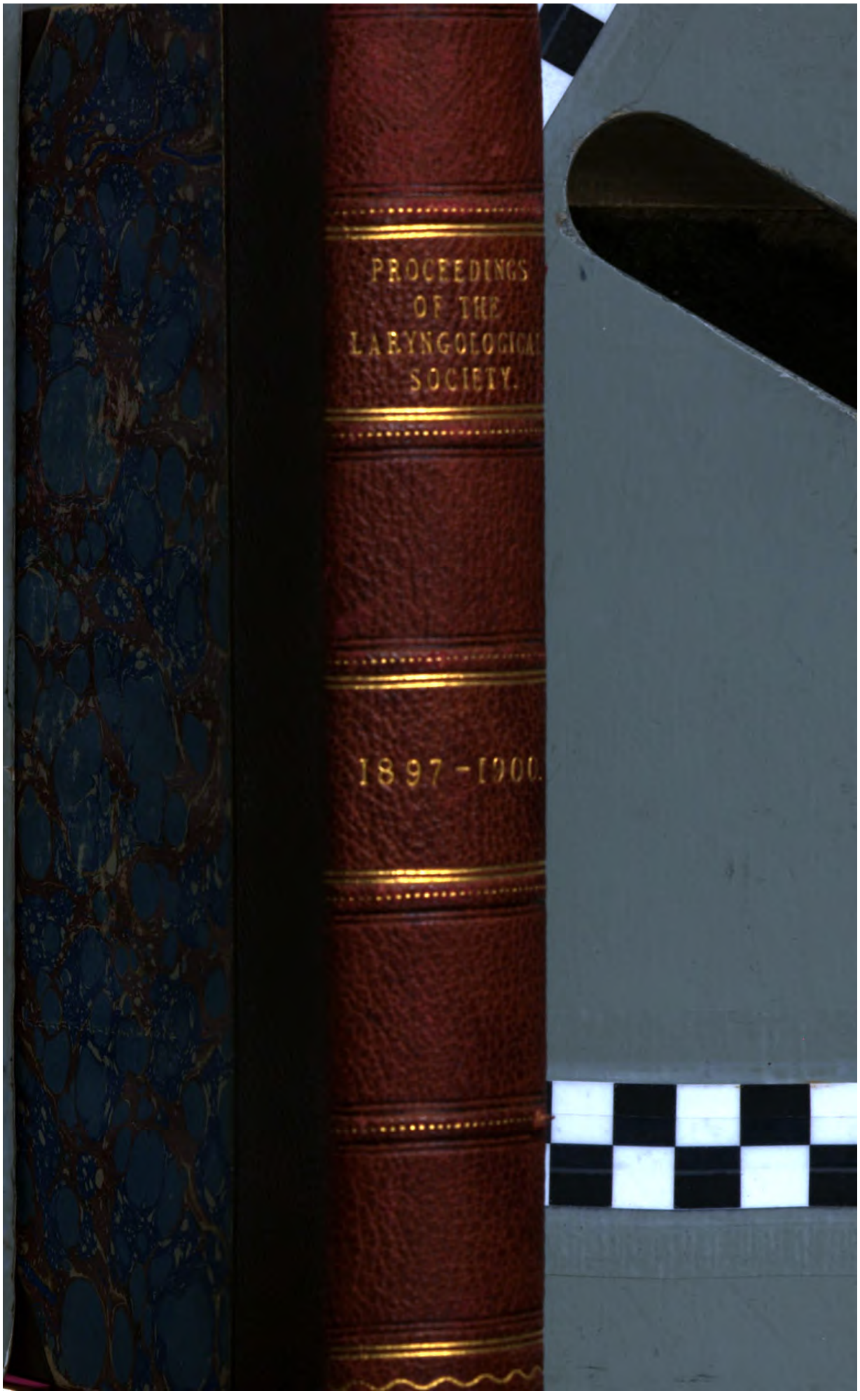
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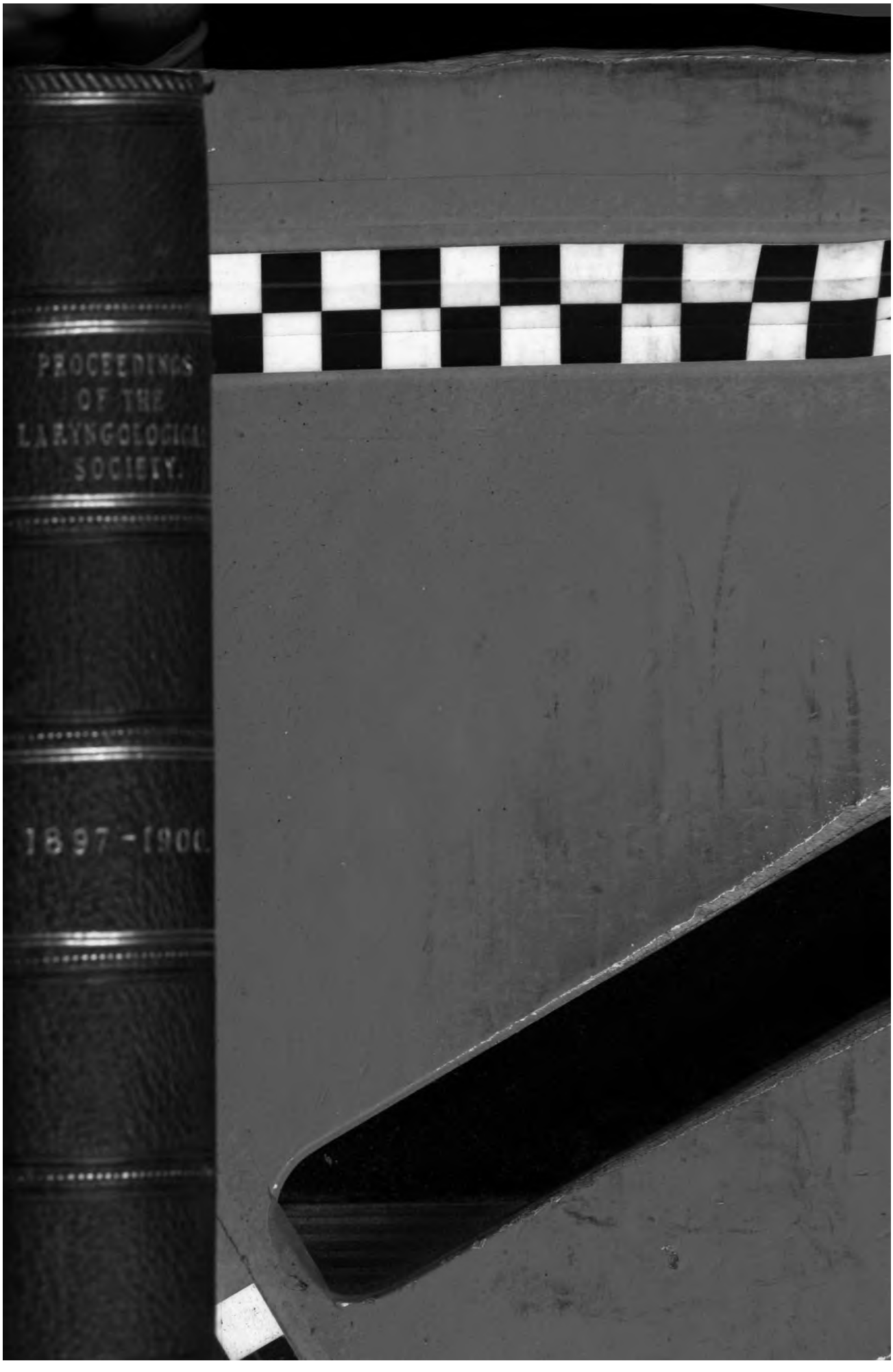
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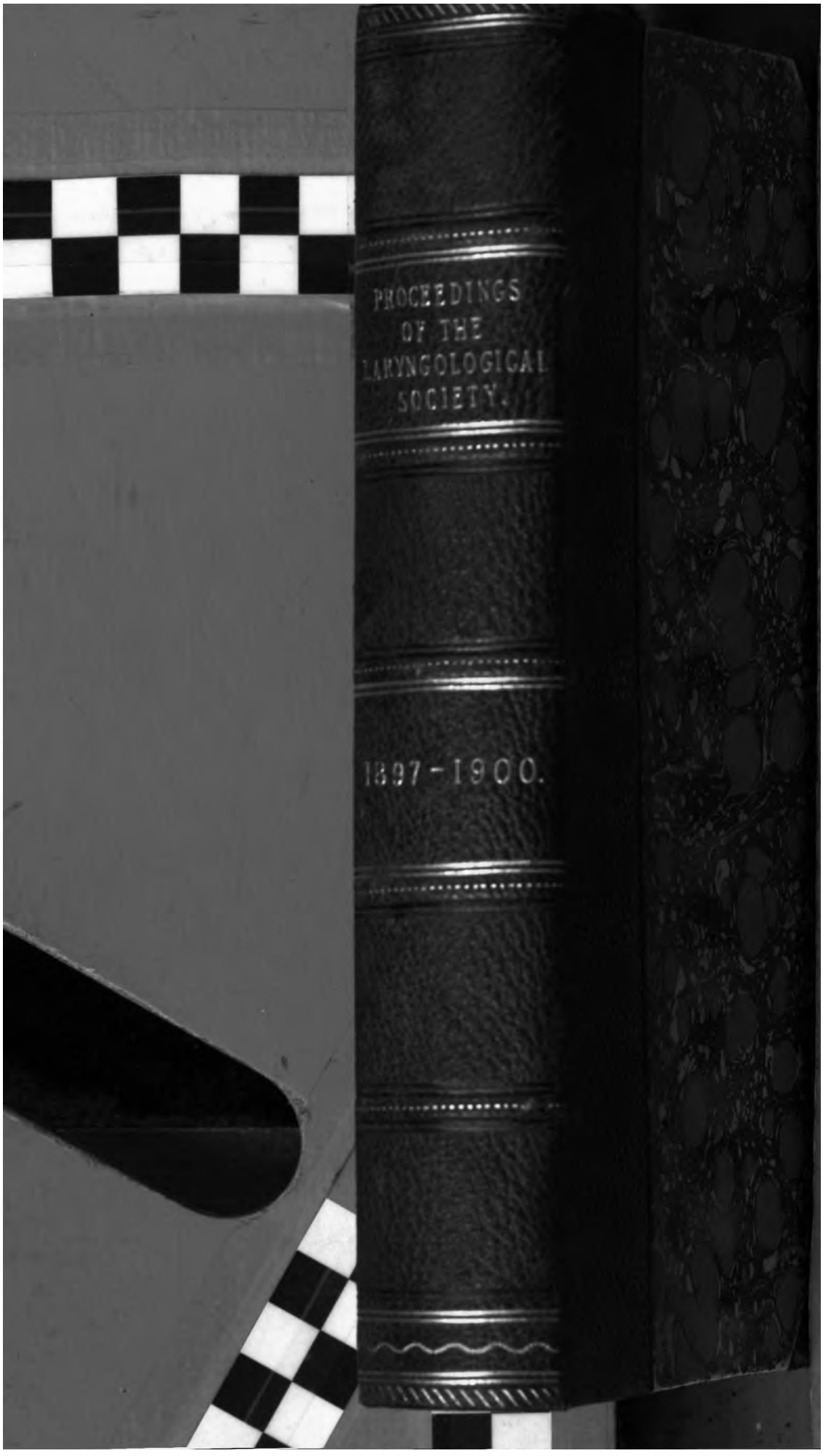
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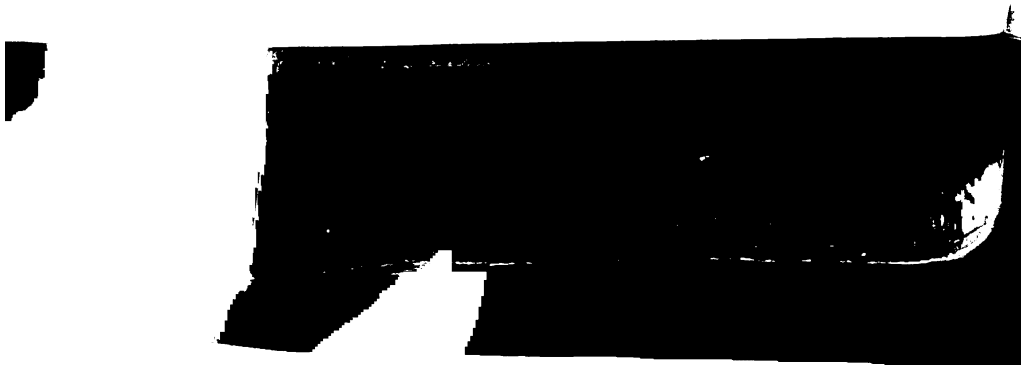

OF THE

LARYNGOLOGICAL SOCIETY

OF

LONDON.

VOL. V.

1897–98.

WITH

LISTS OF OFFICERS, SUPPLEMENTARY LIST OF MEMBERS, ETC.

LONDON:
PRINTED BY ADLARD AND SON,
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1898.

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OF THE

Laryngological Society of London

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THE ANNUAL GENERAL MEETING,

JANUARY 12TH, 1898.

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(*From its Formation.*)

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1895	Sir Felix Semon, M.D., F.R.C.P.
1896	Sir Felix Semon, M.D., F.R.C.P.
1897	H. Trentham Butlin, F.R.C.S.

Laryngological Society of London.

SUPPLEMENTARY LIST OF MEMBERS

(*To July*, 1898).

LONDON.

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COUNTRY.

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1898 FRAZER, WILLIAM, M.R.C.S., L.R.C.P.Eng., Johannesburg.

1898 HUTCHINSON, ARTHUR, M.A., M.B., C.M Glas., 225, Bath street, Glasgow.

Elected

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1898 MARSH, FRANK, F.R.C.S.Eng., 34, Paradise street, Birmingham.

1898 SCATLIFF, JOHN E., M.D.Aberd., M.R.C.S.Eng., 11, Charlotte street, Brighton.

1897 SNELL, SYDNEY, M.D., B.S.Lond., M.R.C.S.Eng., L.R.C.P. Lond., D.P.H., Shaftesbury House, Grays, Essex.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *November 10th*, 1897.

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

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

Present—42 members and 6 visitors.

The minutes of the previous meeting were read and confirmed.

Mr. Stephen Paget, F.R.C.S.Eng., and Charles McIlwraith, M.D. (Glasgow), were elected ordinary members of the Society.

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

Charles Lamplough, M.R.C.S., L.R.C.P., Chest Hospital, Victoria Park.
Sydney Snell, M.D., B.S. (Lond.), M.R.C.S., Grays, Essex.
Charles Edward Bean, F.R.C.S. (Edin.), M.R.C.S. (Eng.), L.R.C.P. (Lond.), of Plymouth.
Frederick Walter Foxcroft, M.B., C.M. (Edin.), of Birmingham.
Herbert Ramsay, F.R.C.S. (Edin.), of London.

NEW TRACHEOTOMY TUBE FOR PERMANENT USE.

The designer, Mr. W. Heywood, a working jeweller, of 81, Davies Street, W., was introduced by Sir Felix Semon, and exhibited the instrument.

The main tube is similar to that of an ordinary tracheotomy tube, but has a small, easily removable metal box, fitting into the proximal end of the tube. The anterior wall of the box is replaced by a narrow metal bar, and hanging from the upper surface of the box, a little way from its anterior extremity, is a light metal flap, so inclined that a current of inspired air easily passes through the box, but on expiration the metal flap is driven forward, and effectually acts as a "stop" to expiration through the tube. Hence the patient can (in this case suffering from abductor paralysis) phonate quite easily without placing his finger on the proximal end of the tube, as is necessary in the ordinary patterns. Moreover the little box is very easily detached and cleaned, and having a larger and freer lumen is much less liable to become obstructed by mucus than the common tracheotomy tubes.

The inventor acknowledged that he derived the idea of the instrument from Mr. de Santi's tube, but considered the new design presented advantages over any previously invented tracheotomy tubes.

Mr. DE SANTI remarked that the new tracheotomy tube for permanent use shown by Sir F. Semon's patient was practically a modification of his own shown some time ago at the Society's meeting. He, however, considered that the present modification was a distinct gain, because it gave more breathing space and was far easier to clean than his own tube. He had two patients, however, who were wearing and were well satisfied with his tube, and his friend Mr. Bowlby also had a couple of patients wearing his tube with great satisfaction. He congratulated Sir F. Semon's patient on the improvements he had made, and hoped he would get the patent he had applied for.

SYRINGE FOR MAKING SUBMUCOUS INJECTIONS IN LARYNGEAL TUBERCULOSIS.

Dr. DONELAN showed a syringe for this purpose. His attention was recalled to this treatment by Dr. Chappell's paper, read before the New York Laryngological Society in 1895, reporting a number of successes with this method. The exhibitor since that time tried the injections in seven cases of advanced laryngeal tuberculosis which had proved refractory to curetting and lactic acid, and was able to speak most favorably of the effect of the injections on the local condition. The syringe consists of a steel barrel and tube mounted on a modified "pistol handle." The tube has a rect-

angular laryngeal curve, and at the distal end a rather coarse thread, capable of carrying safely nozzles varying in length according to the depth at which it is desired to make the injections. Each nozzle terminates in a rounded shoulder from which a hollow needle projects ¼ inch, that being the depth of puncture found necessary to insure retention of the fluid. As it was found that the creasote speedily rendered the piston leathers useless, these were replaced in this syringe by a "plunger" fitting closely to the interior of the barrel and graduated in minims. The whole instrument and its case are therefore sterilisable.

The syringe is filled by pouring guaiacol into the barrel until it is full, and the oil begins to drip from the needle. The plunger is replaced and compressed until only the desired dose is left in the barrel. The needle is then guided by the laryngoscope into the previously cocainised larynx, and inserted in the site selected. Then the thumb is placed in the button of the plunger, which is driven quickly home. The needle should not be withdrawn if possible for a moment or two longer.

In the cases referred to the injections were followed by remarkably little local reaction, which was always controlled by sucking ice. The most remarkable immediate effect of this treatment was the relief of dysphagia, especially after two to three injections.

In another case an obstinate tubercular ulcer in the interarytænoid fold was quite cured. The injections were made at intervals of from four days to a week. The dose was generally one minim of pure guaiacol, and never more than two minims in obstinate cases. Besides the injections the most important part of the treatment was the frequent cleansing of the larynx by antiseptic and other sprays, most frequently an oily solution of guaiacol.

Case of Fibro-sarcoma of the Nasal Septum.

Shown by Dr. J. B. Ball. Emily P—, æt. 25, seen August 14th, 1897, complaining of a stoppage of the nose. About three or four months previously she began to suffer from repeated attacks of epistaxis. The bleeding was from the left nostril at first, but subsequently from both nostrils. During the last two or three months the nose gradually became more and more obstructed, first the left side,

then the right, but the bleeding was less frequent and severe than before. She had experienced no pain.

Examination showed each passage to be almost completely obstructed by a smooth pinkish mass presenting in the upper part of each vestibule. Its attachment was made out to be to the cartilaginous septum. The posterior choanæ were found to be free, and the growth could not be felt with the finger passed into the posterior nares.

A small portion of the tumour was removed with a snare from the left side for microscopical examination. Its removal was followed by brisk hæmorrhage. The Clinical Research Association's report was that the growth consisted of young connective tissue, and might be termed a fibro-sarcoma.

On August 24th the growth was removed by Mr. Swinford Edwards. For this purpose the left ala nasi was detached and turned up, and the growth was easily removed together with a certain amount of the cartilaginous septum. The greater part of the cartilage had, however, been absorbed. The tumour was about the size of a walnut, and presented a constriction towards the right side marking the point where it had grown through the septum.

The patient was shown together with the tumour and microscopical specimen.

Tumour of Tongue—Patient and Specimen.

Shown by Mr. Morley Agar. The tumour was removed from the right posterior dorsum of tongue in a lad æt. 15. It was readily enucleated, and followed by very little hæmorrhage. The growth had apparently only taken one week to attain its size.

Mr. Butlin suggested that it was a fibroma or fibro-sarcoma, and noticed a thickening around the area of removal which was suspicious of its sarcomatous nature. At his suggestion the specimen was submitted to the Morbid Growths Committee for examination.

Separation of Old-standing Adhesion of the Soft Palate to the Pharynx.

Shown by Mr. W. G. Spencer. The patient, a middle-aged woman, had suffered severely from tertiary syphilis, and the soft

palate had become completely united to the back wall of the pharynx. As a result of this she had great pain in the ears and over the mastoid processes, as well as collections of muco-pus which she could not expel from the nose. Antisyphilitic remedies had ceased to give any relief, and so severe and continuous was the pain that her general health and spirits had become impaired.

When she was anæsthetised, the mouth gagged open, and the tongue depressed, the respiration became bad or stopped. Therefore the operation had to be carried out with only a partially opened mouth. The head was hanging low. The line of union between the palate and pharyngeal wall was first incised by an angular cleft palate knife, when it was found that the whole of the naso-pharynx above the palate was filled by dense fibrous tissue. This was penetrated from the mouth by using cleft palate raspatories, and from the nose by thrusting in a strong pair of nasal dilators. The soft palate was after this drawn forwards and fixed by two silk sutures to the muco-periosteum of the hard palate. There was free venous hæmorrhage during and after the operation, but the nose and naso-pharynx could not be plugged because the soft palate largely obstructed respiration through the mouth. The hæmorrhage stopped the next day. The sutures holding the soft palate forwards cut out in about a week. The separation has since then been kept up by the patient passing full-sized nasal bougies, and by stretching at intervals of a fortnight the soft palate by using an aneurism needle under cocaine. The patient has lost the pain in the ears, and can breathe easily through and blow the nose. She is now in very good health, and is cheerful. The opening will admit two fingers when the palate is stretched; the latter is mobile. There is still a small muco-purulent discharge.

It is generally held that the occurrence of these adhesions cannot be prevented by any of the contrivances which have been proposed, and that it is useless to separate them when formed, owing to the tendency to recurrence. This opinion is no doubt correct as a rule, and Mr. Spencer had not heard of a successful case. But this patient is brought forward to show that, granted sufficient indications, the operation may be undertaken with some hope of affording relief. It will doubtless be necessary to keep up the dilatation in the present case for some time.

No better way of operating seems to have been proposed. Measures which entail the cutting or partial excision of the soft palate

would be likely to set up fresh trouble, owing to the passage of food into the nostrils.

Mr. DE SANTI congratulated Mr. Spencer on his excellent result. He had a similar case under observation where the patient had severe pain in the ear and mastoid; he intended to try Mr. Spencer's method of operation.

PAPILLOMA OF THE TONSIL.

Dr. WILLIAM HILL showed two tonsils, on the surface of each of which a papillary growth, about one third of an inch in diameter, was seen. They had been removed from a female and male, æt. 21 and 22 respectively, who were sufferers from chronic pharyngitis. Although these neoplasms were common enough on the palate and pillars of the fauces, little information appeared to be obtainable of papillary growths springing from the surface of the faucial tonsils. It was suggested that these cases might, up to now, have been considered too trivial to be worth recording. A papilloma on the tonsil in a middle-aged person, however, might in certain circumstances be of much clinical significance.

Messrs. WINGRAVE and WAGGETT reported having met with cases similar to those described by Dr. Hill. In Mr. Wingrave's case the papilloma seemed to be attached to the base of a follicle.

Sir FELIX SEMON thought it would be of great interest if members would bring full reports of such cases, and expressed surprise that so many cases had been seen by members of the Society. Hitherto he had shared in the general belief that benign tumours of the tonsil were practically non-existent.

Mr. BUTLIN recalled two cases of papilloma of the tonsil, and agreed that it would be well to obtain full reports of any such cases occurring in future.

Dr. JOBSON HORNE remarked that he had met with these growths on the tonsils, and referred to notes of two cases. CASE 1.—January 25th, 1894. Edward C—, æt. 17, with a history of a sore throat extending over six months. A papilloma of the size of a boot button, surface finely papillated, springing from the lower part of the left tonsil close to the junction of the anterior pillar with the base of the tongue. Both tonsils were hypertrophied and indurated. CASE 2.—May 22nd, 1896. Sarah E—, æt. 48, subject to sore throats for fifteen months. Follicular tonsillitis, follicles of right tonsil plugged; projecting from behind anterior pillar on right side, and lying across the upper surface of the tonsil, was a smooth white polypoid growth attached to a stalk running behind tonsil. After removal of growth

the abnormal sensations and discomfort referred to the fauces disappeared.

Mr. Macleod Yearsley said that in 1894 he saw a patient, aged 45, who presented a small polypoid growth about the size of a grape-stone at the upper part of the left tonsil, which was itself enlarged. It had only been noticed by her for about four weeks, and caused no symptom beyond a frequent desire to swallow. It was removed under cocaine and did not recur. On section it was found to consist of adenoid tissue with a covering of stratified epithelium. At one spot in the growth was a small hæmorrhage.

Lupus of the Larynx.

Dr. William Hill showed a young girl, æt. 13, who had been brought before the Society last winter, when she had lupus of the tip of the nose and palate. By persistent scraping and cauterisation (she had been under an anæsthetic nearly twenty times) the nose and palate had healed by August last, and the epiglottis showed no infiltration at that period, when she was sent to a convalescent home. Six weeks ago the patient presented herself again, complaining of cough; on examination the epiglottis was seen to be thickened and infiltrated and rather pale,—in fact, very suggestive of the ordinary form of tuberculosis; now, however, it was red, irregular and granular on the surface, and conforming with the appearances of chronic tubercular lupus. The patient also had a patch of lupus on the face and on the left foot.

Dr. Dundas Grant thought it a case of lupus of the larynx.

Dr. Beale had seen many such cases, and found the surface of the epiglottis remained free from ulceration, and therefore he advised leaving the local condition alone.

Dr. Hill, in reply, said he purposed trying a new form of tuberculin.

Cyst of Epiglottis.

Shown by Dr. Jobson Horne. The patient, a man æt. 36, complained of cough and wasting. Pulmonary tuberculosis was diagnosed, and it was whilst looking for evidence of tubercle in the larynx that he met with this cyst on the epiglottis.

The cyst had the appearance of a small grape; it was tense, slightly translucent, and coursed by vessels. It was situated on the lingual

surface of the epiglottis, occupying the left half, and was attached by a broad base close to the free edge.

The man had been suffering from dysphagia for six months; for some time he had been taking only food fairly chopped, but latterly had had to reject even fluid food. The dysphagia had been so gradual in developing that he regarded it as occasioned by his general ill-health.

The cyst was removed with a hot snare, a faint linear scar indicating its situation. It contained a watery thin fluid. Since the removal of the cyst dysphagia had completely disappeared, the cough had been less, and the man's health had considerably improved.

Dr. Horne considered that in the interarytænoid folds there was evidence of a deposition of tubercle.

In both nostrils the mucous membrane of the turbinal borders was in a condition of true hypertrophy, and was causing partial obstruction.

Mr. Cresswell Baber instanced a case of a child æt. five months in whom there was a cyst, about the size of a marble (apparently congenital), to the right side of the epiglottis. It produced noisy respiration and occasional dyspnœa. The cyst was ruptured by means of forceps, and collapsed completely. The breathing was relieved.

Dr. Bronner, Sir Felix Semon, and Dr. Dundas Grant reported similar cases in which large cysts had been present and given rise to well-marked symptoms.

Case of Paralysis of Right Vocal Cord, Right Side of Soft Palate, and Right Side of Pharynx, probably due to Nerve Lesion high up in Neck.

Shown by Dr. Scanes Spicer. J. W—, æt. 72. Has been a smith. In good health until Christmas, 1896, when after a cold he became hoarse and had difficulty of swallowing; no difficulty of breathing even on exertion, though occasionally his breathing is noisy; when first ill could not lie on his left side. On examination the right vocal cord is seen to be immobile and in the middle line; the right arytænoid cartilage jerks a little on commencing phonation; there is no marked alteration in contour of the right crico-arytænoid joint, and the left side of the larynx is normal. The right side of soft palate is paretic, the faucial arch being lower than the other and flatter, and the patient states he does not feel as well on right side of pharynx as on left when probed. The tongue, sterno-mastoid, and

trapezius are not paretic or wasted. These points were confirmed by Dr. Wilfrid Harris, who also examined the chest with a negative result. No evidence of pressure in neck. By process of exclusion it appears probable that some lesion has involved some of the roots of the spinal accessory and vagus, perhaps a peribulbar pachymeningitis, or possibly focal degeneration of bulbar or spinal nerve cells.

The patient denies specific history, and there are no evidences of it. He has, however, been taking iodide of potassium, ten-grain doses thrice daily, for three months, without any marked change in condition three weeks ago.

Dr. HALL was inclined to view the local appearances as due to inflammatory mischief.

Sir FELIX SEMON thought the appearances were almost within physiological limits, in which Mr. BUTLIN agreed; but Dr. GRANT thought the palate paralysis was quite marked.

Dr. STCLAIR THOMSON also confirmed Dr. Grant's opinion, and observed that Dr. Hughlings Jackson laid stress on observing the soft palate in all cases of motor impairment, and to accept as distinctly typical of hemiparesis that condition in which on phonation one side of the palate remained lax, while the opposite showed a contraction dimple, and the median raphe was drawn towards the unaffected side.

In reply, Dr. SCANES SPICER thought that the palate condition had altered since his last examination, and the faucial arches were now of equal height.

CASE OF CHRONIC LATERAL HYPERTROPHIC LARYNGITIS SIMULATING MALIGNANT DISEASE.

Shown by Dr. HERBERT TILLEY. Patient is a male æt. 38. He had suffered from hoarseness for six months, but no pain or difficulty of swallowing, and has not lost weight to any appreciable degree.

He is a confirmed asthmatic, and has to rise every night to smoke his "powder."

On examination the right vocal cord is seen to be quite immobile on phonation. It is in parts of a pale milky colour. The thickening extends nearly the whole length of the cord, and some is seen in the anterior commissure.

There is an enlarged gland in the right submaxillary triangle.

Sir FELIX SEMON said that it was only fair to say that the title of the case was really due to his suggestion made some week or two ago, when he saw the case in consultation with Dr. Herbert Tilley, who had brought the patient to him for confirmation as a case of malignant disease, and to discuss the advisability of operating. Appearances in the patient's larynx had since altered, and now he felt inclined also to look upon it as malignant, but would not like to be positive in the matter.

Dr. BRONNER suggested removing a piece for microscopic examination, and Dr. DUNDAS GRANT asked that the sputa might be examined for tubercle bacilli.

Dr. HERBERT TILLEY, in reply, stated that he thought there was no suggestion of tubercle in the case; the patient was a great sufferer from asthma, and asthma and phthisis were rarely found together. It would be difficult to examine his sputum, as it was impossible to obtain anything except small pellets of clear mucus, which he expectorated after burning his "asthma powder." He thought the case would turn out to be malignant.

THYRO-HYOID CYST.

Shown by Mr. WYATT WINGRAVE. A little girl, æt. 5, when first seen complained of a "running sore" in her neck. Her history was that ever since a few months old a swelling had existed below her chin, which gradually grew to the size of a cobnut. Twelve months ago, becoming red and tender, it was "cut" by her doctor, and had discharged ever since.

On examination the aperture of a fistula was seen in the middle line of the neck, superficial and apparently attached to the isthmus of the thyroid body, moving with deglutition and discharging pus-like matter, which was found to consist of epithelial cells undergoing fatty degeneration, suggestive of colostrum corpuscles.

From its situation, anatomical relations, and history it was diagnosed as the vestige of a cystic thyro-hyoid duct.

It was dissected out, and on microscopical examination presented an irregularly corrugated canal with diverticula, lined by spheroidal and ciliated "palisade" epithelium, resting on an ill-defined hyaline basement membrane, outside which were occasional clusters of small-cell tissue. The wall or capsules was composed of densely packed bundles of white fibrous tissue.

These histological details exactly correspond with those occurring in a perforation made two years ago from a case under the care of

Dr. Dundas Grant, and although such examples may not be of unfrequent occurrence clinically, in the absence of other microscopic records relating to this particular portion of the thyreo-glossal duct they may be of interest to the Society.

Mr. Butlin had removed two or three of such cysts with their ducts, and had been obliged to follow the latter up to the base of the tongue by going in front of the hyoid bone.

Mr. Walsham and Mr. Stewart reported similar cases.

Case of Necrosis of the Left Inferior Turbinal with a History of Traumatism.

Shown by Dr. Pegler. Mrs. A—, seen July, 1897, complained of discharge from and obstruction in the left nostril. When a young woman she had struck her nose violently against a post. The organ was said to have been broken, and there was much epistaxis at the time. Since that time there had been some trouble connected with it, *i. e.* obstruction, offensive discharge, and more recently bleeding. Two pieces of dead bone are said to have been taken away some time ago.

Externally there is now some deflection of nose to the right. There is a mucocele in the inner canthus of the left eye. A mass of granulation tissue blocks up the left meatus and is bathed in pus. With the probe a rough grating may be felt beneath the granulations like that of dead bone. Little has been done in treatment, owing to patient's objection to an anæsthetic.

Such cases are probably not rare, but have not received the attention they deserve, and the exhibitor would like the opinions and experiences of members of the Society in similar cases.

Mr. Cresswell Baber thought the rough body in the left nasal cavity was either a piece of necrosed bone, a rhinolith, or a foreign body. He advised its removal with forceps after it had been, if necessary, broken up.

Mr. Walsham said he thought the mass would easily come away.

Dr. StClair Thomson thought that the history of injury dated rather far back, but that if trauma was actually the cause it was important to put such a case on record along with Mr. Walsham's, for Tissier said that necrosis of a turbinal was so pathognomonic of syphilis, that whenever found it was superfluous to inquire for a specific history.[1]

[1] 'Wiener klin. Wochenschrift,' No. 37, 1897.

Dr. PEGLER, in reply, stated that he had not regarded the case as syphilitic, because the appearances were entirely different from what he had seen of that disease.

In reply to Dr. StClair Thomson, the history might be rather ancient, but the woman was very intelligent in the matter. There seemed to be a definite continuation of nose trouble, traceable directly back to the date of the accident.

In reply to Dr. William Hill, there was no reason why the case should not be regarded as one of rhinolith with dead turbinate bone for a nucleus.

DISEASE OF THE RIGHT VOCAL BAND FOR DIAGNOSIS.

Shown by Dr. PEGLER. E. C—, æt. 56, complains of loss of voice.

History.—The trouble commenced five or six years ago by a feeling as of always wanting to swallow; this was followed by a bad cough. Her voice gradually left her, and has never returned. The woman has had seven children born alive; the eighth pregnancy terminated in a miscarriage. There is no pain in the throat.

Laryngoscopically the most conspicuous object is a deep red somewhat conical growth occupying the upper surface of the anterior third of the right vocal band. The right vocal cord is entirely concealed, the left is intensely red. The arytænoid cartilages move freely and equally on attempts at phonation, and there was no infiltration of the laryngeal structures.

Mr. BUTLIN thought a piece of growth might be removed, in which Sir FELIX SEMON concurred.

In reply to the President, Dr. PEGLER said he had not been able to decide between malignant disease and syphilis. Dr. Whistler had examined the patient with him, and was inclined to regard it as syphilitic; he should try the effects of an antisyphilitic treatment in the first instance.

PROLAPSE OF VENTRICLE OF MORGAGNI.

Dr. WORTHINGTON, who showed the case for Dr. Percy Kidd, said that there was dyspnœa and stridor for three weeks before her admission to hospital, and great dyspnœa on admission; also great œdema of epiglottis, which subsided in a day or two, leaving the small tumour which is now seen.

Dr. StClair Thomson reminded the Society that Koschier—Stoerk's first assistant—had published a paper founded on the histological examination of nineteen cases, and demonstrating that there was no actual eversion of the sinus in the condition known as "prolapse of the ventricle of Morgagni." Such cases turned out to be solid tumours, cystic or fibromatous, taking their origin from the wall of the sinus; but the actual wall of the sinus remained *in situ*.

Dr. Bond also made remarks on the case.

Case of Early Tubercular Laryngitis.

Shown by Dr. Lawrence. C. N—, æt. 22, general servant. One sister of nine suffers from "weak chest." Patient lost her voice two years ago, and at that time had atrophic rhinitis, pharyngitis, and laryngitis. She quite recovered from this under appropriate constitutional and local treatment. There is almost complete aphonia now, and pharynx is as before. Vocal cords do not move freely, and there is a small pinkish swelling in the interarytænoid space.

Examination of chest shows a flattening and impairment of the note at right apex, fine crepitations and cogwheel breathing under right clavicle. The exhibitor considered these latter symptoms with the swelling of the interarytænoid space indicated early tubercular laryngitis.

Dr. Beale thought there was no evidence of tubercle, but only chronic laryngitis, which was probably secondary to nasal disease,—an opinion in which Mr. de Santi agreed.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *December 8th*, 1897.

CRESSWELL BABER, Esq., M.B., in the Chair.

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

Present—33 members and 5 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were elected as ordinary members of the Society:

Charles Lamplough, M.R.C.S., L.R.C.P.
Sydney Snell, M.D., B.S. (Lond.), M.R.C.S.
Charles Edward Bean, F.R.C.S. (Edin.), M.R.C.S. (Eng.), L.R.C.P.
Frederick Walter Foxcroft, M.B., C.M. (Edin.).
Herbert Ramsay, F.R.C.S. (Edin.).

THE POSITION AND CONDITION OF THE VOCAL LIPS IN THE CHEST AND HEAD REGISTERS.

Dr. JOBSON HORNE, on behalf of Dr. Musehold, of Berlin, showed a series of photographs of the larynx demonstrating the above conditions. Dr. Horne referred to the researches of Dr. Musehold, and drew attention to what he understood from Dr. Musehold to be the more important conclusions which had been arrived at with the help of the stroboscope, and which the photographs demonstrated.

In the chest register it was seen that the glottis is "opened and shut, whereas in the head register it is "widened and narrowed," a difference still more demonstrated with the stroboscope.

The cords themselves in the chest register, and more particularly in the production of loud chest-notes, showed a rounded or tumid form. This was accounted for by the expiratory current of air meeting with an increased resistance, and forcing the cords upwards; and it was the analogy of this condition of the cords with the condition of the lips when applied to the mouth-piece of a trumpet in producing loud notes that suggested the term "vocal lips" in the present instance.

The photographs further showed that the deposition of the mucus secreted on to the cords was along different lines in the two registers; this was attributed to a difference in the manner and intensity of the vibrations.

For a more detailed description of the photographs and of the photographic apparatus and stroboscope used, Dr. Horne referred to Dr. Musehold's paper which had recently appeared in the "Archiv für Laryngologie und Rhinologie.'

Defect of Speech resulting from Paresis of Soft Palate, occasioned by Lymphomatous Tumours projecting posteriorly from either side of the Septum.

Shown by Dr. Pegler. The patient is a youth æt. 23. The defect of speech precisely resembled that of cleft palate.

There was complete nasal obstruction, depending upon hypertrophies and moriform bodies attached to both middle and inferior turbinates, &c., in addition to the septal growths. A diffuse lymphoid mass presenting a well-marked Tornwaldt's bursa lined the roof of the nasopharynx, but there were no post-nasal adenoids.

The appearances of the septal lymphomata and microscopical sections (here shown), displaying pure lymphoid tissue throughout, were described in two recent numbers of the 'Journal of Laryngology' (9 and 12). The growths were exceedingly tough, and had been taken away by means of the turbinotome. The other sources of obstruction having also been removed, nasal respiration was quite free. A much thickened septum is exposed.

The drawings handed round showed the post-rhinal image before

and after operation. Papilliform lymphoid hyperplasiæ had been suspected to occur by Jonathan Wright and others, but these were the first that had been microscoped and recorded so far as Dr. Pegler was aware. The paresis of the palate was bilateral and reflex, and the defect of speech remained, but was improving.

The Case of Apparent Necrosis of Left Inferior Turbinate following Injury shown at the Last Meeting by Dr. Pegler.

The patient was brought up again to show the condition of the nasal fossa after the loose body had been removed, and also the fragments themselves. The granulating surface was entirely healed over. The two pieces handed round had all the appearance of necrosed inferior turbinate bone encrusted with lime. The precise date at which pieces of dead bone had been extracted after the original accident had been ascertained. Dr. Pegler said he should be happy to have sections made if that were possible and report again.

Papillomata of Faucial Tonsil.

Shown by Mr. Wyatt Wingrave. The interest exhibited in Dr. Hill's cases shown at the last meeting, and the suggestion made by the President and Sir F. Semon, induced the exhibitor to present two examples occurring in his own practice.

1. Papilloma removed from the left tonsil of a man æt. 44. Consisted for the most part of a fibro-vascular core covered with fimbriæ of stratified squamous epithelium, with a few concentric bodies. Slight symptoms of irritation. Tonsils enlarged; with history of several quinsies.

2. Fibro-vascular papilloma removed from the right tonsil. It looked like a red polypus hanging from the surface of the tonsil, but under cocaine became anæmic. It apparently grew from a dilated lamina, and was removed by snare, coming out like a tooth. It was about 2 cm. in length, and consisted of fibro-vascular and small-cell tissue covered with smooth stratified epithelium. Sore throat and history of quinsies. Reported in 'Journal of Laryngology' as "Polypus of Tonsil," vol. viii, p. 358.

The papillomata generally grow from the surface, whilst the so-called polypi spring from the interior of lacunæ. Their origin is suggested by examining sections of chronic lacunar tonsillitis, in which papillary excrescences will be found growing from the fundus and sides of dilated lacunæ. An exaggeration of such a condition would readily form a papilloma or a polypus.

Female on whom Tracheotomy had been performed, with Immobility of Left Cord and Partial Immobility of Right.

Shown by Dr. J. W. Bond. (No notes received.)

Female with Tumour of the Epiglottis.

Shown by Dr. Bond. (No notes received.)

Mr. de Santi thought that the tumour was too soft and vascular-looking for an epithelioma, and took the view that it was sarcomatous and considered the enlarged glands to be a contra-indication to any operation.

Case of Paralysis of Left Vocal Cord and Dilator of Pupil, with Ptosis of the Same Side.

Shown by Dr. Spicer. T. R—, æt. 59, a gardener, complains of hoarseness and swelling in the neck.

Laryngoscopic examination shows the left vocal cord in the middle line, and immobile. There is no deformity in the larynx nor pathological changes. Left pupil contracted. Left upper eyelid in condition of ptosis. There is a mass of three or four enlarged glands under the left sterno-mastoid opposite the cricoid cartilage. Patient has taken iodide of potash for more than six weeks. No history of syphilis.

? Mucous Patches on Fauces; Case for Diagnosis.

Shown by Dr. Scanes Spicer. Charles D—, æt. 3. About four months ago the mother noticed a white, ulcerated-looking surface on

the tonsils, uvula, and soft palate, which has never disappeared but varies in its extent of surface. There are enlarged cervical glands, and swallowing is easy. Patient had "thrush," which lasted three weeks, when he was a month old, followed by an ulcer on eye and in the groin. He has also had an hydrocele. There has been no contact with diphtheria. When the white patches are removed the surface bleeds.

The diagnosis seemed to be between chronic diphtheria, mucous patches, lupus, tuberculosis, papillomata, and simple ulceration.

Dr. Plimmer reports that there are diphtheritic organisms present.

A cultivation of the ulcerated surface shows streptococci and sarcinæ.

The treatment had consisted of internal administration of chlorate of potash, but it had not altered during the past six weeks.

Dr. Barclay Baron had seen a similar case, which was not syphilitic.

Dr. Lambert Lack had a patient in whom a similar ulceration was combined with lupus, and he advised arsenic as an internal remedy.

Rapidly Recurrent Tumour of Nasal Septum.

Shown by Dr. Spicer. Albert H—, æt. 35, sent to St. Mary's for epistaxis. On examination a spongy, very red and vascular growth is seen attached by a broadish base to right side of cartilage of nasal septum. A portion was at once removed with scissors, and felt hard on cutting through. It has grown again nearly to original size in a fortnight, and base is larger.

Report by Dr. Plimmer.—Large amount of fibrous tissue; few sarcomatous cells; lymphoid tissue; very few vessels; prognosis as to benignancy favorable.

Dr. StClair Thomson was of opinion that the growth was simple in character, and was a fibro-angioma or bleeding polypus of the septum. He recalled a very similar case he had shown to the Society two years ago ('Proceedings,' vol. iii, January, 1896). In that case the growth rapidly recurred soon after removal, and the sections of the growth were found by some members to be so suggestive of sarcoma, that they warmly recommended speedy and radical excision. However, the recurrence was simply removed with the snare, the base curetted and then well seared with the galvano-cautery (without

perforating the septum). He had kept the patient under observation, and now, at the end of two years, there had been no recurrence. The growth was declared by the Morbid Growths Committee to be a fibro-angioma, and he suggested that the sections in the present case might be submitted to the same Committee.

Mr. WINGRAVE suggested that the tendency to alveolation of the cells was in favour of its sarcomatous nature.

CASES SHOWN BY DR. LAMBERT LACK.

A girl æt. 6 and a boy æt. 3, who have had congenital obstruction, to show the persistent malformation.

The two cases are in most respects similar. Both came under the care of my colleague Dr. Sutherland and myself, when a few weeks old, presenting all the characteristic signs of the affection known variously as *congenital laryngeal stridor, infantile respiratory spasm,* &c. The signs of laryngeal obstruction increased for some months, and then gradually passed off until, at two years of age, they had practically disappeared. The true pathology of this affection, hitherto generally considered a form of laryngeal spasm, was demonstrated in a recent paper by Dr. Sutherland and myself ('Lancet,' September, 1897). We found that the epiglottis is folded laterally so sharply that its lateral halves come very close together, or even into actual contact. The arytæno-epiglottic folds, thus approximated, flap inwards at each inspiration, reducing the upper aperture of the larynx to a narrow slit or even completely closing it. In these two cases the stridor and other signs of laryngeal obstruction have completely passed off, apparently because the upper aperture of the larynx is larger, and the tissues forming it less flaccid than in infancy. The malformation of the epiglottis, however, remains unaltered—in the girl the folds being very close, in the boy in actual contact. This persistence of the curved epiglottis seems to me very important as showing (1) that although, as above stated, constantly present in this affection, and playing an essential part in its pathogenesis, it is not the actual curve of the laryngeal obstruction, and (2) that this form of epiglottis is not the normal type in infancy, as Escat and others have stated. The latter point is further shown by the fact that I have never yet found the malformation in a large series of examinations of the larynx in babies during the past two years.

Dr. HILL and Dr. GRANT had seen similar cases, and the former asked Dr. Lack if there was ever any subluxation of the crico-arytænoid joints in such cases.

CASE OF TORNWALDT'S DISEASE.

Shown by Mr. RICHARD LAKE. The patient, a young woman, had been troubled for ten years by the crust formation, which she used to expel every second or third day. A point of interest in this case lies in the fact that the patient went to a throat hospital three years ago, and was treated for this trouble by having her inferior turbinates removed, and she seems to believe she has since become somewhat worse.

Mr. CRESSWELL BABER had found the galvanic cautery applied with the aid of the rhinoscopic mirror of considerable benefit in these cases in arresting both the discharge and hæmorrhage.

LARGE TUMOUR IN THE NECK.

Dr. DONELAN showed a man æt. 56 with a large tumour occupying the left side of his neck from the temporo-maxillary joint to the clavicle. In last April the patient first noticed a small swelling behind the jaw, which was painless but continued to grow until in September it was about the size of an ostrich egg. He then went to University College Hospital, where its removal was advised, but patient declined. Since then the growth had rapidly increased to its present size. There had been, however, no pain until within the last few weeks, when there was some neuralgia in the left side of head.

The points of interest to the Society were the paresis of the tongue, the immense displacement of the larynx to the right with paresis of left vocal cord and swelling of left arytænoid body. The latter is difficult to see from overlapping of ary-epiglottic tissues and ventricular band. There was entire absence of dysnœa and dysphagia, and but little change in the voice. On seeing the patient for the first time Dr. Donelan thought the case one of lymphadenoma, but now believed it to be a malignant tumour, probably sarcomatous. It was doubtful if anything could now be done.

Mr. DE SANTI considered this case to be one of malignant disease; probably primary epithelioma of the cervical glands. The mass was fixed, extensive, and of stony hardness. He could not get a view of the larynx. An examination of the œsophagus should be made. The case was quite inoperable.

SKETCHES AND SPECIMEN OF BENIGN TUMOUR OF THE TONSIL.

Shown by Mr. WAGGETT.

SKETCHES AND SPECIMEN OF PAPILLARY HYPERTROPHY OF THE TONSIL.

Shown by Mr. WAGGETT. This patient has complained for about six months of "stoppage in the nose." About two months ago he came to the London Hospital, and some polypi were removed from both nostrils. The posterior ends of both inferior turbinates were also removed, and he ceased attending for the time. The polypi were not examined microscopically, but gave rise to no suspicion of being anything beyond simple polypi.

Patient returned again on December 8th, appearing very ill. No polypi were seen anteriorly. On digital examination a hard mass about the circumference of a shilling was felt on the posterior naso-pharyngeal wall, apparently growing from the first or second cervical vertebræ in the middle line. It was very tender to the touch, and bled slightly after examination. There was no impairment of movement of the cervical vertebræ.

Dr. HERBERT TILLEY instanced a case recently seen by him in which it was almost impossible to get the finger into the naso-pharynx because of the prominence of the upper cervical vertebræ. The patient was well built, with no obvious deformity in the neck.

Dr. DUNDAS GRANT said he had referred in another Society to such a prominence simulating the presence of adenoids.

Mr. CRESSWELL BABER said he had not had an opportunity of making a thorough examination in this case, but he had noticed considerable thickening of the soft palate and prominence of the tubercle of the atlas.

Soft Swelling in the Neck.

Shown by Dr. Pegler. Patient was a young female with a large swelling in the neck, apparently extending outwards and backwards from beneath the left sterno-mastoid.

Dr. Herbert Tilley said that by getting a strong light behind it and examining it like a hydrocele, a small amount of light penetrated it, and from its feel he thought it was cystic.

Mr. de Santi looked upon this case as one of cystic nature, probably cystic hygroma. Probably the fluid was thickish and the aspirating needle small, thus accounting for the negative result on puncturing. It might be a very soft fatty tumour; but its shape, situation, history, and non-adhesion of the skin and absence of lobulation were against this diagnosis. He advised an exploratory incision.

Case of Persistent Branchial Cleft in Neck.

Shown by Dr. Dundas Grant. (No notes received.)

Symmetrical Ulceration of Tonsils, Perforation of Nasal Septum, in a Young Boy.

Shown by Mr. Atwood Thorne. A boy æt. 13, under the care of Dr. William Hill (by whose permission the case was shown).

On admission the boy had been ill for three weeks, complaining of a "cold, sore throat, and running from the nose."

Examination showed symmetrical inflammation of both tonsils, spreading on to the soft palate, and with a well-defined margin. The right tonsil contained a cheesy mass, which was removed, and the cavity painted with chromic acid. The glands behind the sterno-mastoid were enlarged and hardened on both sides.

There was a blood-stained discharge from both nostrils, and a perforation of the bony septum, covered with scabs. Over the chest there was a well-marked macular rash.

Mr. Thorne suggested as a provisional diagnosis "secondary, or early tertiary syphilis."

Mr. Cresswell Baber suggested that the case was one of congeni-

tal syphilis, and considered that one of the teeth was somewhat suggestive of that disease.

Dr. HILL concurred in this opinion.

Dr. ATWOOD THORNE, in reply, said that the family history seemed to negative "hereditary syphilis." Both history and examination contra-indicated tubercle.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ANNUAL GENERAL MEETING, *January 12th*, 1898.

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

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

Present—43 members and 3 visitors.

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

Dr. Jobson Horne and Mr. Atwood Thorne were appointed Scrutineers of the ballot for the election of Officers and Council for the ensuing year; they reported the result of the ballot as follows:

President.—H. Trentham Butlin, F.R.C.S.
Vice-Presidents.—J. W. Bond, M.D.; A. Bronner, M.D.; F. de Havilland Hall, M.D.; Scanes Spicer, M.D.; T. J. Walker, M.D.
Treasurer.—W. J. Walsham, F.R.C.S.
Librarian.—J. Dundas Grant, M.D.
Secretaries.—Herbert Tilley, M.D.; William Hill, M.D.
Council.—A. A. Kanthack, M.D.; Sir F. Semon, M.D.; W. R. H. Stewart, F.R.C.S.; StClair Thomson, M.D.; P. Watson Williams, M.D.

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

The Council has much pleasure in reporting the continued prosperity of the Society, both as regards the increase in the number of its

members and the sustained interest in the work of the Ordinary Meetings.

The Society now numbers 119 ordinary members and 9 honorary members, 16 ordinary members having been elected during the past year.

We have not lost any members through death, but Dr. Walton Browne of Belfast has resigned owing to distance from London, and Messrs. Ewen Stabb and Davis have severed their connection with the Society owing to other claims upon their time.

The meetings of the Society have been well attended, the average attendance of ordinary members being 31, of visitors 5. This is a higher average than any formerly attained by the Society.

The ordinary meeting held May 12th was given up to a discussion, introduced by Dr. Dundas Grant, on "The Uses of Turbinotomy as applied to the Inferior Turbinate Bone." The subject being one of much importance elicited some interesting experiences from many members who joined in the discussion which followed the reading of the paper.

The Council have discussed, without coming to any definite conclusion, the advisability of limiting in some way the admission to the membership of the Society, in order to minimise the excessive examination to which many patients are subjected at the Ordinary Meetings.

The Council consider that the Society is to be heartily congratulated on the honour of knighthood which has been conferred during the past year upon its past President, Sir Felix Semon, M.D.

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

The actual receipts for the year ending December 31st, 1897, have amounted to £141 15*s.* 6*d.* This amount includes four subscriptions for 1898.

There are still a few subscriptions for 1897 outstanding (£7 7*s.*), all of which are good, and will appear in the balance-sheet for 1898.

The actual expenditure was £83 17*s.* 8*d.*, leaving a balance for the year of £57 17*s.* 10*d.* This, with the balance of £112 2*s.* 7*d.* brought forward from the 1896 balance-sheet, leaves in the Treasurer's hands on December 31st, 1897, the total balance of £170 0*s.* 5*d.*

BALANCE-SHEET, 1897.

Income.	£	s.	d.
Balance from 1896	112	2	7
Subscriptions—			
100 members at £1 1s.	105	0	0
13 members at £2 2s.	27	6	0
1 member at £9 9s.	9	9	0
Excess on Edinburgh cheque	0	0	6
Returned by Rogers (excess paid on cheque)	0	0	3
Total	£253	18	4
The income for the year is	£141	15	6

Expenditure.	£	s.	d.
Rent and Electric Light (20, Hanover Square)	31	10	0
Adlard for Printing and Postage, October 8th, 1896, to June 3rd, 1897	44	14	6
Mayer and Meltzer (specula, &c.)	2	15	0
Petty Cash—			
Rogers (Carbolic Acid and Spirit) £0 14 6			
Secretarial Expenses:			
Dr. StClair Thomson £1 5 0			
Dr. Tilley 0 2 5			
1 7 5			
Stamps 0 12 0			
Doughton, attendance 1 0 0			
Bank Charges:			
Scotch and Irish cheques 0 1 6			
Indexing volume, 1897 (Clarke) 1 1 0			
	4	16	5
Deficit on foreign cheque	0	2	0
Balance in Treasurer's hands	170	0	5
Total	£253	18	4
The expenditure for the year is	£83	17	8

Audited and found correct, *January* 6, 1898.

E. B. WAGGETT.
StCLAIR THOMSON.
E. CLIFFORD BEALE.

The following embodies the Librarian's Report, which was then read.

The following works have been added to the Library during the past year:

Laryngologische Gesellschaft zu Berlin Verhandlungen, Band vi, 1895. Ausgegeben 1897.

Gesellschaft der Ungarischen Ohren- und Kehlkopfärzte, Jahrbucher, Band ii, 1896.

Brighton and Sussex Medico-Chirurgical Society. Proceedings and Annual Report, 1896–7.

Niederlandische Gesellschaft für Hals, &c., Bürger's Berichte, 1896.

Moritz Schmidt, Krankheiten der oberen Luftwegen, 2nd edition. (Presented by the author.)

Photographic Album of Views of the Vanderbilt Clinic for Diseases of the Throat. (Presented by Dr. Lefferts.)

Monographs and Reprints on Laryngological and Rhinological Subjects, by Dr. Hugo Bergeat. (Presented by the author.)

Gouguenbeim, Dr. Monographs and Reprints. (Presented by the author.)

Moure, Dr. E. J. (Bordeaux). Monographs and Reprints. (Presented by the author.)

Ardenne, Dr. Tumeurs benignes de l'Amygdale. (Travail de la Clinique de Moure, 1897.)

Stirling, Dr. On Bony Growths invading the Tonsil; Chicago, 1896. (Presented by the author.)

Monographs presented by Dr. de Havilland Hall:

Cagney, J. On the Laryngeal Motor Anomalus, Abductor Tonus, and Abductor Proclivity, 1894.

Donaldson, F. Gr. Paralysis of the Lateral Adductor Muscle of the Larynx, with Unique Case, New York Med. Journ., February 12th, 1887.

Donaldson, F. Gr. Further Researches upon the Physiology of Recurrent Laryngeal Nerve (Johns Hopkins University), New York Med. Journ., August 13th, 1887.

Sewill, H., and England, W. Empyema of the Antrum.

American Laryngological, Rhinological, and Otological Society, Transactions of the Second Annual Meeting, 1896.

The numbers of the newly added exchanges have duly arrived, and several will start in January, 1898.

The following volumes have been bound:

Archiv für Laryngologie (Fränkel), vols. iv, v, vi.

Revue de Laryngologie, &c. (Moure), vols. 1894, 1895, and 1896.

Revue Internationale (Natier), vol. 1896.

Bolletino delle Malathe, &c. (Grazzi), vol. 1896.

Archivii Italiani (Massei), vol. 1896.

The Librarian expects to present the volumes for 1897 at the next Annual Meeting.

The Morbid Growths Committee for the ensuing year will be composed of the following gentlemen:

Mr. Bowlby, Dr. Kanthack, Dr. Pegler, Mr. Spencer, Mr. Waggett, Dr. Tilley.

The Thirty-seventh Ordinary Meeting of the Society was subsequently held, the President being in the Chair.

The minutes of the previous meeting were read and confirmed.

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

John Fallows, L.R.C.S.E. and L.S.A.(Lond.), 66, Victoria Street, S.W.

William Frazer, L.R.C.P., M.R.C.S., Johannesburg.

Two Pressure Pouches of the Œsophagus.

Shown by Mr. Butlin (President). Removed from living subjects. The references are to be found in the 'Medico-Chirurgical Transactions,' vol. lxxvi, p. 269, 1893, and in the 'British Medical Journal,' 1898, vol. i, p. 8. The attention of the members of the Society is particularly directed to the return of particles of undigested food many hours or even days after they have been swallowed, as the one constant symptom in the diagnosis.

Nasal Hydrorrhœa—Analysis of Liquid.

Mr. Cresswell Baber read notes of this case, and brought forward the analysis of the liquid. Patient, a married lady æt. 42. The right side of the nose only affected. Five years before, after eight months' excessive watery discharge following influenza, she had had a polypus removed; the secretion then stopped, but returned again at Christmas, 1896, after another attack of influenza. A polypus was removed in May, 1897, and the galvanic cautery applied, but as the secretion still continued the case was referred to me. When I first saw her, on June 16th last, there was no obstruction, very little sneezing, no pain, only profuse non-fœtid watery discharge from the right side, which continued day and night. No headaches of consequence. Examination showed that the right nasal cavity was much narrowed by deflection of the septum, and the mucous membrane was sodden and catarrhal in appearance. No polypus, but a little irregularity on the middle turbinated body. Transillumination showed both infra-orbital regions light, and nothing came out of the right antrum on hanging down the head. The fundus was normal in both eyes. No loss of sensation could be detected in the right nasal cavity. Spirit and cocaine spray was tried, but without any effect; the dripping of watery liquid continued constant, and on one occasion

(July 17th) I collected 70 mm. in five minutes. On this date I began the constant current, applying eight cells externally to the nose. This stopped the secretion for a few minutes. Patient was ordered to use it for five minutes twice a day. In a week's time (July 24th) she reported that the running was rather less in the mornings, but when I saw her it still continued. A small piece of projecting mucous membrane was snared from the middle turbinated body, but only proved to be hyperplasia of normal tissue. Ordered, in addition to the constant current, a 20 per cent. solution of menthol in paroleine for a nasal spray twice a day. I did not see the patient again till September 15th, when she reported that about a month previously the running began to diminish, and had got so much less that she only used two handkerchiefs daily instead of twelve. Character of the secretion as before. Treatment continued. October 5th.—No watery discharge at all for the last four days. Examination shows that there is much less swelling of the mucous membrane in the nasal cavity. To use spray and galvanism once a day only for three weeks. November 3rd.—No discharge at all from the right side since the last visit. Omit all treatment. Letter received from patient dated January 3rd, 1898, reports that there has been no return of the nose trouble. About an ounce of the liquid was sent to the Clinical Research Association, and they report that its chemical composition is as follows:

	Per 100 c.c.
Organic solids	0·160 gramme.
Containing—Mucin . . .	0·060 „
Proteids . . .	0·025 „
Undetermined constituents .	0·075 „
	0·160 „
Inorganic solids	0·880 gramme.
Containing—Sodium chloride . .	0·770 „
Calcium phosphate, &c. .	0·110 „
	0·880 „

Microscopical examination showed the presence merely of a few squamous epithelium cells and a few leucocytes. They note that the greater proportion of the solid matter consists of sodium chloride, and that the proportion of this closely approximates to the "normal saline" fluid.

From the absence of head symptoms, and especially from the beneficial effect of the continuous current, I think we are justified in concluding that the liquid in this case is simply an excessive secretion from the nasal mucous membrane, and not an escape of cerebro-spinal fluid. It seems probable that many of the cases reported may be explained in a similar manner.

Dr. StClair Thomson said that the analysis which had been made for Mr. Baber was unfortunately, so far as the question of cerebro-spinal fluid was concerned, most incomplete. Since he had shown his case to the Society, he had assisted at repeated analyses of cerebro-spinal fluid, and also of other fluids from the nose which were supposed to come from the subarachnoid space. In hopes that other members might come across similar cases, he would just recapitulate the chief points which were characteristic of cerebro-spinal fluid. It was perfectly colourless and limpid, feebly alkaline, varying in specific gravity from 1005 to 1010, contained no albumen, but traces of a proteid which was found to be globulin; it reduced Fehling's solution, but it did not contain sugar, for it failed to give the fermentation test with yeast. This reducing body was pyro-catechin, which had a pungent taste, and formed particular crystals. The analysis of the present case gave no information on these points.

Dr. de Havilland Hall asked Mr. Baber if he thought that the menthol spray had any real effect on the issue; his experience was that it rather increased the discharge from the nasal mucous membrane.

Mr. Baber thought it was the constant current rather than the menthol spray that had had the beneficial effect in this case.

Radical Operation for Frontal Sinus Disease.

Mr. Ernest Waggett showed a patient on whom he had performed Luc's operation five weeks previously for right frontal sinus suppuration of many years' standing. The skin incision followed the line of the eyebrow, and the trephine hole was made immediately above the superciliary ridge. The sinus was completely cleared of all the mucous membrane, which was throughout polypoid and bathed with pus. Attention was drawn to the advantages of carefully suturing the periosteum over the trephine hole, and of removal of the anterior end of the middle turbinate. From the first the cavity was irrigated by passing a fine flexible tube up through the drain-tube. The latter was removed on the thirteenth day. No pus had been seen since the operation, symptoms were absent, no depression of the bone could be detected, and the skin scar was unnoticeable.

Dr. HERBERT TILLEY thought that the case was a good illustration of the value of the incision through the line of the eyebrow, for the resulting scar was scarcely noticeable. He mentioned this because one authority on frontal sinus disease had maintained that a median vertical incision should be made in every case, whether the symptoms were uni- or bi-lateral. Mr. Waggett's case was at least the second or third which had been before the Society, and in which the value of the supra-orbital incision was very evident.

NEW INSTRUMENT—TURBINOTOMY CAUTERY.

Mr. ERNEST WAGGETT showed a galvano-cautery point, practically of the same shape as Jones' turbinotome, a hot platinum wire taking the place of the cutting edge. He has used it to remove hypertrophies of the mucous membrane of the turbinates, particularly moriform bodies. All hæmorrhage is avoided, and the shrinkage caused by cocaine rather facilitates matters than otherwise. The copper wires should be thick, so as to avoid over-heating by the current.

TRIGEMINAL NEURALGIA RELIEVED BY TURBINECTOMY.

Shown by WALTER G. SPENCER. The patient was a carpenter, æt. 46, who had had good health, and had not suffered in any similar way before. In April, 1897, he was in bed for two days with influenza. Some few days afterwards, at 9 a.m., he was suddenly seized with severe pains in his face. The pains first occurred in the lower lip and skin over the left side of the jaw, then on the cheek over the infra-orbital foramen, over the supra-orbital nerve at the back of the eye, and at the back of the nose. He became dazed, and cannot remember his journey home from work; he is said to have staggered up the street like a drunken man. His memory is also a blank for the next fortnight. He suffered from neuralgia involving all the branches of the fifth nerve, attended by most severe paroxysms of pain, for which his doctor had to give opium and morphine in increasing doses. My colleague, Dr. Allchin, was after three weeks called to a consultation, and he concurred in the treatment by opium and morphine in large doses.

The patient got somewhat better, but on account of the pain could not sleep well at night, nor concentrate his attention on any work. He was much depressed, and opium or morphine was required when the pain became severe. This was his condition in September, after he had been ill five months, and Dr. Allchin then consulted me with a view to some surgical measure. I could not insert a speculum into the left nostril, on account of hyperæsthesia, until he had been given an injection of morphine. The interior of the left nostril showed no definite disease. On touching the interior with the end of a blunt probe, nothing occurred until I touched the anterior part of the left middle turbinal, when a severe paroxysm of pain and itching was set up of the kind from which the patient had been suffering. After the nostril had been treated with cocaine 20 per cent. the middle turbinal could be touched without exciting the above symptoms.

No other lesion was found, in particular there were no signs of antral disease. Some teeth had been removed without affording any relief. I and Dr. Allchin agreed that, assuming the neuralgia to have originated from an attack of influenza, it was not unlikely that the neuralgia would in course of time pass off. Therefore we considered that there were then scarcely sufficient indications for surgical treatment of the three roots of the fifth nerve, or of the Gasserian ganglion. I proposed to try removal of the middle turbinal for much the same reason as a specially tender tooth is extracted in the hope that it may afford relief to trigeminal neuralgia. I therefore excised the middle turbinal, taking away also the anterior end of the inferior turbinal to obtain room. I found nothing abnormal in the tissue removed, and it was not in contact with the septum. From the time of the removal the patient has never had any pain, and has not required any narcotic. He has slept well, recovered his spirits, and has been at his work for three months. He still has, however, at times, itching in the distribution of the terminal ends of the fifth nerve on the face, also at the back of the eye and nose. This annoys him and tempts him to scratch, but does not prevent his work. It is worse in the day, and is quite relieved by lying down, whereas the old pain was worse when lying down. The interior of the left nostril is now hyperæsthetic, so that the patient is easily made to sneeze, but no pain or itching is excited by touching the interior. I have told the patient that this itching will pass off in time, but I shall be glad to learn of any means of hastening its disappearance.

Mr. Cresswell Baber mentioned the use of common salt as a snuff in cases of facial neuralgia, and also suggested the use of the galvanic cautery where very sensitive spots on the nasal mucous membrane were detected.

Dr. Spicer said that the patient's nasal passages were still deficient, and were producing an "exhaustion rhinitis;" he advised the use of dilators to alleviate the chronic rhinitis, and removal of a small spur which was present.

Dr. StClair Thomson said that the present case confirmed what he had ventured to insist upon elsewhere,* viz. that every case of trigeminal neuralgia should be submitted to a thorough exploration of the nose and accessory cavities before operative procedures were undertaken. He happened to know of cases where extensive, dangerous, and in some instances unsatisfactory operations on the Gasserian ganglion had been carried out, and where the idea of examining the nose had never been even entertained. Amongst other instances of trigeminal neuralgia relieved by intra-nasal medication, he instanced one where a medical man had placed himself under the care of a distinguished neurologist who had referred the case to Dr. Thomson, although the patient himself was perfectly convinced that he was suffering from "brow ague," having passed some years in the tropics, where he contracted malaria, he scouted the idea of the "brow-ague" being due to an empyema, and was only convinced when an exploratory puncture expelled a quantity of foul-smelling pus, and drainage at once cured his neuralgia. As to labelling the present a case of "cure," he thought we should be a little careful of using that term when the objective symptoms in the nose had been so slight. We all knew the beneficial effects of operation *per se*, and these were especially marked in the case of idiopathic trigeminal neuralgia. In Sir William Gowers' well-known text-book on nervous diseases there was the record of a case which an American author had traced for some dozen or so years. During this period the one individual's case had been published by something like fifteen different physicians, and each one claimed to have cured him.

Subpharyngeal Cartilage of the Tonsil.

Mr. Wyatt Wingrave exhibited microscopic sections of tonsils showing small islands of hyaline cartilage representing the *subpharyngeal cartilage*, a rudiment of the third visceral arch.

The cartilage was enclosed in the connective tissue of the bed of the tonsil, but according to MacAlister it is generally situated beneath the mucous membrane below the tonsil, and often attached to it.

He had found three examples in about 200 cases examined.

* 'The Year-book of Treatment' for 1897.

Larynx of Patient shown at Meeting held November 10th, 1897.

Dr. Herbert Tilley stated that shortly after the November meeting the patient died after suffering for three or four days from fever, intense headache, and delirium. Only the larynx and the brain were available for examination. The base of the latter was thickly covered with lymph and other evidences of meningitis.

The larynx exhibited extensive superficial ulceration of the right vocal cord and process, but the left side was healthy. A small track led through the mucous membrane of the right arytænoid cartilage, the latter being felt bare at the end of the sinus.

When seen during life the right cord was rigidly fixed during phonation; there was an enlarged gland in the right submaxillary region, and what appeared to be a greyish mass was seen situated in the position of and hiding the right vocal cord. The almost unanimous opinion then was that it was a case of malignant disease, but the exhibitor thought that the recent history indicated tubercular laryngitis, and at his suggestion the growth was referred to the Morbid Growths Committee for more detailed examination.

Case of Malignant Disease of Larynx.

Shown by Dr. Furniss Potter. A man æt. 64, who came under observation complaining of hoarseness for nine weeks previously, but who in other respects was in good health. On examining the larynx the left side was seen to be occupied by an extensive infiltration, involving the arytænoid region, the ventricular band, and the aryepiglottic fold; the left vocal cord was invisible, and the crico-arytænoid joint appeared to be fixed and immoveable.

There was no history of syphilis, and no complaint of pain except a little occasionally shooting into the left ear; there was no dysphagia, but slight stridor occasionally. The patient had been put on potassium iodide in doses increasing to grs. xx three times a day, but as yet with no appreciable result.

Papillomata of Larynx.

Dr. Bronner (Bradford) showed a large number of papillomata removed from the larynx of a man æt. 48, on December 13th. On several previous occasions growths had been removed, the last time in March. Various local and internal remedies had been used.

On December 13th patient had a violent attack of dyspnœa whilst in a railway carriage, and was unconscious for some time (?).

Dr. Bronner wished to have the advice of the Society as to whether laryngotomy or tracheotomy should be performed, or if the growths should be periodically removed *per os*.

Mr. Butlin and Sir Felix Semon concurred in the view that thyro-chondrotomy would afford no guarantee against recurrence of the growth, and might induce other undesirable complications.

Mr. Spencer suggested that a crico-tracheotomy might be useful in enabling the operator to more efficiently remove the growths.

Complete Recurrent Paralysis.

Mr. Symonds exhibited a man of 61 showing the left cord lying in the cadaveric position. The patient had a stricture of the œsophagus 12½ inches from the teeth, and gave a history of nine months' dysphagia, with loss of voice for four months. When first seen two months ago the condition was identical with that now existing. The case was brought forward to illustrate paralysis of the lateralis muscle following upon that of the posticus, which was presumed to have preceded the present stage. The patient also exhibited well the inability to speak a sentence of more than a few words, and gave a good view of his larynx.

Sir Felix Semon said that he could not agree to this being a case of adductor paralysis, and expressed a hope that his friend Mr. Symonds would see his way to change the title of his communication. Adductor paralysis clearly meant that a vocal cord could not be properly adduced on intended phonation, whilst on deep inspiration it freely went outwards. In the present case, however, the vocal cord stood motionless between the phonatory and ordinary cadaveric position, and there was no question of adductor paralysis. He made it a point to protest against the title because otherwise it would be almost certain to be made capital of. Of greater importance, however, than this individual case was another question he wished to submit to the

Society. Was it not time to altogether abolish the expressions "adductor" and "abductor" paralysis? No doubt they were convenient enough, but somehow or other there seemed to be a sort of fatality about misprints with regard to these two expressions, which but too often absolutely spoilt the author's meaning. He instanced several recent experiences of his own to that effect. In Germany, following an analogous proposition of Professor Moritz Schmidt, the two expressions had almost completely vanished. If the words "glottis openers" and "glottis closers" were considered to be too clumsy, why not simply speak of "posticus," "lateralis," "externus," &c.?

In his reply to remarks by Sir Felix Semon, Mr. SYMONDS recast the original title of the case from that of adductor paralysis.

REMOVAL OF HALF THE LARYNX.

Shown by Mr. SYMONDS. Mr. S— was brought before the Society in February, 1897, with fixation of the right cord, and a diagnosis of early carcinoma. The general opinion at that time was in favour of tubercle. A gland made its appearance in the end of April, and was removed March 17th. It had grown with great rapidity, and was already softening. The right half of the larynx was removed April 20th. The man was brought forward again, not to show the result of the operation, but because it was thought members would be interested to recall the early appearances. At present the man does full work, and has a moderate voice.

SUBGLOTTIC CARCINOMA?

Shown by Mr. SYMONDS. A man of 55 had been hoarse six months. He came under treatment at Guy's Hospital in December with grave stenosis of the larynx. Both cords were fixed, and were visible; the chink was in the centre, and was elliptical in shape; the left cord appeared then slightly pushed up. The arytænoids were fixed. Tracheotomy was necessary on January 1st. The diagnosis lay between malignant disease and syphilitic perichondritis. There was no breach of surface, but there was an abundant foul expectoration. The man was then in low health. Mr. Symonds regarded the case as one of subglottic carcinoma, and asked for an expression of opinion.

Note.—At the meeting Mr. Symonds reported that since his last examination of the patient three days ago, when the above report

was written, a marked change had taken place. The left side had become more prominent, and a whitish edge was visible along the left cord—appearances pointing to malignant disease.

January 17th.—Mr. Symonds sends a note to say the whole interior of the larynx has become swollen, that a papillated whitish mass can be seen in the position of the left cord, leaving no doubt of the malignant nature of the case. The general health has greatly improved.

Formative Osteitis (Leontiasis Ossium).

Shown by Dr. Watson Williams (Bristol). A specimen of the septum nasi and a portion of the frontal bone and left malar bone from a male æt. 46. There was no history of syphilis, and no known cause for the disease.

Post-mortem examination.—The patient presented large, smooth, bony thickenings on either side of his nose, and a smaller boss on the left side of the forehead.

On removing the cranium pus was found situated between the dura mater and the bone over the frontal lobe. This pus seemed to have originally started from the frontal sinus on the left side, which was full of pus. The frontal sinus on the right side was found to be obliterated by soft cancellous bone. The pituitary body was normal in size.

Examination of the nose showed that the sphenoidal sinus and ethmoidal cells were entirely obliterated by cancellous bony growths. The cavity of the nose on the left side was almost entirely filled up by growth from the septum. Apparently also the antra of Highmore were completely filled up with cancellous bone formation. The bones in the face were found to be growing from the malar and upper part of the superior maxillary bones. There was nothing noteworthy about the other organs, and no deformity of bones elsewhere.

Case of Clonic Spasm of Pharynx.

Shown by Dr. Lambert Lack. The patient, a girl æt. 19, came under observation at the Throat Hospital about two months ago, complaining of "phlegm in the throat." On examining the pharynx, one

at once notices a twitching movement of the posterior pharyngeal wall, which seems to be sharply drawn to the left and then relaxed. The movement curiously resembles nystagmus. The palate sometimes seems to move slightly in association. The larynx is healthy, and there is no twitching of the laryngeal muscles. The patient has some chronic rhinitis, but otherwise is in robust health, and is not of a specially nervous disposition. This pharyngeal spasm has been constantly present every time the patient has been seen in the last two months, but its duration beyond that is doubtful, as it apparently gives rise to no symptoms.

The case seems identical with that of a man shown by Dr. Bond during the last session of this Society, and is brought forward in the hope that other members of the Society will state their experience of this apparently rare affection, or give some information as to its ætiology or pathological associations.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *February 9th*, 1898.

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

HERBERT TILLEY, M.D., WILLIAM HILL, M.D., } Secretaries.

Present—32 members and 2 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were elected ordinary members of the Society:

John Fallows, L.R.C.S.Ed., L.S.A., 2, Princes Mansions, Victoria Street, S.W.

William Frazer, L.R.C.P., M.R.C.S.(Eng.), Johannesburg.

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

Frank Marsh, F.R.C.S.(Eng.), 34, Paradise Street, Birmingham.

John E. Scatliff, M.D.(Aberdeen), M.R.C.S.(Eng.), 11, Charlotte Street, Brighton.

Henry B. Robinson, M.S., F.R.C.S.(Eng.), 1, Upper Wimpole Street, W.

Adam B. Kelly, M.B., C.M.(Glasgow), Blythwood Square, Clifton.

Arthur J. Hutchinson, M.B., C.M.(Glasgow), 225, Bath Street, Glasgow.

Report of Morbid Growths Committee.

The following reports were drawn up:

Slide L.S.L. (Laryngological Society of London), No. 11.—From case shown by Dr. Spicer as "Rapidly Recurrent Tumour of the Nasal Septum" ('Proceedings,' vol. v, p. 19, December, 1897). The committee finds that the growth is a fibro-angioma, and quite benign in character.

Slide L.S.L. No. 12.—From case shown by Mr. Morley Agar as "Tumour of Tongue" ('Proceedings,' vol. v, p. 4, November, 1897). The specimen is composed in part of dense fibrous tissue, and in other parts of a looser connective-tissue with some connective tissue cells. There is no evidence of malignancy. The committee would call attention to the fact that such growths in the tongue without any admixture of lymphangiomatous tissue are rare.

Slide L.S.L. No. 13.—From case shown by Dr. Bond as "Recurrent Laryngeal Growth" ('Proceedings,' vol. iv, p. 104, June, 1897). The patient was a female æt. 27, and had had a growth removed from the larynx at least five times in two years. Growth was as large as a couple of small peas, and sprung from the very bottom and posterior part of the left ventricular band, and hung down between the cords. It did not look like a papilloma, and on section it seemed to be an epithelial growth of unusual character. The committee confirms Dr. Bond's observations, but as the members had only one section to examine, they desire to postpone a definite report until they have examined other sections.

January 6th, 1898.

The Supra-tonsillar Fossa.

Dr. Paterson showed specimens and photographs of this space. His attention was drawn to its importance by a case which came under his care two years ago, and since that time he had accumulated a large number of observations on its variations and the affections to which it is subject. A search into the literature showed that it had been practically ignored by writers on diseases of the throat, and the index of the 'Centralblatt für Laryngologie' contained no reference

to it. The space which is met with in the majority of individuals is situated behind the anterior palatal fold in its upper part, and has been erroneously looked upon as an enlarged tonsillar crypt. It has been described by His as an anatomical space, to which he gave the above name, and he regarded it as the remains of the second visceral cleft. The exhibitor, from the examination of a large number of specimens, both in the living and the dead subject, concluded that two main factors influenced the situation and relations of the space. (1) The disposition of the plica triangularis may affect the size and the outlet of the cavity. This structure is a triangular fold of mucous membrane found projecting from the anterior palatal arch between the fourth and fifth months of fœtal life, and frequently persistent into adult life. (2) The development of the tonsillar adenoid tissue in the sinus tonsillaris varies considerably, and will modify the extent and even the position of the fossa; in some, indeed, its situation is not above the tonsil, and the designation "palatal recess" would perhaps be a more appropriate term. It extends in various directions, and comes into relation with the deeper parts. It is liable to certain affections; in two cases the exhibitor observed it as the starting-point of malignant disease, and its importance is increased by the fact of it being frequently the seat of infection in certain forms of disease.

Dr. Scanes Spicer was much interested in the definite anatomical and developmental facts concerning the supra-tonsillar fossa brought forward. He had long regarded the fossa as a morphological entity. Clinically the morbid conditions (retention cysts, grit, calculus, and suppuration) as common causes of chronic and recurrent discomforts referred to the tonsils were well known to most specialists, and personally he considered they usually demanded surgical interference. Formerly he had confounded these fossal conditions with lacunar disease; later he had regarded them as occurring in a cavity formed by abnormal adhesions; but for some years he had been convinced that we had in this supra-tonsillar recess a definite and regular anatomical structure. He had frequently known the adenoid mass of the faucial tonsil to hypertrophy into the fossa, from which it could be easily withdrawn.

Dr. Hill expressed some surprise that Dr. Paterson had found no literature on the subject, as in the 'Proceedings' of the Society a little while ago a case was brought forward in which a calculus was lodged in the fossa.

Dr. StClair Thomson was also surprised to hear that there were so few references to the subject in leading text-books. He was under the impression that the supra-tonsillar fossa was recognised and frequently referred to in current German literature. Quite recently he had read an article by Grünwald in the 'Münchener medizinische Wochenschrift' recommending that peritonsillar abscesses should be opened

through the supra-tonsillar fossa; and Killian (in the 'Monat. für Ohrenheilk.') had pointed out that abscesses of the tonsil could be easily opened with a probe in the peritonsillar fossa. This region, which had been so fully investigated and well described by Dr. Paterson, was of clinical importance with regard to peritonsillar collections of pus. For Dr. Thomson thought that most laryngologists opened the abscess cavity in this region, although they did not enter it, as Grünwald recommended, between the pillars of the fauces, but by puncturing the anterior pillar with a pair of sharp sinus forceps, which were then opened as they were withdrawn.

In reply, Dr. PATERSON wished to emphasise the important difference between this space and what it has usually been regarded as, viz. an enlarged tonsillar crypt.

PAPILLOMA OF TONSIL.

Shown by Dr. PATERSON. The specimen was obtained from a boy æt. 10, who came under notice for enlarged tonsils. These were excised, care being taken to bring away intact the little tumour. It was about the size of a hemp-seed, was provided with a well-marked stalk, and consisted microscopically of squamous epithelium. It gave rise to no symptoms. The object in showing the specimen was to point out that, although situated on the anterior and inner aspect of the tonsil, it did not grow from that gland, but sprung from the plica triangularis, which was well marked. The latter fold could be readily made out lying loosely over the tonsil and giving origin to the papilloma. From his observations the exhibitor concluded (1) that most of the so-called papillomata of the tonsil—which may either be little masses of lymphoid tissue covered to a varying extent with epithelium or true papillomata, as in the present specimen—spring from the plica, and do not grow from the tonsil; and (2) that they are frequently in relation to the outlet of the supra-tonsillar fossa, and may be induced by discharge from that cavity. Care is often necessary to distinguish the plica, which may be intimately adherent to the subjacent tonsil.

A NEW SNARE FOR THROAT AND NOSE WORK.

Shown by Dr. LAMBERT LACK. The chief advantage claimed for this snare is that the wire loop having been adjusted round a growth can be rapidly drawn tight so as to seize the growth firmly, and that

then, if required, the loop can be further tightened by a screw. By this latter movement sufficient force is obtained to cut through the firmest growths; at the same time the division is slowly effected and all bleeding arrested. The instrument is strong in all its parts, the mechanism simple, and it has nothing to get out of order. The instrument is entirely of metal, and easily takes to pieces for cleaning, &c. The wire can be easily and quickly attached, and is very firmly fixed. It may be of any size, and the loop may be over six inches long. The snare works noiselessly; the clicking of some instruments is very distressing to sensitive patients. The instrument has three ends—a thick barrel for very tough growths, a fine end for aural and nasal polypi, and a curved end for use in the larynx or post-nasal space.

The instrument requires the use of two hands to work the screw; but the growth having been already firmly seized, I do not think this can be considered a disadvantage.

I am greatly indebted to my friend Mr. Bingham (an engineer) for much help, and for suggesting the method by which the screw is brought into action; and to Messrs. Mayer and Meltzer, who have made the instrument for me.

Radical Cure of Long-standing Antral Empyema.

Mr. Waggett showed a middle-aged woman with an eight years' history of left antral empyema, during which time she had practised daily irrigation through a tube in the alveolus. He performed Luc's operation, making a large opening through the canine fossa, removing entirely the polypi and the thick purple papillated lining of the cavity, which was cleared until the white bone was laid bare throughout. The bony structure was exceedingly soft and yielding, and in inserting a drain-tube held in a pair of fine sinus forceps through the hole drilled into the inferior meatus, the hard palate was wounded. The latter fortunately healed in the course of a few days; nevertheless to avoid such accidents it would seem advisable to puncture and insert the tube from the nasal side rather than the antral. The muco-periosteum was sutured over the canine fossa wound, which healed firmly. The drain-tube into the bone was removed on the third day, and in the speaker's opinion might well be dispensed with altogether.

No reaction followed the operation. From the day of operation, five weeks ago, no pus has been secreted in the cavity; injections made through the inferior meatus opening at intervals of eight days returning perfectly clear, while the nose has been entirely free from discharge.

Dr. WILLIAM HILL and Mr. LAKE demurred to the credit of this operation being given to Luc, as Dr. Spicer had reported and shown a case of this particular operative procedure before Luc had written his paper on the subject. Senn has also independently described an osteoplastic resection of the anterior wall with a nasal opening.

Dr. STCLAIR THOMSON asked if a piece of the bony wall was detached and replaced in making the opening through the canine fossa, and how long the drainage-tube from the antrum into the inferior meatus was left *in situ*.

Dr. SCANES SPICER was surprised at Dr. Waggett's referring to the method as a new one. Dr. Luc ('Bull. et Mém. de la Soc. Franç. d'Otologie, Laryng., et de Rhinol.,' 1897) had, indeed, claimed it as a "new operative method for the radical and rapid cure of chronic empyema of maxillary sinus. He specially claims (ibid., p. 81) as the original feature of his operation the "creation of an artificial opening which serves to drain the sinus cavity by the corresponding nasal fossa." He also gives as the date of his first operation case February 16th, 1897 (ibid., p. 84). Both Dr. Waggett and Dr. Luc have overlooked the numerous references which have appeared in the English medical press during the last four or five years detailing a method differing in no essential detail from that now put forward (*vide* 'Brit. Med. Journ.,' December 15th, 1897, 'Journ. of Laryng.,' 'Proc. Laryng. Soc. Lond.,' &c.). Moreover, a formal discussion on chronic antral empyema was held by the Laryngological Society of London, one of the leading features of which was the general condemnation of the method advocated by the speaker on that occasion as unnecessarily severe, leading to facial deformity and falling in of cheek, rendering patient unable to smoke his pipe, and leaving a permanent bucco-antral fissure. Further experience has confirmed the speaker that these objections were visionary and theoretical; and, in fact, not one of these sequelæ ever followed. Many others besides Dr. Luc were now using the method with success. What he wished to emphasise was that this large canine fossa opening, curettement, no buccal drainage-tube, free counter-opening into inferior meatus of nose for drainage, had been practised largely by British rhinologists for about five years, and numerous references to the results are to be found. He congratulated Dr. Waggett on his result in this case, and, speaking from a large experience, could assure the Society that in *uncomplicated chronic* antral empyema they would find the method radical and certain, and not followed by any one of the dreadful results predicted for it.

Mr. WAGGETT, replying to Dr. Thomson, said that with the exception of some white fibrous tissue underlying the infra-orbital nerve, all the soft structures were removed. He did not for a moment dispute

Dr. Spicer's claim to originality in the method, and would give him all credit for it; and with reference to the latter's opinion that where the floor of the antrum was on a lower level than that of the nose, it was advisable to leave the canine fossa opening patent for purposes of drainage, Mr. Waggett thought it better to avoid the necessity of prolonged drainage altogether by removing the glandular lining of the cavity.

Immobility of Right Cord.

Shown by Dr. Willcocks. Henry O'B—, æt. 70. He first came under observation about five months ago, when he had loss of voice and considerable swelling, affecting chiefly the right side of the glottis and the interarytænoid space. The swelling gradually subsided under the influence of soothing inhalations and iodide of potassium, and was for a time confined only to the posterior end of the right cord.

Present condition.—The right vocal cord is immobile and somewhat congested. There is no evidence of intra-thoracic pressure of any kind.

Sir Felix Semon thought the case one of mechanical immobility, both from the history and the improvement under potassium iodide. There was a particularly "clean" appearance about the larynx, which he thought was indicative of its non-malignant nature.

Mr. Butlin inclined somewhat to the malignant nature of the case on account of the presence of enlarged glands and the bad health of the patient.

Early Epithelioma of Cord.

Shown by Dr. Herbert Tilley. Fred. W—, æt. 49. Patient complained of loss of voice for two months, but there was no pain or difficulty of swallowing. At the anterior end of the left vocal cord is a whitish patch; the posterior part of the cord congested, and more so than the corresponding part of the right one. There is slight loss of movement on phonation.

The President and Sir Felix Semon both agreed it was an excellent case for operation, but suggested the advisability of removing a small portion of the growth for examination previous to the radical operation.

Case of Primary Epithelioma of the Uvula. Two Coloured Drawings of the Parts and Microscopic Sections of the New Growth.

Shown by Dr. Walker Downie. The patient, a man æt. 56, came under observation in July, 1897. He complained of having had sore throat for fully two months, and that within the past few days he had had some difficulty in swallowing, along with considerable discomfort in breathing while asleep.

On examination the uvula was represented by a large fleshy body; the greater portion of its surface anteriorly and to the right was ulcerated, the mucous membrane in the middle line and to the left side being alone intact. The tip, which rested on the dorsum of the tongue, was also raw. The whole structure was found to be hard and firm on palpation, and manipulation caused the surface to bleed. The faucial pillars were unaffected.

It was diagnosed epithelioma, and without delay the whole of the uvula was removed under cocaine, the incisions going well into the soft palate. The surface was practically healed in four days; and now, at the end of six months, the man is in perfect health, and there are no evidences of recurrence.

Interarytænoid Growths.

Shown by Mr. Lake. Patient was a female. The growth occupied the upper portion of the interarytænoid region, and was a pale pink colour, but no breach of surface. No subjective symptoms except loss of voice.

The pieces shown were removed on February 3rd, 1898. Since then the patient has improved very much in her general condition.

Dr. Clifford Beale asked Mr. Lake to keep the patient under observation if possible, and to report the result of the operation after an interval of three months. He thought it very desirable that the limits of operation on this class of case should be defined. The interarytænoid tumours were well recognised since Professor Stoerk first drew attention to them; and, as a rule, they did not give rise to sufficient trouble to warrant any operation. The resulting wound was apt to remain unhealed, and to become the starting-point of a further tubercular infiltration. In Mr. Lake's case the voice had been improved, but there remained a large ragged sore in the interarytænoid space, and it would be desirable to watch its progress.

Carcinomatous Tumour of the Epiglottis and Base of the Tongue.

Mr. Spencer showed a tumour which had occupied the upper epiglottis and superficially the base of the tongue. It was about the size and shape of a Tangerine orange, with a nodular surface, and appeared firm and white on section. Under the microscope the growth was found to be a carcinoma. Columns of epithelial cells projected downwards from the surface epithelium to mingle with the main structure of the tumour, which consists of polyhedral oval and spindle cells, and soft connective-tissue stroma. In the lymphatic gland, which was enlarged in the neck, the structure at first sight appeared like an oval and spindle-celled sarcoma with a stroma between the individual cells. There are a few nest-cells in the primary growth, about one in each section, but none have been met within the glands. A distinct alveolar arrangement is absent both from the primary and secondary growth; but there can be little doubt that the growth originated in the epithelium, in the fold between the epiglottis and tongue.

The tumour was taken from a man over 70, who complained of increasing difficulty in swallowing. He had suffered for three or four months, and had become reduced to soft substances like well-masticated bread and butter. He was further troubled by the constant rising up into the mouth of ropy mucus, and a tense swelling in the neck had formed, which gave him pain. He had lost flesh and felt weaker since the swallowing had become difficult. His breathing had not troubled him, but his voice had become somewhat muffled. On examination the lower part of the pharynx appeared to be completely filled by the tumour, which could be touched by the finger; but neither the opening of the larynx nor that of the œsophagus were visible. There was an enlarged superficial gland in the neck, which was breaking down, and was tense. When the administration of the anæsthetic was commenced the patient became dyspnœic, and preliminary tracheotomy was at once done. The pharynx was then more thoroughly explored by the finger. The larynx was found to be drawn up behind the tumour, and the arytæno-epiglottic folds were stretched over its posterior surface. Transverse subhyoid pharyngotomy was therefore done, the base of the epiglottis cut across, and the

arytæno-epiglottidean folds divided. A pedicle was thus made, and the tumour was quickly removed by the galvano ecraseur. The wound in the pharynx was completely sewn up, the tracheotomy tube removed, and the broken-down gland in the neck incised, wiped out with a strong antiseptic, and the skin united. The previously weak patient stood this palliative operation well, could swallow easily, and felt relief from the tension in the neck. Unfortunately on the fifth day there was a bad fog, some bronchitis then started, and the patient died a week after the operation. There were no signs of pneumonia, neither during life nor post mortem. The pharyngeal wound and the cut made into the broken-down gland were firmly stuck together, and the tracheotomy wound was filling up by granulations. The primary tumour had been completely removed, but there were some small nodules, apparently in the lymphatics of the pharyngeal wall, also the secondary gland in the neck, but nothing else abnormal.

It does not appear that the tumour could have been satisfactorily removed by an ecraseur through the mouth, even at an early stage, for there was no pedicle until the base of the epiglottis and the arytæno-epiglottidean folds had been cut through; and if these latter had been included in the snare, œdema glottidis or other complications might have ensued.

Mr. Waggett suggested that the Morbid Growths Committee should investigate the nature of the growth.

Sir Felix Semon commented on the curious fatality which attended subhyoid pharyngotomy, and yet the post-mortem evidences gave no explanation of the matter. He could recall no case which had recovered.

Mr. Butlin's experience was much the same, and he instanced a case in which jaundice and acute mania preceded death.

Epithelioma of Left Vocal Cord.

Shown by Mr. Stephen Paget. D. R—, male æt. 43, had suffered from hoarseness for six months, and now experienced some pain on swallowing.

The left vocal cord was ulcerated and thickened, the ulceration extending to the interarytænoid space. It was quite immobile on phonation. An enlarged gland was present in the left submaxillary region.

Sir FELIX SEMON advised operation without delay, and said that he feared the disease would be found more advanced than the laryngoscopic appearances suggested.

Mr. BUTLIN agreed, and also stated that there was an enlarged submaxillary gland, and that a partial laryngectomy might be necessary as well as removal of the gland.

ERRATUM.

'Proceedings,' December 8th, 1897, p. 22, line 9, *read* "shown by Mr. Morley Agar (by kind permission of Mr. Mark Hovell)."

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *March 9th*, 1898.

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

HERBERT TILLEY, M.D., WILLIAM HILL, M.D., } Secretaries.

Present—38 members and 2 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were elected ordinary members of the Society:

Henry Betham Robinson, M.S.(Lond.), F.R.C.S.(Eng.), 1, Upper Wimpole Street, W.

Arthur J. Hutchinson, M.A., M.B., C.M.(Glasgow), 225, Bath Street, Glasgow.

Adam Brown Kelly, M.B., C.M., B.Sc.(Glasgow), Blythwood Square, Glasgow.

Frank Marsh, F.R.C.S.(Eng.), 34, Paradise Street, Birmingham.

John Scatliff, M.D.(Aberdeen), M.R.C.S.(Eng.), 11, Charlotte Street, Brighton.

REPORT OF MORBID GROWTHS COMMITTEE.

Slide L.S.L. No. 14.—From larynx of case shown by Dr. Herbert Tilley at the November meeting, 1897. The Committee report, "Along the border of the section in the subepithelial lymphoid layer are several typical giant-cells, in some of which nuclei can be distinguished,

and mostly surrounded by an abundance of small-cell infiltration. Tubercle bacilli were also found in the section. Lower down is to be seen a large tubercle in a state of caseous degeneration. We consider that the case was, therefore, one of tubercle of the larynx."

Slide L.S.L. No. 15.—From specimen shown by Mr. W. G. Spencer on February 9th, 1898, as "carcinomatous tumour at the base of tongue and epiglottis." The Committee report that "the tumour is of malignant type, and is composed of epithelial cells. The cells are arranged in masses without intercellular substance, and are partly spheroidal and partly squamous, and cell-nests were not found in the depth of the tissue, but only in the superficial layer of epithelium. The growth is a carcinoma, but whether it originated from the squamous epithelium is not certainly shown by the specimen; it is, however, probable that such is the case. Considering the situation, it is probable that it originated from the surface epithelium."

Slide L.S.L. No. 16.—The gland shows collections of exactly similar cells, and here also without cell-nests. In neither growth is there any evidence of keratinous change.

Lepra Tuberosa of the Larynx, Mouth, and Nose, with Remarks upon the Origin and Nature of "Globi" and "Giant-cells."

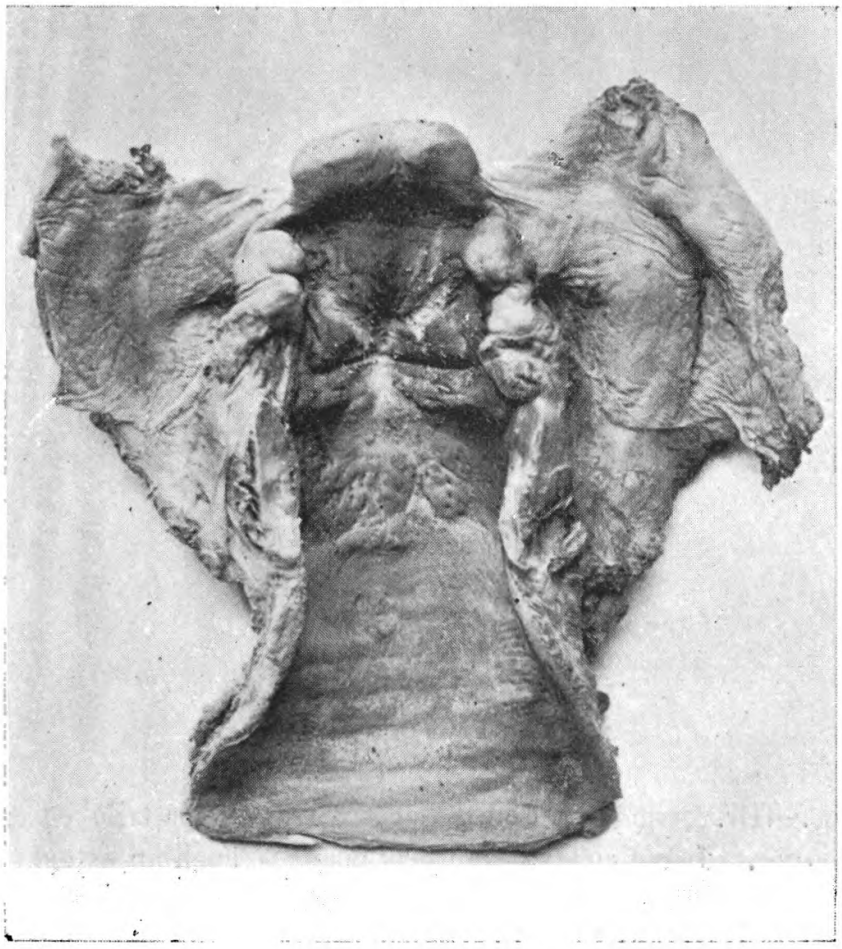
For Dr. Paul Bergengrün (Riga), communicated by Prof. A. A. Kanthack. Prof. Kanthack demonstrated for Dr. Bergengrün a complete series of photographs and coloured drawings illustrating the macroscopic and microscopic appearances of leprous lesions of the larynx, tongue, fauces, and nose; and a number of coloured sketches of the laryngoscopic images obtained in lepra tuberosa laryngis.

Larynx.—Indurative and ulcerative processes are well marked; ulceration along or below the vocal cords or in false cords is common; ulceration may be extensive, and the whole epiglottis may be destroyed. Thickening and infiltration of epiglottis, in some cases amounting to lepromata, is remarkable. Favourite seats of infection are the epiglottis, and especially its petiolus, the region just above and below the anterior commissure of the vocal cords. The ary-epiglottic folds are thickly infiltrated and often nodular. The epiglottis is often curved upon itself, and may be so thickened that the interior of the larynx

cannot be seen. The cords may be normal, although there is extensive disease. The mucosa over the arytænoid cartilages often becomes swollen, in the shape of thick globular masses. The ventricular bands are almost always diseased, either infiltrated, nodular, or ulcerated.

Tongue.—The tongue frequently becomes irregular and nodular; the nodules may be large and numerous; they may be arranged symmetrically on either side of middle line, separated by a deep groove. Occasionally the "silver tongue" of Léloir may be observed, when there are flat, low, silvery, disc-like swellings on the tongue, with a finely granular surface, and also broader silvery streaks.

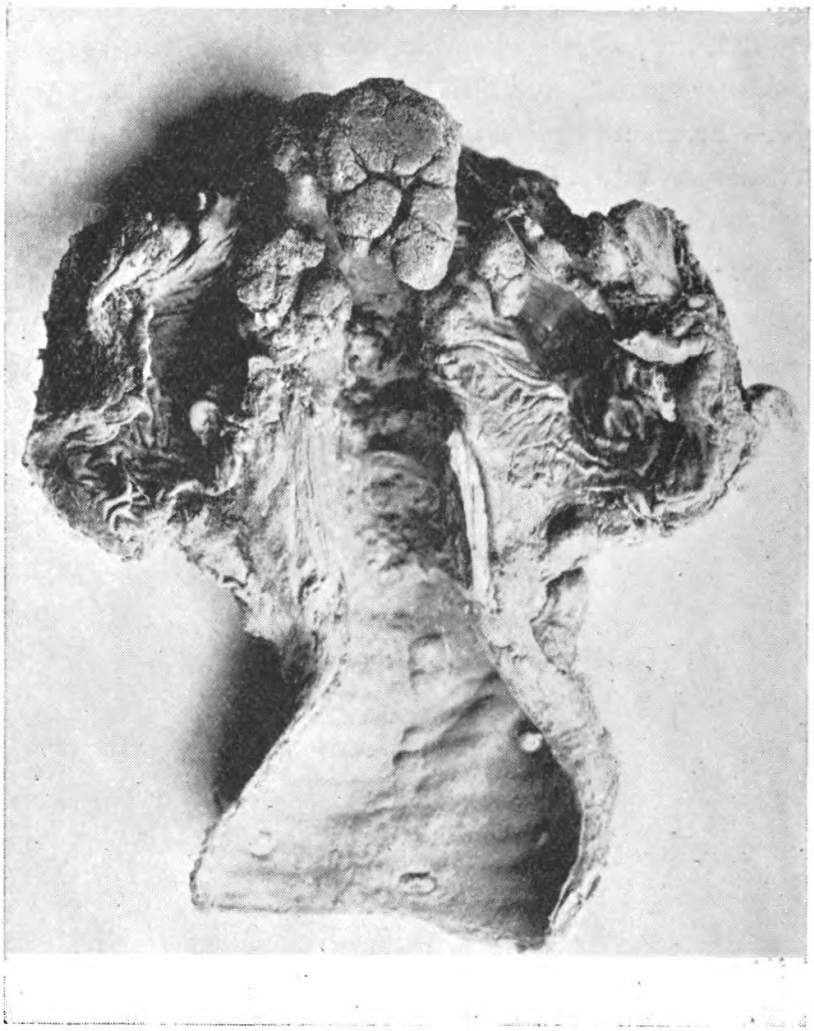
Uvula.—Frequently diseased; may be converted into a coarse nodular mass or into a pyriform swelling with granular, nodular, or ulcerated surface; may become fibrous and cicatrised or completely slough away.



Leprous larynx seen from behind.

Fauces.—While the anterior fauces remain intact, the posterior become nodular or ulcerated.

Palate and Gums.—Hard and soft palate may be infiltrated with small lepromatous nodules, extending backwards in the middle line as far as the uvula, and forwards through the incisors as far as the gums. Ulcers on the gums and palate are also observed.



Leprous larynx seen from behind.

Nose.—Dr. Bergengrün lays special stress on the trilobed external appearance. Local cicatrisation may occur to such an extent that the rima oris becomes reduced to a small opening, through which only one or two teeth can be seen.

Histological observations.—Prof. Kanthack also demonstrated beau-

tiful microscopical specimens and coloured drawings prepared by Dr. Bergengrün, which clearly proved two points: (*a*) that the so-called "globi" are bacillary thrombi lying in the dilated lymphatics; and (*b*) that the lepra giant-cell develops from the lymphatic endothelium. As to the globi, in longitudinal section, they appear as sausage- or chain-like narrow strands or bands, which run through the connective tissue as parallel streaks. These are curved and tortuous, short and long, broad and narrow, and often lie in spaces lined by a typical endothelium. The formation of the lepra giant-cells is explained as follows:—The bacillary thrombi in the lymphatic vessels act like foreign bodies, and irritate the endothelium lining the lymphatics, so that here and there endothelial cells divide and proliferate. The diseased cell protoplasm cannot keep pace with the nuclear division, and the protoplasm of different cells fuses into a plasmodial mass. Thus a giant-cell forms around the bacillary thrombus, gradually wrapping itself around the latter. The microscopic specimens left no doubt as to the correctness of this interpretation.

Dr. Bergengrün has once and for all settled the old controversy regarding the distribution of the leprosy bacilli, by thus showing that the intra-cellular distribution is almost insignificant when compared with their endolymphatic distribution. This has recently also been confirmed by Dohi, Herman, and others.

Case of Ozæna following Removal of Inferior Turbinate.

Shown by Mr. Stewart. P. S—, a female. For some years she had suffered from the usual discharge and symptoms consequent on hypertrophy of the nasal mucous membrane. Turbinotomy was performed in 1893 for deafness and discharge from right ear. Since operation crusts have formed in the throat and back of nose, with a considerable amount of fœtor.

Dr. Spicer thought that the history of the case scarcely proved the *post et propter* aspect of the operation. The patient had a distinct history of nasal suppuration since a child, and it was possible that the operation only accentuated the intra-nasal drying of the discharge. The shape of the nose is also that seen in atrophic rhinitis, a condition which could scarcely have developed since the operation.

Mr. Waggett said the patient had distinctly told him that there were no crusts before the operation.

Mr. Stewart in reply stated that he brought forward the case for

what it was worth. They could not, however, get over the facts that the patient stated that, previous to the operation, the discharge from the nose was what one usually finds in hypertrophic conditions of the mucous membrane, and that since the operation there had been crust formation, and both objective and subjective fœtor, and that when first seen at the hospital the nose and throat were thickly coated with very offensive crusts.

Case for Diagnosis—Laryngeal Swelling.

Shown by Mr. Edward Roughton. J. P—, an iron moulder æt. 52, has suffered from hoarseness for one year and eight months, and from pain on speaking and swallowing and dyspnœa for six months. Attributes his condition to inhaling fumes of sulphur. Both false cords are swollen; they overlap on phonation; some swelling of arytænoids and ary-epiglottic folds; true cords remain almost immobile during respiration, and adduct with difficulty on phonation, the left moves more than the right. There is also some subglottic thickening. Œsophageal bougie passed without encountering obstruction.

Lungs.—Chronic bronchitis and emphysema. No evidence of phthisis.

No history of syphilis; gonorrhœa many years ago. Has been taking Pot. Iodid. for a month; no improvement.

Dr. Clifford Beale regarded the case as tubercular, and called attention to the excessive amount of sputum, which might, if examined, show the presence of bacilli.

Dr. StClair Thomson entirely agreed with Dr. Beale's suggestion.

Mr. Symonds thought that it was possibly a case of malignant disease, and pointed out the enlarged submaxillary glands in support of this view.

Lupus of Face, Nose, and Mouth.

Mr. Roughton also showed a young woman suffering from lupus of face, nose, palate, tongue, and epiglottis.

Mechanical Fixation of Vocal Cords.

Shown by Dr. Herbert Tilley. Patient is a man æt. 43, who two years ago applied to hospital for hoarseness and pain on swallow-

ing of three weeks' duration. There was also slight stridor, which much increased in the course of the next few days. Examination of the larynx showed marked œdema over the arytænoids and sluggish action of the cords. There were no physical signs in the chest, nor evidence of nerve lesions of any kind. The stridor increased so rapidly that tracheotomy was performed, and the man has worn the tube ever since. He is in perfect health, and can produce a fairly good voice with expiration. Inspiration is impossible without the tube. The history of sudden onset with a cold, pain on swallowing, and œdema over the arytænoid region suggest implication of the crico-arytænoid joints, with subsequent fixation of the cords in their present adducted position.

Double Abductor Paralysis without Apparent Cause.

Shown by Dr. Herbert Tilley. Patient is a man æt. 49, who seven years ago applied to hospital for difficulty of breathing, especially marked on exertion. He was otherwise a very healthy man, with no abnormal physical signs in his chest and no evidence of commencing tabes. The vocal cords were seen to be adducted, but were otherwise healthy in appearance, as also the rest of the larynx. Tracheotomy was performed at once and without anæsthesia. After the skin incision the patient complained of very little pain.

Patient is now a particularly healthy-looking man; he still has to wear his tube, and, as in the last patient, his voice is very good.

The knee-jerks and pupils have normal reactions. The question arises whether such a condition might not be a form of peripheral neuritis, and whether many of the laryngeal paralyses which are seen where there is no evidence of pressure on the recurrent laryngeal may not be due to a similar cause.

Fluctuating Swelling over the Left Ala of Thyroid Cartilage.

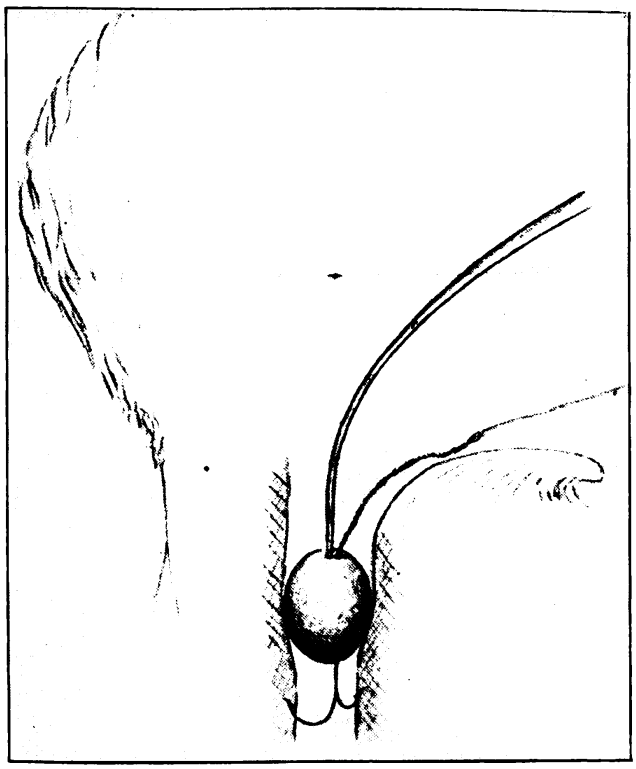
Shown by Dr. Herbert Tilley. Patient is a lad æt. 10, with a swelling as described. It has been noticed only three weeks, and no reason can be assigned for its presence. It extends slightly across the middle line, fluctuates, and is rather painful on pressure. The left

side of the larynx (internally) is distinctly more swollen than the right, especially the left vocal process.

Mr. BUTLIN thought it was a thyro-lingual duct tumour, which are occasionally situated to one side of the median line.

ORIGINAL DRAWING AND DESCRIPTION BY SIR ROBERT CHRISTISON OF A METHOD FOR REMOVAL OF A DOUBLE FISH-HOOK FROM THE GULLET (DATE 1819).

Shown by Dr. STCLAIR THOMSON for Dr. WALKER (Peterborough).



[COPY.]

EDINR.;
Septr. 24*th*, 1819.

DEAR SIR,

The rude sketch given above will communicate a pretty good idea of the mode in which the hook was extracted from the boy's throat at our hospital here about a fortnight ago. The hook was double (one division being less than the other), and had fixed itself across the gullet from before backwards, though not so far down as I have represented it. The wire attached to it hung out of the

mouth. A hole was drilled through the *Ivory* ball of a Probang, *but not in its centre,* the reason of which is evident when it is considered that the two divisions of the hook were unequal. The boy was able to give a tolerably accurate description of its size and form, so that it fortunately happened that the ball suited it exactly; both barbs were covered by the ball, and the whole was easily removed after being first slightly pushed down in order to loosen the attachments of the barbs. The extraction was considerably facilitated, in the opinion of the surgeon, by previous suppuration. Though it had remained about twelve days the boy recovered without a bad symptom.

I remain, yours most sincerely,

R. Christison.

Epithelioma of the Larynx from a Case exhibited on January 12th.

Mr. Symonds reported that the patient, æt. 55, he exhibited at the January meeting improved so much in general health, owing to local treatment, that he was able to remove the larynx on January 24th. The œsophagus and pharynx were closed anteriorly, and the muscle and skin united. The severed trachea was attached to the skin just above the sternum. Primary union took place in the greater part of the wound, and the man was able to swallow after twenty-four hours, and made an excellent recovery.

Mr. Symonds exhibited the patient, who showed great improvement in general health.

The disease proved extensive, as the specimen showed. The right ala was penetrated by growth and the left partly destroyed. There was also considerable extension to the pharynx, a further inch having to be removed after separation of the larynx. The specimen showed extensive disease of the whole interior of the larynx, the cords being destroyed. The starting-point was probably in front below the left cord, but as both sides were almost equally involved, it must have really spread to the right.

Though rapid extension took place after the man was exhibited on January 12th, the pharyngeal growth must have existed at that time. No enlarged glands were found at the operation.

The microscopic characters were those of a squamous-celled epithelioma.

Microscopic Specimen of Early Epithelioma of Vocal Cord from Dr. Tilley's Case shown at February Meeting.

Shown by Mr. Ernest Waggett. The correctness of the diagnosis was abundantly proved by the nature of the specimen.

Post-mortem Specimen of Epitheliomatous Larynx which had been twice operated upon.

Dr. David Newman showed the larynx removed post mortem from a man who had thyrotomy performed twice for epithelioma.

The patient was first operated on for epithelioma on the anterior third of the left vocal cord in 1890 by thyrotomy,* and no recurrence took place till 1893, when a small growth the size of a barleycorn was discovered close to the anterior commissure, and on removal proved to be an epithelioma. From 1893 till 1897 no appearance of recurrence, although patient was examined regularly every two months. In March, 1897, symptoms of slight laryngeal obstruction and evidence of œdematous swelling in larynx, which prevented a complete view of larynx being obtained. Laryngeal symptoms were accompanied by symptoms and physical signs of chronic parenchymatous nephritis. Patient died suddenly from laryngeal œdema, and post mortem the larynx was found to be occupied by an epitheliomatous ulcer.

Naso-pharyngeal Papilloma.

Dr. David Newman also showed a very large papilloma removed from the naso-pharynx of a young man. The growth was the size of a hen's egg.

* See Newman, 'Malignant Diseases of the Throat and Nose,' p. 93.

Adhesion of Soft Palate to Posterior Pharyngeal Wall.

Shown by Dr. Willcocks. Mrs. R—, æt. 43. This patient had always enjoyed good health until eleven years ago, when at about a month after her confinement (the fourth) she had an ulcerated throat. She is the mother of five children, all living and healthy, and has had no miscarriage.

Present condition.—The soft palate is adherent to the posterior pharyngeal wall, and the only communication with the naso-pharynx is a small slit in the median line of the soft palate.

The vocal cords are normal, but the edge of the epiglottis is somewhat nodular.

For the last two months she has been taking a mixture containing Liquor Hydrargyri Perchloridi and iodide of potassium.

Mr. Symonds thought as there was an opening into the nose, the patient had better be left alone. A small aperture permitted respiration and descent of mucus, and prevented the cleft-palate voice.

Mr. Spencer said that with regard to the operation for the separation of the soft palate from the pharynx, he had never done nor recommended it except for the relief of distinct complication, Eustachian obstruction with pain in the ear, persistent laryngitis from breathing through the mouth, and so forth.

Case of Syphilitic Pharyngeal Stenosis.

Shown by Mr. Walsham. Patient is a middle-aged man in whom the soft palate is drawn into contact with the posterior wall of the pharynx as the result of cicatrisation following tertiary syphilitic ulceration. There is also destruction of the septum and falling in of the bridge of the nose.

A Case of Rhinitis, Pharyngitis, and Laryngitis Sicca.

Shown by Sir Felix Semon, M.D. The patient is a gentleman æt. 48, sent by Dr. Rattray of Upper Holloway, who began to suffer from a discharge from the right nostril without any definite cause being known. Crusts were formed in the right nostril, and also often

evacuated through the mouth, whilst the throat became dry and the voice gradually hoarse. There has never been any dyspnœa. The patient has not lost the sense of smell, and is not aware that the discharge has ever been very fœtid. On examination the right nostril is found to be abnormally wide, with considerable atrophy of the lower and middle right turbinated bones, but without any evidence of actual disease of the bony framework of the nose or of any of the accessory sinuses. Further, there is considerable dry naso-pharyngeal and pharyngeal catarrh, with formation of crusts, after removal of which the mucous membrane looks wrinkled and shining. In the larynx on the first examination both vocal cords were completely covered with green dry crusts, after removal of which the cords appeared red and dry, whilst the ventricular bands were considerably swollen and equally dry. The patient having been treated for a week with benzoin inhalations aud the use of salt water injections into the nose by means of a Higginson's syringe, all the conditions described appeared to be considerably improved on the occasion of his second visit, but as soon as these simple cleansing measures are neglected the previous conditions return.

The case is shown, first, on account of the one-sidedness of the atrophic rhinitis, which in the observer's experience is comparatively rare unless due to a distinctly local process, such as impaction of a foreign body, or disease of the accessory cavities, or again to a syphilitic process, of all of which contingencies there is not the least evidence in the present case.

The second remarkable feature consists in the persistence of the process. In the observer's experience ordinary ozæna usually exhausts itself about the age of forty or thereabouts, but it is remarkable that in a man of forty-eight like the patient it should still be so active.

The third remarkable fact is the extension of the process into the larynx, which in this country at least is very rare. It is seen with slightly greater frequency on the Continent.

Case of very Uncommon Laryngeal Tumour.

Shown by Sir Felix Semon, M.D. The patient, æt. 40, is a married lady who formerly lived in North-west Canada, and up to about ten years ago enjoyed good health, apart from the fact that she sometimes suffered from slight "spasms in the throat."

Ten years ago she first observed a swelling in the left submaxillary region, which gradually grew until it attained its present size, that of an average walnut. At first it gave no discomfort, and particularly caused no difficulty in breathing, or, so far as she knows, in the voice. In spring and autumn it used to swell, but always returned to its previous size. Gradually it became tender on pressure, and her breath became permanently short, whilst the previous attacks of spasms in the throat increased in severity. She went to Montreal and consulted Dr. Major, who found not only the external growth as described, but also a growth in the larynx. He is stated to have attempted to puncture the latter, but without striking fluid. He also tried, according to the patient's statements, to snare the laryngeal growth, but the snare broke. Dr. Major then recommended the patient to go to England and to take further advice; he had never seen a similar growth. The patient went to London and was treated in a special hospital. This was seven years ago. Her medical attendant is stated to have attempted to snare the intra-laryngeal growth off with the galvano-caustic snare, but to have brought up a very small piece of growth only, whilst during the attempt the throat and the tongue were severely burnt. Three weeks afterwards her difficulty in breathing had increased to such a degree that tracheotomy had to be performed. This was followed by immediate relief of the breathing and very great improvement in general health, the patient previously, according to her description, having wasted away to a skeleton. The little piece of growth removed was stated by her attendant to have been of a malignant nature,—indeed, of a cancerous character. No further attempts were made to interfere with the intra-laryngeal growth. The external swelling has never been explored. Two years ago the external swelling in the spring again became so much increased and gave the patient so much discomfort that she returned to her medical attendant, who is said to have thought that there was fluid in it, but he did not want to perform any further operation unless it was absolutely necessary. No further steps were then taken. Recently there has been again some external swelling, which has now subsided, with a good deal of shooting pain in the throat extending to the jaws and to both ears. All this is again better now. The patient has not recently lost flesh, and has never had any dysphagia. Her voice is so surprisingly clear and strong, although she still wears a tracheal cannula, that the history, as given above, was listened to with a certain amount of incredulity. The

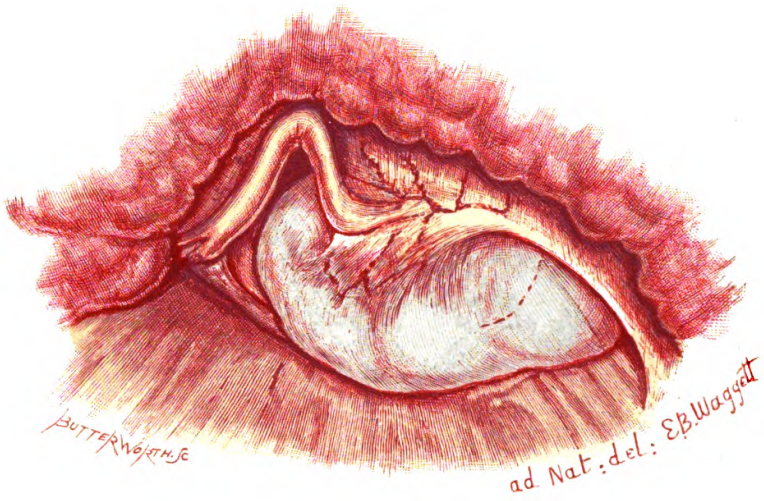
result of the objective examination, however, was very surprising. Externally the small tumour in the left submaxillary region was tender to the touch, and any pressure on it, unless extremely gentle, each time caused immediate retching and cough. It was, however, ascertained that it was not adherent to the skin, and somewhat mobile in various directions, although it seemed to be fixed to something very low down. No enlargement of lymphatic glands in its neighbourhood. On laryngoscopic examination a very surprising condition was seen. Whilst from the almost normal voice one would have expected a corresponding normal aspect of the larynx, it is seen that almost the whole laryngoscopic image is filled out by an enormous tumefaction of the left half of the larynx, which above extends to nearly the free border of the epiglottis and below to the left arytænoid cartilage. All the constituent parts of the larynx within that distance have perished, as it were, in the smooth round tumefaction, covered by apparently normal mucous membrane. Of the epiglottis itself not much more than the free border can be seen, which is twisted so that the epiglottis is looking towards the right. From this small remnant both on the dorsal and on the ventral aspect the tumefaction of the left side begins, which involves the ventricular band, the arytæno-epiglottidean fold, and the arytænoid cartilage. To the right of this tumefaction a small chink remains, which is bordered on the right by the right ventricular band. Neither of the vocal cords can be seen, and it can only be concluded from the integrity of the voice that the left vocal cord cannot be involved in the process. The right arytænoid cartilage moves well, the left half of the larynx is almost immoveable. On touching the tumefaction with the probe a feeling of an elastic resistance is encountered, similar to that experienced on pressing the external tumour.

The observer wished to have the opinion of the Society on this most uncommon condition, the like of which he did not remember having ever seen.

Dr. NEWMAN regretted not having heard the history of the case, and judging merely from the clinical appearances he thought it looked like a sarcoma; the long history, however, was somewhat against this suggestion, and he should suggest it was a fibrous or fibro-cystic growth.

Dr. SPICER thought the tumour encapsuled, and that if the mucous membrane were divided it would shell out.

Mr. SYMONDS found difficulty in deciding what was the relation of



SIR FELIX SEMON'S CASE.

the outside to the inside tumour. He thought the case might be surgically attacked, and without any great danger.

Mr. DE SANTI remarked that though very uncertain as to the nature of the tumour, he inclined to the opinion that it was a slowly growing fibro-sarcoma. With reference to Dr. Newman's remarks he would point out that the history of eight years' duration was not incompatible with a diagnosis of sarcoma. Recently he had had under his care a girl of twenty, who for eighteen years had had extensive tumours of the neck and scalp. Six years ago one of the largest was removed by one of his colleagues, and Dr. Hebb, a well-known pathologist, reported it to be a fibro-sarcoma. Four and a half years ago another was removed, and also reported to be a fibro-sarcoma. Last summer Mr. de Santi made a clean sweep of all the tumours, some thirty or forty, and those, microscoped by Dr. Hebb, showed almost pure fibrous structure The girl got quite well, but some ten months after died with supposed secondary growths in the lungs. He hoped to hear soon from the medical man who did the post-mortem whether there were definitely secondary growths or not. At any rate the case showed the very slow malignity of some of these cases of sarcomata.

Mr. BUTLIN thought that possibly the tumour was glandular in nature, and might be an extension or outgrowth of the thyroid gland, and pointed out that the external tumour moved with the hyoid on swallowing. He thought that an operation for removal might be attempted, and with prospects of success.

Sir FELIX SEMON was glad to hear the suggestions which had been made relative to active interference with the tumour, but he could not yet make up his mind as to whether he should advise the patient to undergo the risks of such a severe operation as the case would necessarily entail. At present the patient is comfortable, her voice is good, she has no trouble with the tracheotomy tube, and the tumour is obviously a very slowly growing one. On the other hand, an operation, the extent and limits of which we cannot foretell, has been suggested for a tumour of whose nature we are ignorant, and which is probably closely connected with the vagus, an operation which, therefore, is necessarily of a very serious nature. At present he thought he would watch the case a little longer, and report later to the Society as to what course, if any, had been adopted, and its results. The Society is indebted to Mr. Ernest Waggett for the accompanying sketch of the tumour.

LOCALISED THICKENING OF INTERARYTÆNOID FOLD OF TUBERCULAR ORIGIN.

Dr. BRONNER (Bradford) showed a microscopic specimen of hypertrophy of the mucous membrane of the interarytænoid fold of eleven years' duration. The patient, æt. 34, was first seen in November, 1894. She complained of hoarseness and occasional loss

of voice for over seven years. The symptoms were not increasing in severity. There was the well-known thickening of the interarytænoid fold. Sprays, insufflations were tried. The parts were then removed with cutting forceps several times; they always grew again. The use of the galvano-cautery was equally ineffectual. The patient was under treatment for nearly two years. The present appearance of the parts was just the same now as it had been four years ago. The Clinical Research Association had reported, "There are several distinct tubercles having a nodular outline, and large giant-cells. Other pieces consist of ulcerated mucous membrane, the raw surface being covered with granulation tissue. The evidence points to the existence of tuberculous laryngitis."

The mother of the patient had died of phthisis, and patient had nursed her for some months. There were no other symptoms of tuberculosis.

Dr. Bronner wished to have the opinion of the meeting—(1) if many cases of chronic thickening of the interarytænoid fold, without any apparent cause, were of tubercular origin; (2) if there was any danger of the disease spreading.

Dr. Herbert Tilley referred to a case which he had shown the Society nearly twelve months ago. He pointed out that there were two distinct forms of thickening found on the anterior face of the arytænoid commissure. (1) Tubercular granulation tissue such as was shown at the last meeting by Mr. Lake. The granulations were soft, easily removeable, and tended to recur rapidly. Associated with this condition one found signs of tubercle in the lung or in the larynx. (2) That form which is found in cases of chronic laryngitis, especially in alcoholics, and not in any way associated with tubercle. The growth is a tough, fibrous hyperplasia covered with epithelium natural to the part. Often there is a vertical fissure in it, and then there is usually sharp pain on swallowing. He did not know what was the best treatment for such a condition, though galvano-cautery, lactic acid, and removal of pieces by forceps (cutting) only seem to give temporary relief, and he was inclined to believe that such cases did best when left alone.

Mr. Spencer also thought that such a condition would not increase if it was left alone.

Dr. Jobson Horne observed that the section of the part removed showed, under the microscope, an increase in the breadth of the epithelium, with papillæ passing into the subepithelial layer. Accompanying this hyperplasia there was a metaplasia of the cells constituting the condition of pachydermia. He attributed the condition to the chronic irritation caused by the subjacent tubercle.

Extensive Syphilitic Adhesions of Soft Palate.

Mr. de Santi showed a woman on whom he had operated for extensive syphilitic adhesions of the soft palate to the posterior wall of the pharynx. The patient's mother had suffered from syphilis, the woman herself had inherited the disease, yet after marriage she contracted the disease again, and her child had congenital syphilis. The whole of the naso-pharynx was cut off from the oropharynx by the dense adhesions, and recently patient had had intense pain in the right mastoid and ear. There were old perforations of both drums, and the patient was deaf to both air and bone conduction. The pain in the ear and mastoid always started from the throat. Mr. de Santi operated by thoroughly separating all the dense adhesions with scissors and knife as close to the pharynx as possible. There was but little bleeding; on the left side no soft structure could be detached, but on the right side a fair amount of tissue was separated and then stitched forwards to the muco-periosteum of the hard palate, according to Mr. Spencer's method. The case did very well, re-adhesion did not take place, and the patient became entirely free from the mastoid and ear pain. She also now is able to speak better, and all post-nasal discharges pass down the normal way. She is able to blow her nose and breathe with her mouth shut.

Ivory Exostosis of Frontal Sinus causing Pressure Symptoms.

Mr. de Santi also showed a case of a man suffering from an ivory exostosis involving the right frontal sinus, and which had by pressure caused a suppurating mucocele. The man had had the exostosis for over five years, but beyond the disfigurement had not troubled about it until within the last ten days, when the whole of the parts at the inner canthus of the eye began to swell and cause pain. The exostosis was a very hard, large, and sessile one, and Mr. de Santi dealt with the abscess only by incision and scraping, and proposed to operate on the exostosis a little later. If left alone it would probably destroy the right eye.

Syphilitic Periostitis of Forehead.

Mr. de Santi also showed a case of a man with a syphilitic periosteal swelling in the mid-frontal region of the head, just above the articulation of the frontal bone with the nasal bones. It was of interest because the patient two years ago had been shown by his colleague, Mr. Spencer, for symmetrical enlargement of both parotid glands. Some of the members of the Society, notably Dr. Lack, had considered the case to be syphilitic parotitis. At any rate, under iodide of potassium both parotids soon resumed their normal size. It was, however, of interest to note that concomitant with the diminution in size of each parotid gland there was a yellow discharge from each ear. This discharge did not last long, and there is no sign of perforation recent or old to be seen in the membranæ tympani. Nor at the time of the enlargement of the parotids was there any "dry mouth" or symptom of obstruction of the parotid ducts.

Tumour of Lower Lip.

Mr. Lawrence showed a case of tumour in middle line of lower lip in a man æt. 61. Disease of a warty character, and hard and ulcerated. No history of previous disease and no loss of flesh. There was little doubt but that it was malignant.

Enlargement of Tonsils after Tonsillotomy.

Mr. Lawrence showed a young woman æt. 22, who had been "troubled with her throat" for twelve years. Tonsils were removed last November. Since then they have grown considerably, and there are masses of large glands behind and below the angles of the jaw.

Mr. Butlin and Sir Felix Semon thought the case was one of syphilis occurring in a tubercular subject, an opinion generally concurred in by other members.

Mr. Spencer thought it was possibly a slow diphtheritic growth, and suggested that a bacteriological investigation should be made.

Cutting Laryngeal Forceps.

Mr. R. Lake showed a pair of punch forceps for use in double curetting of the larynx in tubercular laryngitis.

Gumma and Perichondritis of Nose.

Shown by Mr. Atwood Thorne.

Bilateral Abductor Paresis of Vocal Cords—for Diagnosis.

Shown by Mr. Atwood Thorne.

Case of Phthisis and Healed Laryngeal Tuberculosis.

Shown by Dr. Lambert Lack. The patient, a girl æt. 19, came under his care in July, 1896, complaining of hoarseness and cough. The symptoms pointed to an acute but early phthisis, the lung signs being most marked at the right apex. The sputum was crowded with tubercle bacilli, there was a history of night sweats, cough, &c., for three months, but not much interference with the general nutrition. On laryngeal examination the right ventricular band was seen to be much swollen, and in its anterior two-thirds covered with pale fleshy granulations. The anterior third of the left ventricular band and the intervening area of the anterior part of the larynx were similarly affected. The vocal cords were congested, but the rest of the larynx appeared normal. The whole of the apparent tubercular tissue in the larynx was removed with the cutting curette in some three or four sittings; on each occasion chromic acid fused on a probe was applied to the resulting raw surface. This somewhat extensive surface healed readily, lactic acid being occasionally applied to stimulate it. After about two months' treatment the larynx was entirely healed, and the patient's general condition had considerably improved. Now for more than eighteen months the patient has had no further treatment, the disease in the chest has quieted down, and the general health remains fairly good, although the patient has unavoidably continued work as a waitress in London.

The larynx remains healed, the absence of the right ventricular band disclosing a large part of the upper surface of the right vocal cord.

Dr. CLIFFORD BEALE agreed that healing had taken place in this case, but pointed out that there was still a good deal of difference on the two sides. The patient's throat showed none of the characteristic anæmia of tubercular disease, the mucous membrane looking particularly well nourished—an important point in the selection of cases for operation. He thought that surgical wounds of the ventricular bands were more likely to heal than those made in the interarytænoid space, as being less likely to become infected by secretions from above or below. He congratulated Dr. Lack on the results obtained. The successful removal of foci of active disease from the larynx showed a distinct advance in treatment.

ERRATUM.

In the report of the discussion of Mr. Spencer's case of "Carcinomatous Tumour of the Epiglottis," the statement is ascribed to Sir Felix Semon ('Proceedings,' February 9th, 1898, p. 50, line 26) that he could recall no case which had recovered after subhyoid pharyngotomy. This statement is due to an error on the part of the reporter. What Sir Felix Semon said was that, according to Sendziak, in more than 50 per cent. of the cases of laryngeal cancer, in which subhyoid pharyngotomy had been performed, death had ensued.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *April 13th*, 1898.

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

HERBERT TILLEY, M.D., WILLIAM HILL, M.D., } Secretaries.

Present—26 members and 1 visitor.

The minutes of the previous meeting were read and confirmed.

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

Arnold Fergusson, F.R.C.S.E., 34, Canfield Gardens, Hampstead.

CYST OF THE EPIGLOTTIS.

Shown by Mr. WYATT WINGRAVE. Girl æt. 13 complained of sore throat and occasional deafness for six years, on and off, following scarlet fever. Her tonsils were removed four years ago, when nothing wrong with her throat was noticed.

On examination a mass is seen attached to the left half of the laryngeal aspect of the epiglottis, resembling a small white-heart cherry in size and colour. The only symptom is occasional pain on swallowing, her singing and speaking voice being normal.

Dr. LAW said that he had often noticed these cases following excision of the tonsils for chronic hypertrophy, and questioned whether a traumatism might account for them.

CASE OF CHRONIC PHARYNGITIS.

Shown by Mr. WYATT WINGRAVE. Man æt. 26 has been under treatment for chronic suppurative middle ear disease for six years.

Suspecting adenoids, his pharynx on examination showed a symmetrical flesh-like thickening, which commenced behind the posterior pillars and met in the middle line above the level of the soft palate, extending upwards into the naso-pharynx. This tissue proved tough on attempting to scrape with finger-nail.

There is a doubtful history of hereditary syphilis.

Is the condition due to asymmetrical hypertrophy of the lymphoid tissue? or is it of inflammatory origin?

Dr. SPICER called attention to the adhesion in this case between the salpingo-pharyngeal fold and the pharyngeal wall, as had been observed in connection with Tornwaldt's disease.

Dr. GRANT ascribed the condition to hyperplasia of the salpingo-pharyngeal folds, which had become adherent to each other at a lower level than the choanæ.

Mr. SPENCER advised removal of the bands on account of deafness.

Dr. HILL suggested that it was a case of adhesion of the lower portion of the hypertrophied salpingo-pharyngeal fold to the posterior pillar of the fauces.

Dr. EDWARD LAW thought it resembled a gummatous condition of the lateral pharyngeal wall.

Dr. STCLAIR THOMSON suggested that the condition might be an hypertrophy left by a syphilitic process. He had seen a gumma in the region of Luschka's tonsil break down in the upper part, but leave a thickening across the pharyngeal wall—at the level of the soft palate,—and uniting with a hypertrophic lateral pharyngitis of both sides. This condition had remained unaffected by antisyphilitic remedies. In the present case some further help might be obtained by the microscopical examination of a portion, which could easily be removed for that purpose.

Mr. WINGRAVE in reply said that on digital examination the finger simply passed between the soft palate and the deposit, upwards to a free and well-defined vault. The deposit did not *hang* in front of the posterior pharyngeal wall, but was flush with it. There was a doubtful history of congenital syphilis which suggested a possible pre- or post-natal inflammatory process.

Modification of Baratoux' Electrical Laryngo-phantom.

Shown by Dr. Dundas Grant. In the original instrument there is a model of the larynx, with a number of metallic points at definite positions. Each of these points has, in communication with it, a flexible wire and a pin, to which a numbered label is attached. In front of a machine is a tracing of the larynx, on which the corresponding points are numbered.

When the student wishes to exercise himself in touching with the laryngeal probe any given point in the larynx, the pin corresponding to that point has to be selected by its numbered label (the number having been discovered by examination of the aforesaid tracing), and is then fixed in a screw connection. When this is done, and the probe is made to touch the correct spot—and no other spot—a loud electric bell rings. A considerable time is spent in seeking out the proper number, label, and pin, and the present modification has been devised by Dr. Grant to minimise this trouble.

The pins and labels are removed, and in the place of them there are small pieces of brass tubing. These are inserted in the appropriate places in another tracing of the larynx on an ebony plate. All that is then necessary is to insert the single pin into the appropriate hole on this tracing, and the necessary connection is at once complete.

(The instrument in this form was tested by many of those present at the meeting, and was highly approved by them. The original instrument is manufactured by Gaiffe, of Paris, and the modification has been effected by Mr. Trood, of London.)

A Case of Empyema of the Frontal Sinus cured by the Ogston-Luc Operation.

Shown by Dr. Dundas Grant. The patient was a man æt. 40, who had suffered from fœtid purulent discharge from his left nostril, accompanied by pain in the left frontal region, which he alleges to have been only of six months' duration. The discharge was traced to the middle meatus, but by transillumination and exploratory irrigation, disease of the antrum was excluded. On transillumination of the frontal sinus there was found to be distinct comparative opacity

on the left side. The anterior extremity of the middle turbinated body was considerably swollen.

Relief was afforded by cocainisation of the middle turbinal, followed by the use of Politzer's bag to the left nostril, while the opposite one was closed with the finger; both ears were stopped up, and the patient uttered the sound "ee." As a palliative measure this process was carried out for some time by his family attendant, and an alkaline antiseptic douche was employed to wash away the pus as it collected. The patient was laid up with an attack of gout, so that he disappeared for some time, but his nasal condition remained comparatively unchanged, and he came into hospital for operation by Luc's method—a free opening, thorough curettement, the insertion of an india-rubber drainage-tube through the infundibulum, and immediate closure of the operation wound by suture of the periosteum, and then of the superficial parts. The patient was kept in bed, and unfortunately had almost immediately a recurrence of his gouty or rheumatic joint affection, which involved his right wrist-joint. The wound in the eyebrow healed almost entirely by first intention, although there was on one occasion a slight temporary superficial oozing from the inner extremity, which, however, was not visible when Dr. Grant inspected it. The drainage-tube was extracted on the tenth day. A glass syringe was applied to the extremity of the drainage-tube which protruded from the nostril, and an extremely minute quantity of pus was withdrawn. This was repeated daily, and at the end of a week a fine intra-tympanic tube was pushed up through the drain, and the sinus was washed out with boracic acid, pressure being exercised over the wound during the process, a precaution also adopted whenever the patient wished to blow his nose. This was repeated on three successive days. By that time the patient's arthritis had disappeared, and he was allowed to return home. He is now free from pain and from discharge, there is no disfigurement, and the middle meatus of the nose is quite dry.

Microscopical Section of Tissue from Frontal Sinus. (Dr. Dundas Grant's Collection.)

Shown by Mr. Wyatt Wingrave. This consisted of small-cell or lymphoid tissue, containing nodules similar to ordinary adenoid growth.

Dr. StClair Thomson directed attention to the fact that at that meeting there was a demonstration of the presence of adenoid tissue in the lining of the frontal sinus, and in the hypertrophies of the arytænoid bodies, while it was well known that adenoid tissue could be found in the hypertrophies of the inferior turbinals. He would like to ask pathologists—especially those whose practice was not limited to the upper air-passages—what their views were as to this distribution.

Mr. Spencer remarked on the development of lymphadenomatous tissue after chronic irritation, and considered the tissue in the frontal sinus to have been antecedent to the suppuration. He also referred to the difficulty of distinguishing diffuse forms of tubercular formation from lymphadenomatous tissue. In some cases histological examination did not solve the question, and the only thing would be the inoculation into animals.

Dr. Pegler thought the presence of normal lymphoid tissue in the section very remarkable. In sections made from a case of Dr. Tilley's the polypoid growths consisted entirely of granulated tissue, such as one finds in analogous growths from the antrum.

Mr. Symonds suggested that it might not be out of place to mention the possible dependence of the adenoid tissue in this case upon tubercle. He referred to one instance of persistent suppuration of the frontal sinuses, which resisted curetting and the use of iodoform, and subsequently died of pulmonary tubercle.

Mr. Wingrave in reply said he considered that it was not of a tuberculous nature, owing to the strong resemblance which it bore to ordinary pharyngeal tonsil tissue, and the regularity of the grouping of the lymphoid nodules.

Œdematous Hypertrophy of Arytænoids.

Shown by Mr. W. G. Spencer. More than a year ago Dr. de Havilland Hall showed the patient, a man æt. 47, to the Society. It was difficult to get a good view of the laryngeal condition, and the case was considered to be an unusual one of chronic laryngeal œdema. The history of the affection was mainly negative, merely a gradually increasing hoarseness and difficulty in breathing. After this Dr. Hall tried to remove some of the swelling by intra-laryngeal forceps under cocaine. But before he could do anything the patient had a bad fainting attack.

As dyspnœa was increasing the extra-laryngeal method became necessary. On retracting the alæ of the thyroid cartilages I found that each arytænoid had become a tumour of the size of the thumb, with a perfectly smooth surface, and that there was but very little change in the

size of the larynx. Each tumour was seized with a volsella, and cut off with scissors, the line of division being through the apex of the cartilage. There was no important hæmorrhage. Healing occurred, and the patient has remained well for a year, except for an occasional catarrh. On examining the larynx now there is not much deviation from the normal, except that the arytænoids appear flat-topped.

Under the microscope the tumour is seen to be a soft œdematous fibroma, covered by normal stratified epithelium, and containing normal arteries, veins, and nerves, also groups of mucous glands embedded in it.

The peculiarity of the case lies in the situation of the affection, as it is evidently the same as the common hypertrophy of the inferior turbinal. It was clearly of inflammatory origin, not liable to recur.

Papilloma of the Septum Nasi.

Shown by Mr. Yearsley. E. B—, æt. 20, complained of pain in the right nostril, lasting three months. There was occasional slight bleeding on rubbing, picking, or blowing the nose. Latterly she had found some difficulty in breathing through the right side of the nose. On inspection the condition was as shown in the photograph, kindly taken for me by Dr. Fallows. The growth was situated upon the cartilaginous septum, about three quarters of an inch inside the vestibule. There was also some hypertrophic rhinitis and a small spur on the right side.

The growth was easily removed under cocaine with a cold snare, the hæmorrhage being very trifling.

The specimen shown under the microscope passes through the delicate fimbriæ, and shows the growth to be a papilloma.

Dr. Logan Turner showed one specimen before this Society on December 9th, 1896.* Another, in a man aged 82, was reported by Mr. De Santi in the *Lancet*.† A third case (that of a Roumanian woman aged 28) was brought before the American Laryngological Congress of 1895 by Wright. To Wright's and De Santi's papers I would refer members for other published cases.

* 'Proceedings of Laryngological Society of London,' vol. iv, p. 21.

† December 8th, 1894.

Case of Laryngeal Stridor and Nasal Obstruction.

Shown by Dr. Lambert Lack. The patient is a weakly child aged five months. Within a few hours of its birth it was noticed that respiration was accompanied by a crowing noise, and this has continued more or less since. The infant has almost complete nasal obstruction, and snuffles and snores a great deal. Also at the end of inspiration there is a higher pitched, much louder sound, which, as far as the ear can judge, is true laryngeal stridor. When the child is awake and breathing through the open mouth this stridor is very slight or quite inaudible, but it at once becomes marked if the mouth be closed as in suckling. Also in sleep the stridor is intensified, and sometimes the patient's rest is disturbed by severe suffocative attacks. There is recession of the chest walls on inspiration, apparently constant but varying in amount. The child is wasting, and seems to be much enfeebled. The case seems to be one of laryngeal spasm, probably due to adenoids. It is proposed to give an anæsthetic, to examine the throat thoroughly, and remove the adenoids or other cause of nasal obstruction.

Dr. Hill asked if Dr. Lack would accept the explanation that in this case the cause of the stridor was that the tongue in certain positions alluded to fell back on the pharynx, pushing with it also the epiglottis, and so causing partial collapse of the vestibule of the larynx.

Dr. Spicer thought the obstruction was intra-nasal rather than post-nasal, and recommended treatment in that direction.

Mr. Symonds called attention to the emaciation of the child and the appearances of general illness, and suggested that the difficulty of breathing when the mouth was shut might be due to the child not inspiring sufficient air into a diseased lung. He did not question the fact of post-nasal obstruction. He suggested a post-pharyngeal abscess as a cause of the child's illness, or possibly pulmonary tubercle.

In reply to questions, Dr. Lack said that there was no malformation of the upper aperture of the larynx in this case. Judging purely from the characters of the sound he thought the stridor was produced in the larynx, probably by the vocal cords, but there was no direct evidence of this. The air entered the chest badly, and there was probably some collapse of the bases of the lungs, but this was the usual condition in all cases of congenital laryngeal obstruction.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *May 11th*, 1898.

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

HERBERT TILLEY, M.D., WILLIAM HILL, M.D., } Secretaries.

Present—38 members and 4 visitors.

The minutes of the previous meeting were read and confirmed.

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

Arnold Fergusson, F.R.C.S.E., 34, Canfield Gardens, Hampstead.
Claude C. Claremont, M.D., B.S. (Lond.), 57, Elm Grove, Southsea.
Francis J. Steward, M.S. (Lond.), F.R.C.S. (Eng.), 24, St. Thomas's Street, S.E.
Albert H. Burt, M.R.C.S. (Eng.), L.R.C.P. (Lond.), Throat and Ear Hospital, Brighton.

A CASE OF CARCINOMA OF LARYNX SUBSEQUENT TO LARYNGEAL TUBERCULOSIS.

Shown by Mr. H. BETHAM ROBINSON. E. D—, a single woman æt. 36. The first sign of any throat trouble was in 1878, when she was hoarse, and at times aphonic. She had no pain or difficulty in swallowing until August, 1882, after an attack of tonsillitis. In December, 1885, she saw Sir Felix Semon, who ordered daily treatment. This

she did for three months, and then ceased attendance. After some months she returned with chronic laryngitis. She attended the hospital for some years with varying laryngeal symptoms, but since the beginning of 1893 she has been unable to speak above a whisper. In July, 1896, when she complained of weakness, shortness of breath, loss of appetite, and wasting, Sir Felix Semon said it was tuberculous laryngitis, and she had lactic acid applied twice a week. She gradually got worse, and in March, 1897, the extreme dyspnœa required tracheotomy done. Her condition improved, gaining flesh and speaking fairly up to November, since which time she has been only able to whisper. In December last the swelling on the right side of the neck was first manifest, and about the same time the margins of the tracheotomy wound were becoming prominent. Laryngeal examination showed that the subglottic space was completely filled with growth. Since this time it has extended, so that now the right pyriform sinus has become invaded and filled up, and both cords are almost completely obscured. The sprouting about the tracheotomy wound has increased. The growth on the right side of the neck has softened, so that a carcinomatous cyst has formed. During this time, however, her health has remained very good, and she has not lost flesh appreciably.

There is a history of consumption on both sides of the family, father and one sister in particular succumbing; there is also a history of cancer, both mother and grandmother dying of cancer of the womb.

The chest gives signs of excavation at both apices, especially on the right side, but the disease is now quiescent.

On microscopical examination of portions of the growth it proves to be a non-cornifying epithelioma, such as might arise from the glands of the laryngeal ventricle.

A Case of almost Fixed Cords from Syphilis simulating Bilateral Abductor Paralysis.

Shown by Mr. H. Betham Robinson. E. J—, a married woman æt. 50, has enjoyed good health except on occasions during the past few years. She has had five children, all healthy.

In October, 1886, she first attended St. Thomas's for laryngeal tumour, and the diagnosis was secondary syphilis. She complained then of sore throat, loss of voice for a few weeks at a time, and bronchitis. In May, 1887, she returned with similar symptoms, and was treated for

a while. Five years ago she again sought advice for similar symptoms, which have continued since.

In February of this year she had influenza, followed by increased shortness of breath.

Early in April there was great dyspnœa, and on examination of larynx the present local condition was seen.

Present condition.—On inspiration the cords are seen almost meeting in the median line except in the interarytænoid region, the left cord being on a plane slightly superficial to the right; on expiration they recoil about to their normal position,—in fact, the appearance produced is suggestive of delayed innervation. On phonation the cords are adducted normally. There is no definite swelling of soft parts, but some appearance of thickening in the arytænoid region. The left cord is still injected.

The chest is normal, no swelling in the neck, and no signs of any bulbar or nerve affection. Her pupils and knee-jerks are normal.

The question in this case seems to be whether the local laryngeal signs are dependent on nerve lesion or on an old syphilitic infiltration causing some hampering of the movements at the crico-arytænoid joints and muscular degeneration. There has probably also been some perichondritis in addition in posterior part.

The muscular wasting and altered tension of the cords fully explain the appearance produced on inspiration.

With the disappearance of the catarrh her voice and dyspnœa have nearly gone.

For general treatment she has had iodide of potassium, but owing to the great discomfort produced this has been given up.

Kirstein's Autoscope.

Mr. Cresswell Baber showed the latest form of instrument used by Dr. Kirstein, which consists of a strong rectangular metal tongue depressor. The blade of the instrument measures about 11 centimetres by 51 millimetres, and is 3 millimetres thick. For a distance of 5 centimetres from the tip the blade is curved, forming a segment of a circle of 13·5 centimetres radius. The end has a slight depression to receive the middle glosso-epiglottic ligament, and the edges are carefully rounded. For illumination the ordinary forehead mirror or Kirstein's electric frontal lamp may be employed. This is all that is

required for examination; for demonstration the electric autoscope is used.

The method of using the instrument was explained, and the opinion expressed that direct inspection of the larynx and trachea as employed by Kirstein was worth practising by laryngologists for use in suitable cases, as a supplementary means of examination, not as a substitute for laryngoscopy.

Case of Malignant Disease of the Laryngo-œsophageal Region.

Shown by Dr. Pegler. R. D—, æt. 37, married, complained of swelling in the throat and difficulty, but not pain, in swallowing.

Examination showed extensive thickening and ulceration of the œsophageal aspect of the arytænoid region and interspace, and ary-epiglottic folds. A broad-based neoplasm projected towards the middle line from the left arytænoid, and obstructed the view of the larynx. It was ulcerated on the surface. A mass of hypertrophied glands, the uppermost of which was breaking down, and on the point of discharging through the thinned epidermis, was conspicuous on the left side of the neck. Others were commencing to enlarge on the right side. The throat trouble dated from about a year. From the laryngoscopical appearance and history there seemed at first some chance of the disease being syphilitic, or at all events of its being a mixed case, but sections of the neoplasm, part of which had been removed with a snare for the purpose, displayed every characteristic of epithelioma, and scrapings from the broken-down gland cavity yielded epithelial squames only, and no tubercle bacilli. The interior of the larynx was healthy so far as could be seen after removal of the growth.

Constant spitting of an abundant watery secretion was the chief trouble besides the dysphagia, and it was very desirable that some means should be found to relieve this.

Dr. Bond stated the same patient had attended his clinique at Golden Square for some weeks. She had then an enlarged gland externally and ulcerating growth on left side of pharynx, extending behind arytænoids. Although there was some slight improvement under iodide at first, the malady afterwards steadily progressed, and was

thought to be malignant. Dr. Bond recommended palpation of the growth in such cases as an aid in diagnosis.

Mr. SPENCER suggested the use of atropine pills to check the excessive salivation.

Dr. PEGLER inquired whether the high palate he observed in this as well as in some of his own cases might have anything to do with the speech disability. Removal of the nasal obstruction, primarily responsible for the paresis of the soft palate, did not improve matters much, as more air passed through the nose than before. When this patient's nostrils were closed she pronounced the "s" in "kiss" very fairly. He thought the elongated uvula in this case rather aggravated the paresis.

A CASE OF RECURRENT MULTIPLE PAPILLOMATA OF THE LARYNX.

Shown by Dr. DUNDAS GRANT. The patient, a female æt. 20, whom he first saw in February, 1895, had then several large papillomata in the larynx. These were removed by means of the forceps, but recurred repeatedly. Various chemicals were applied, among others chloride of zinc, absolute of alcohol, tincture of thuja, and perchloride of iron, but none had any effect until in October, 1896, salicylic acid dissolved in alcohol was applied daily by means of a fine laryngeal probe coated with cotton wool, in strength gradually from 1 up to 10 per cent. Under this treatment the stumps shrivelled up and the recurrence was permanently stopped.

NODAL AGMINATION OF SECRETION ON THE VOCAL CORDS OF A SINGER. ? INCIPIENT NODULES.

Shown by Dr. DUNDAS GRANT. The patient, a female æt. 21, a student of singing, complained of want of timbre in the voice. There was a frequent accumulation of white secretion at the junction of the anterior and middle thirds of both vocal cords, the seat of election of "singer's nodules." On the removal of the secretion a tiny acuminate projection could be seen at the spot, but this was so small that it was doubtful whether it amounted to a morbid condition at all, or whether it was the earliest stage of a nodule. There had been considerable nasal obstruction, which had been removed by treatment, and since then the secretion on the vocal cords had very greatly diminished.

Dr. BENNETT said he could only see a trace of a nodule, and thought the patient might resume her studies without any risk of permanent damage to the larynx.

CASE OF SIGMATIC DYSLALIA.

Dr. DUNDAS GRANT brought forward the case of a female æt. 30, who complained of stuffiness in the nostrils, and a defect of speech resembling that produced by cleft of the palate. In particular, there was absolute inability to produce the hissing of the letter "s," for which was substituted the guttural "k." The palate was somewhat paretic, and the turbinated bodies hypertrophied. On contraction of the latter by means of cocaine the feeling of discomfort in the nose was removed, and utterance of the letter "s," in spite of the increase of nasal freedom, became more easy. When the nostrils were compressed hissing became easier still. The turbinated bodies were cauterised, and the patient instructed in the method of exercising herself in the utterance of the hissing sound.

Note.—Since the exhibition of the case Dr. Dundas Grant has found that the letter "s" is more easily produced when the patient projects the lower jaw forwards, and she is exercising herself in this movement.

SESSILE PAPILLOMA OF THE LEFT TONSIL ASSOCIATED WITH PEDUNCULATED PAPILLOMA OF THE LEFT POSTERIOR FAUCIAL PILLAR.

Shown by Dr. SHARMAN. F. H—, a boy of 15, came to the hospital on April 25th, 1898, complaining of difficulty in swallowing and in breathing through the nose of about one year's duration. He was found to have chronic enlargement of both tonsils, a central pad of post-nasal growth, some enlargement of both inferior turbinates, and some slight chronic laryngitis. On the surface of the left tonsil is an apparently sessile papilloma, the size of half a small split pea; and behind the tonsil, growing from the left posterior pillar of the fauces, is a small pedunculated papilloma rather larger in size. Dr. Sharman thought the case worth showing in view of previous remarks at the Society this session on the subject of the rarity of benign growths of

the tonsil, and also in view of Dr. Rose Paterson's theory that such papillomata really grow not from the tonsil proper, but from the plica triangularis. The tonsil will probably be removed, but the boy's throat up to the present has not been subjected to any surgical interference whatever.

Patient with Laryngeal Paralysis (previously shown at March meeting) who has recently had several Epileptiform and Vertiginous Attacks associated with Laryngeal Spasm and Irritation.

Shown by Mr. Atwood Thorne for Dr. Hill. The case, a man æt. 38, was shown at the March meeting of the Society as a case of paresis of both vocal cords of doubtful origin, but no definite opinion of its cause was expressed at that meeting. At that time it was not known that he had had any attacks of giddiness.

On April 7th, while assisting in loading a barge, he felt queer in his head, gave a cough, and fell head over heels into the barge, striking his head in falling. He remained unconscious for an hour and a quarter. (Probably the length of unconsciousness was due to the blow received while falling.)

He has had in all six attacks of unconsciousness, each immediately preceded by a feeling of constriction in the throat, with inspiratory whoops and deep coughs. He has remained unconscious (except when he struck his head) for two to six minutes each time.

At different times the abduction of the cords has been very feeble, and he has suffered from marked stridor, and the question of tracheotomy has been discussed. At the meeting, however, the cords moved fairly well.

There are no signs or symptoms of locomotor ataxy, and examination of the chest gives no hint as to the cause of the paresis.

Dr. Beale questioned whether the infantile shape of the epiglottis, to which attention has recently been drawn in cases of infantile laryngeal spasm, had anything to do with the stridorous attacks.

Drs. Hill, Spicer, and Thomson also briefly discussed the case.

Case of Pharyngo-mycosis.

Shown by Dr. Edward Law. The patient was first seen December 13th, 1897. She complained of her throat aching, and of the sensation of crumbs and roughness in swallowing, which sometimes produced a feeling of sickness; occasionally of a disagreeable taste in the mouth, but never of an offensive smell. She had never used her voice excessively, and her teeth were in a most satisfactory condition. She considered her general health to be good.

In September she lost her voice for a few days after bicyling a long distance, and a week later noticed throat irritation with numerous white patches and excrescences upon the nostril, which she attributed to having eaten bad oysters. Her doctor, who scraped the tonsillar crypts, applied various antiseptic remedies, and prescribed suitable gargles and tonics. The outgrowths quickly returned after removal. On examination the tonsils were found to be large and covered with numerous white patches, which varied considerably in size and shape. With the laryngeal mirror, numerous excrescences could be seen between the tonsils and anterior pillars to pass to the side of the tongue, and resembling in appearance rows of small incisor teeth. The lingual tonsil was largely developed, and studded all over with white elongated projections, especially at the sides. A few very small isolated points could be recognised in Rosenmüller's fossa, on the posterior lip of the left Eustachian tube, and three or four white dots were also visible on the posterior pharyngeal wall.

The galvano-cautery was very freely applied on several occasions to both tonsils after curetting away the soft but firmly adherent masses; various antiseptic pigments and gargles were employed, and iron and arsenic given internally. No improvement was noticed from the local and constitutional remedies, so the patient was sent to Margate for ten weeks in order to get away from a damp bedroom, and to be placed under the best climatic surroundings.

She returned in excellent health, but with only slight improvement in her throat symptoms.

Since her return to London the local trouble has greatly improved, although absolutely no treatment has been employed.

Dr. Waggett has very kindly made the drawings which were handed round, but these sketches unfortunately only represent the condition after great improvement had taken place.

The case is interesting on account of the great number and extent of the excrescences, and as showing the inefficacy of the treatment employed.

Dr. HERBERT TILLEY strongly recommended a solution of salicylic acid in absolute alcohol (salicylic acid one part, absolute alcohol four parts) for these cases. He had recently tried it in two cases in which other remedies had entirely failed, and in which the general health was good, and from the rapid improvement noticed he concluded that the latter was due to the application, and not to a natural cessation of the disease. The preparation is a strong one, and should be used cautiously; it whitens the surface to which it is applied, producing an appearance similar to that of the galvano-cautery. Small surfaces should be dealt with at a time, and the comparison of such a surface with that which has not been treated would, he thought, quite convince members of the efficacy of the application. Where possible a probe tightly wrapped round with wool and dipped into the solution should be screwed into the crypts from which the white masses protrude.

Dr. GRANT said that such applications were also useful in pachydermia of the larynx.

Dr. WILLIAM HILL said that, considering the nature of the disease, we might *a priori* expect salicylic acid to be useful, as in keratinous growths in other parts of the body, *e. g.* corns, warts, &c.

In reply Dr. LAW stated that he had only read Dr. Kelly's very valuable paper on keratosis pharyngis after cauterising the tonsils, otherwise he would have had sections made in order to examine the cornification of the epithelium of the crypts. Remembering the usefulness of boric acid in alcohol in cases of otomycosis, he tried it in this case, but without success. He would try salicylic acid in absolute alcohol, but would hesitate to rub into the lingual tonsil such a strong solution as 1 in 8.

The following report has been received of a small piece which was recently punched out of the tonsil:—"The sections show sufficient to confirm the statement that the crypts in the mucous membrane are filled with keratinised epithelium. The adjacent submucous tissue is unduly vascular, and shows round-celled infiltration."

SYPHILITIC ULCERATION WITH PERICHONDRITIS OF THE LARYNX.

Shown by Mr. SYMONDS. The patient is a man æt. 35. The disease was confined to the left side, and appeared chiefly as a thickening with an outgrowth about the site of the ventricular band. There was a four months' history of hoarseness, and a well-marked syphilitic scar on the neck and chest.

Case of Sessile Fibroma of Vocal Cord.

Shown by Mr. Symonds.

Frontal Sinus Disease.

Shown by Mr. Morley Agar. Patient was a man æt. 27, who for a year had suffered from pains and a "cold sensation" over the lower and middle part of the frontal region. There were no objective symptoms beyond some hypertrophic rhinitis. This had been treated several times with slight relief. However, there still remained some nasal obstruction on both sides. Iodide and mercury had been thoroughly tried on the suspicion that the frontal symptoms were due to a syphilitic periostitis, but without result. Phenacetin or antipyrin did not give even temporary relief. The case was shown to obtain the opinion of members as to "the justifiability of exploring for an exostosis," or as to "the propriety of treating the hypertrophic rhinitis more energetically, on the supposition that the symptoms were due to exhaustion sinusitis." The patient suffered so much distress that he was anxious for something to be done.

Mr. Cresswell Baber did not think that there were any distinct signs in this case of abscess in the frontal sinus.

Dr. Hill thought it was a case of exhaustion sinusitis, and that there was no indication for opening the frontal sinus.

Section of Tubercular Epiglottis removed by the Galvano-cautery Snare.

Shown by Mr. R. Lake. The epiglottis in this case was removed in the manner indicated in the title for two reasons,—its extreme vascularity, and on account of its very horizontal position. It healed well, there was neither primary nor subsequent hæmorrhage, there was immediate relief to dysphagia, and one was able to see definitely the extent of the diseased surfaces, and apply treatment with better prospect of success. Tubercle bacilli are scarce in the sections, and not to be found in all. The sections were cut by Dr. Cobbledick.

In reply to Mr. BUTLIN, the piece was about a third of an inch in thickness at its base, but was all cut up and destroyed in section cutting.

CASE OF SUBGLOTTIC SWELLING.

Shown by Mr. LAURENCE for Mr. BUTLIN. C. M—, æt. 55, has had "throat trouble" since Christmas, 1896. Some ill-defined attack of dyspnœa in July, 1897. Since then more or less hoarseness of voice and noisy respiration.

Condition in January last, 1898: both vocal cords white, the right cord very limited in motion. A pinkish subglottic swelling on each side, greatly narrowing the opening into the trachea. Some pain radiating to the right ear, and also involving the left side of the chest.

This condition has continued with very little variation to the present time. The patient is not losing flesh or strength, and she was shown with a view to diagnosis.

Mr. SPENCER said it was a case of malignant disease, and that some glands in the neck were becoming infected. As in his case, there was no ulceration of the subglottic swelling, but soft, breaking-down glands were found over the jugular vein. The appearances in the two cases were almost identical.

Sir FELIX SEMON and the PRESIDENT said that they could not convince themselves of a tumour being present, and thought that possibly some chronic perichondritis with chronic laryngeal inflammation would account for the appearances. Iodide of potash and Leiter's coil were recommended.

PARESIS OF THE RIGHT DIVERGENTS OF THE LARYNX.

Shown by Dr. BENNETT. Mr. J—, æt. 45, complained at the end of 1895 of a feeling of weakness in the larynx after any use of the voice. He attended a few times at a London hospital, but no weakness of the muscles was noted at that period. In May, 1896, I found the right half of the larynx irregular in its movements; one moment it would remain stationary during inspiration, and the next it would move, but more sluggishly than the left half. Faint sibilant rhonchi were occasionally noticed at the right apex, but nothing else abnormal. In June the right half remained completely stationary.

Although there was no history of syphilis iodides were given for

some time. Before the end of 1896 the movements had again become complete, though somewhat sluggish. During this period of recovery it was interesting to note that marked changes occurred in the course of an examination, as if the nerve could only permit the stronger impulses to pass, whilst the ordinary inspiratory efforts were not sufficient to affect the contraction of the muscles. During 1897 he felt perfectly well, and called to see me recently to say that he was quite better. I found the right half of the larynx again stationary, but this condition is now once more passing off. No intra-thoracic growth can be detected.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *June 8th*, 1898.

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

HERBERT TILLEY, M.D., WILLIAM HILL, M.D., } Secretaries.

Present—33 members and 1 visitor.

The minutes of the previous meeting were read and confirmed.

Albert H. Burt, M.R.C.S. (Eng.), L.R.C.P. (Lond.);
Claude C. Claremont, M.D., B.S. (Lond.), M.R.C.S. (Eng.), Southsea;
Arnold Fergusson, F.R.C.S. (Ed.), Hampstead;
Francis J. Steward, M.S. (Lond.), F.R.C.S. (Eng.), of London, were elected ordinary members of the Society.

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

A. J. Dixon, M.B., B.C. (Cantab.), Welbeck Street, W.
Frederick Spicer, M.D. (Durham), Devonshire Street, W.

ŒSOPHAGEAL TUMOUR REMOVED BY SUBHYOID PHARYNGOTOMY.

Dr. PERMEWAN showed a tumour removed from the œsophagus by the above operation. The tumour was of a benign character, and was very easily shelled out and removed. The patient, however, died on the tenth day from septic pneumonia, three days after the removal of

the tracheotomy tube. Dr. Permewan raised the question of the liability of a fatal issue in these cases, and suggested that they should be treated on the principles advocated by Mr. Butlin in thyrotomy, viz. that the wound should be left open. He compared the wound made in this operation with that in an ordinary cut throat, in which septic symptoms very rarely developed, and believed that the favorable course of the latter case was due to the fact that they usually healed by granulation.

Mr. SYMONDS said that with regard to the fatality of these operations, which was well known, he attributed the result to infection of the connective-tissue planes. He had successfully removed the epiglottis by this operation. He advised that after suture of the mucous membrane the wound should be packed for two days with iodoform gauze, as the best means of excluding this danger.

CASE OF TUBERCULAR ULCER OF THE NASAL SEPTUM.

Shown by Mr. LAKE. Patient, a man æt. 28, suffers with pulmonary tuberculosis of about four years' duration, and has had several attacks of hæmoptysis. The nose began to bleed about twelve months ago from the right side.

The ulcer on the septum was scraped and treated with lactic acid on May 24th, since when the acid has been applied eleven times, and insufflations of iodoform employed constantly.

Dr. STCLAIR THOMSON thought it was open to question if the ulcer in this case was not a simple traumatic ulcer, produced by the patient picking his nose. It had not the thickened, indolent margin of the tuberculous ulcer, and the hæmorrhagic and slightly inflamed base was more suggestive of traumatism.

Dr. BOND asked if members had ever noticed the marked supervention of general tubercular symptoms after removing small tubercular growths.

Mr. LAKE stated that the subject had been investigated by Clark, who concluded that such a complication was not usual—an experience which was corroborated by Dr. WATSON WILLIAMS, who thought these cases generally improved after operation.

CASE OF TUBERCULOMA ON THE RIGHT VOCAL CORD.

Shown by Mr. LAKE. This was a small tumour on the right vocal process, which had been present about two weeks. It has been treated with lactic acid applications, and is now very much smaller than when he first saw the case.

Cured Case of Laryngeal Tuberculosis.

Shown by Mr. Lake. The patient, a man æt. 35, was under treatment the early part of 1897, and was discharged cured on May 8th, 1897. When first seen he had redness and congestion of both cords, an ulcer on each towards the anterior extremity, and an irregular ulcer on the anterior part of the cricoid cartilage. The treatment consisted of daily intra-tracheal injections of a solution of naphthalene, 3 per cent., oil of cinnamon ½ per cent., in parolene.

Epithelioma of the Epiglottis.

Mr. Symonds showed a man (æt. 65) with epithelioma of the base of the epiglottis, also involving the tongue. The man came to the out-patient department at Guy's Hospital for the lump in his neck. The case was beyond operation on many grounds, and was exhibited to illustrate the large glandular infection in these cases; the patient has only recently complained of dysphagia, and noticed the glandular swelling two months before the dysphagia began.

Dr. Bond drew attention to the comparative frequency with which patients sought relief for glands in the neck secondary to malignant disease in the larynx before complaining of inconvenience due to the primary growth.

Mr. Waggett pointed out the value of "orthoform" in relieving the pain in advanced ulceration of the larynx, due to malignant disease.

Dr. Herbert Tilley had had similar experiences in the application of this remedy to relieve the dysphagia of tubercular ulceration of the pharynx and larynx. In a very advanced case in which he had recently used it, where the patient was literally starving to death, the insufflation of ten grains of orthoform enabled him to eat solid food with comfort, and the effect of one insufflation lasted nearly twenty-four hours. He had not met with any toxic effects, and compared with the drawbacks of morphia and the temporary anæsthesia of cocaine he thought the remedy was of very great value.

Dr. MacGeagh had found it very valuable in relieving the pain of an ulcer of the leg, and Mr. Lake pointed out that in order to obtain its good effect a breach of surface was necessary.

Case of Removal of Small Fibroma of Vocal Cord with extremely Pendulous Epiglottis.

Shown by Dr. Dundas Grant. The patient, a young man, had been hoarse for about fifteen months, the epiglottis was extremely pendulous, and the cords could only be seen with great difficulty. A small growth could be detected at the junction of the anterior and middle third of the right vocal cord, and Dr. Dundas Grant's endo-laryngeal forceps were introduced *à l'aveugle*. On the first occasion a small piece of the mucous membrane of the ventricular band was cut off, leaving a superficial sore which speedily healed. On the next occasion the growth was alone removed in its entirety. The exhibitor thought it would have been almost impossible to remove the growth with an unguarded instrument.

Dr. Herbert Tilley gave details of an identical case at present under his treatment. The patient was a clergyman with a soft fibroma on the anterior third of the left vocal cord. It was impossible to get any view of the larynx without cocainising the posterior surface of the epiglottis, and then holding it forwards whilst the other hand held the laryngoscope. The patient himself could only exhibit the arytænoids when phonating an *e*. The speaker had successfully removed nearly all the growth by means of Grant's forceps, and like that operator had been obliged to introduce them "in the dark," so to say. He raised the question as to whether in these particular cases, where one has to adopt such a method and it fails to remove the growth, one is justified in advising external operation, *e. g.* splitting of the thyroid. He was aware there was the difficulty of getting accurate apposition of the cords after the operation, but thought it not an insurmountable one. A tracheotomy would scarcely be necessary. He asked if members had had any experience of the operation; he himself had none. In cases of tubercular ulceration of larynx in suitable early cases he thought the operation was advisable, and should perform it when opportunity offered itself, but of course these cases were on a different footing from those of simple growth.

Dr. Bond cited two cases of tubercular laryngitis in which he had performed laryngo-fissure, one of which was successful.

Dr. StClair Thomson observed that the last remarks were in reference to laryngeal conditions which could not be reached *per vias naturales*. With regard to simple tumours of the larynx, he believed that in the last four years, at least, no case had presented itself in the clinic of any member of the staff of the Throat Hospital, Golden Square, which had not been successfully dealt with through the mouth. As to the question of laryngo-fissure for such cases, he quoted the publications of Professor Massei of Naples, who had had an extensive experience, and had recently published the statistics of

his 500 cases of laryngeal neoplasms. Dr. Massei protested strongly against external operation for simple growths, as being never quite free from danger, and often productive of damage to the voice.

Mr. SYMONDS said he would hesitate to advise the external operation where he had failed to secure a growth by forceps without asking the assistance of some colleague whose dexterity might be greater than his own. In two cases recently he was happy to see the patients relieved in this way. We were not all equally gifted with the manual dexterity requisite for such operations. With regard to the accuracy with which the cords can be adapted after thyrotomy, he would point out that perfect adaptation of the divided edges of the thyroid cartilage does not necessarily include complete restoration of the position of the cords. He pointed out that even in the most careful hands it was not always possible to make the section exactly between the cords, and he had seen a cord divided in very experienced hands. Therefore he would strongly oppose external operation in simple growths until the most skilled help at disposal had failed. He had known a case recently of complete recovery after external operation had been proposed by another operator who had failed to remove intra-laryngeally. In tubercle he had operated in two cases, only to make the patient much worse. In the early stages, where inaccessible to forceps, it might be advisable.

Mr. WAGGETT thought that in discussing this question consideration should also be taken of the formation of granulations on the posterior aspect of the wound. Such formations might cause as much functional disturbance, and give as much trouble in their treatment, as the original growth.

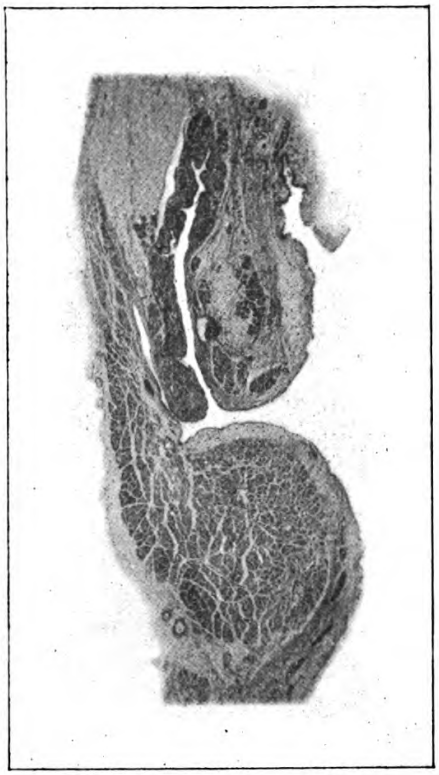
Dr. PERMEWAN could not see the justifiability of thyrotomy in these cases of innocent growths. Loss of voice was the only inconvenience, and owing to the difficulty of exactly hitting the middle line in splitting the thyroid, and to the formation of granulations and cicatrices in healing, the voice was very unlikely to be improved by the operation. But in tubercular disease he thought thyrotomy had a future before it, and he personally would not hesitate to do the operation in a suitable case. But, as a matter of fact, so much could be done by intra-laryngeal surgery that there was seldom any necessity or indication to do more.

Dr. DUNDAS GRANT, in replying, contended for patience in the use of endolaryngeal instruments in cases of non-malignant disease, and protested against the too ready performance of thyrotomy for the relief of conditions which impaired the voice without threatening life. In malignant disease, on the other hand, the justifiability and necessity for early thyrotomy were unquestionable.

Microscopic Preparations of a Growth within the Ventricle of a Larynx: its nature considered with reference to the condition of "hernia" or "prolapse" of the ventricle.

Dr. Jobson Horne showed the right half of a larynx cut into a series of microscopic sections to demonstrate the topography and nature of a tongue-like growth dependent from the roof of the ventricle.

Dr. Horne considered that the specimen perhaps threw light upon the histology of some of those tumours variously described as pro-



lapsus, procidentia, or hernia ventriculi, or fibroma ventriculi; and if seen during life it would probably have been described under one or other of these terms.

The growth was more fully developed in the middle third of the ventricle, and a microphotograph of a section in this region that was shown is reproduced. Under the microscope the tongue-like excrescence was seen to be very similar in structure to the adjacent ventricular band. It was covered from root to tip with a columnar epithelium, which at points of pressure had been worn away, but had undergone

no metaplasia. Immediately subjacent to these points of detrition there was some small-cell proliferation, and this, in the absence of any specific irritant, Dr. Horne was inclined to attribute to traumatism, occasioned by compression of the growth within the sacculus. The growth, taken as a whole, suggested a duplication of the ventricular band.

In reply, Dr. HORNE regretted he was unable to say what clinical symptoms, if any, the condition described had given rise to during life. For the larynx he was indebted to Professor Kanthack. Sections were cut on account of some plication of the epithelium about the vocal processes, and the growth was then met with. Such a growth he thought might readily become the site of tubercular disease in a predisposed subject. From the ventricles of larynges removed from persons that had died of pulmonary tuberculosis, but which presented no macroscopic evidence of laryngeal tuberculosis, he had frequently been able to obtain tubercle bacilli; and in sections cut from such larynges he had found the disease commencing in the posterior and inferior parts of the ventricular band. Minor spurs and excrescences springing from the roof of the ventricle he had met with, but not with such a growth as the one here described.

LARYNGEAL FORCEPS.

Dr. WATSON WILLIAMS showed a pair of laryngeal forceps which had been made from his design. By means of two finger openings in the lower handle, greater steadiness in manipulation is obtainable than in many of the ordinary patterns in use.

PAPILLOMA OF UVULA.

Mr. LAWRENCE showed a case of papilloma springing from the juncture of the uvula and soft palate on the left side, in a boy æt. 15. There was no history of its duration. It caused no symptoms, and was noticed in treating the patient for other throat trouble.

CASE OF DISLOCATION OF THE TRIANGULAR CARTILAGE OF THE SEPTUM.

Shown by Dr. PEGLER. H. J—, æt. 27, received a blow on the nose from a cricket ball last September. The impact occurred from below. The patient entered a provincial hospital, and after the swell-

ing had subsided some operation was deemed advisable, as the scar of an incision is now visible on the dorsum just below the nasal prominence. This disfigurement, together with that resulting from the sunken cartilage, induced the patient to seek further advice. A secondary source of trouble is obstruction to breathing through the nose. On introducing the index fingers into the nasal cavities a sensation as of splitting of the triangular cartilage is felt above at the osseo-cartilaginous juncture. The two lateral halves seeming to separate again when the pressure is taken off, the nasal obstruction is caused by a prominent acuminated cartilaginous spur in the left fossa, and a smaller basal spur in the right one.

Dr. StClair Thomson was not sure that the cartilages seen in each nostril were the displaced lateral cartilages. He was of opinion that what was seen was the broken and dislocated triangular cartilage, for on placing a finger in each nostril it was easily felt that there was no cartilage in the ordinary position, the anterior part of the nostrils being only separated by a septum of mucous membrane. With regard to treatment he advised avoidance of interference in such cases for merely cosmetic reasons. In numbers of these affections of the nose the cause of the collapse of the bridge was not simply the absence of the support of the septum, but the retraction of scar tissue. Surgical interference in this case would possibly only lead to more cicatrisation, and therefore a more saddle-backed nose. He had recently operated on a case where he had been successful in restoring a perfectly upright septum, but the external disfigurement remained. In the present case he suggested that the patient might always wear at night, and possibly by day, the hollow vulcanite splint used in Asch's operation. It would prevent further collapse.

Dr. Dundas Grant had been unable to follow Roe's description of his operations for relief of deformity in similar cases. He thought improvement could be effected by making a median incision and removing the more prominent portion of the nasal bones. In reply to Dr. StClair Thomson, Dr. Dundas Grant pointed out that it was in syphilitic disease that cicatricial contraction was especially accountable for deformity, but that in a traumatic case like the present the same principle was not so applicable.

Dr. Permewan could not see any great need for any surgical interference in this case, and would limit himself to cutting off the projecting pieces of cartilage without regard to their exact anatomical position. Like Dr. Grant, he had found it rather difficult to follow Dr. Roe's methods of subcutaneous operation, though he had been much struck by his excellent results, as shown at Montreal last year.

Dr. Pegler said he gathered that the consensus of opinion was in favour of letting the case alone. He would, however, restore the obstructed breathing way, think over the suggestions that had been made for curing the deformity, and report the result if any operation were undertaken.

Case of Tubercular Laryngitis.

Shown by Dr. Snell. Patient is a married woman 21 years of age. Hoarseness commenced about twelve months previously, shortly before confinement, and has continued to the present time, while some dysphagia and much irritable cough are now present. There is some tubercular taint on her mother's side. There are dry cavities at the apex of right lung. General health is fairly good.

In the interarytænoid region there is a papillomatous-looking mass, probably a tuberculoma, and this was at first almost the only lesion observable, but recently some thickening of the arytæno-epiglottidean folds has appeared, and they are of a dark red colour. There is also some swelling of the false cords. A shallow ulcer is present on the surface of the right cord.

The chief interest in the case is the initial interarytænoid swelling, without other pathological appearances usually characteristic of early tubercular laryngitis.

Dr. StClair Thomson pointed out that the anæmic condition of the larynx, the situation of the hypertrophy in the interarytænoid region, and especially the marked subglottic thickening, all pointed to the case being undoubtedly tubercular. He would not recommend active local treatment.

Tumour of Right Vocal Cord—Case for Diagnosis.

Shown by Mr. H. Betham Robinson. F. G—, æt. 38, complained of hoarseness in 1892, when a growth on the first vocal cord was diagnosed by his medical attendants. Not improving under treatment he applied to St. Thomas's Hospital early in 1893, where the presence of a growth was corroborated and it was painted with acid, which resulted in his getting quite well. He remained quite well till early in May, 1898, when the hoarseness returned, and on June 2nd he again became a patient at St. Thomas's under Mr. Robinson. Examination showed a small sessile swelling a little in front of the middle of the right cord. Its size is about that of a split pea, and it springs from the margin of the cord; it is white in colour, convex on the surface, and evidently is affected by compression on approximation of the cords. The tissues around its base are infiltrated, but the rest of the cord and larynx

appear healthy. There is no pain or cough, but there is a family history of tuberculosis, and the patient himself shows old cicatrices in the neck, but his chest is normal. There is no history of syphilis.

Dr. StClair Thomson thought the growth might be taken as a fibroma, but strongly suspicious of malignancy. In support of the latter was the situation of the growth in the middle of the cord (too far backward for speaker's nodule, and too far forward for pachydermia), its white appearance, and the way in which it seemed to infiltrate the cord, although the latter moved freely. Still, it would be easy to remove a good portion with the forceps, and obtain a satisfactory microscopic specimen.

Dr. Jobson Horne also considered that the position of the growth was not that typical of pachydermia verrucosa laryngis.

Mr. Symonds suggested that this might be a case of pachydermia because of the pyramidal shape, the white summit, and the way in which it was reduced by the pressure of the opposite cord in phonation. The short history of hoarseness, he thought, also supported this view. It was not typical, but resembled pachydermia more than any other formation. He would suggest that the case be watched without any active interference.

Dr. Dundas Grant thought the site was unusual, being neither at the junction of the anterior and middle thirds nor at the vocal process. He recommended removal by means of a suitable instrument —for example, his own endolaryngeal forceps,—and the subsequent application of salicylic acid. The surface of the growth suggested that it was of a warty nature.

Difficulty of Swallowing in an Infant.

Shown by Dr. Bond. Patient, a female infant of 10 months, has always had a great difficulty in swallowing fluids. The child chokes on trying to swallow, makes an attempt many times, and finally swallows a little fluid, generally with a crowing inspiration. Occasionally some of the fluid gets into the nose. There is no history of diphtheria.

Tuberculosis of Larynx and Fauces.

Dr. Jobson Horne showed a case of tuberculosis extensively involving the larynx, soft palate, and left tonsil, occurring in a young man æt. 21, who had sought relief for dysphagia and aphonia.

The patient dated the onset of the disease from an attack of hæmoptysis some eighteen months previously, whilst in his usual health, and free, as he thought, from any lung affection. Hoarseness quickly

followed the hæmoptysis. When the man came under treatment some three months ago the epiglottis was considerably thickened and turban-shaped, and the free border along the right side was ulcerating. The dysphagia was intense. The laryngeal mucosa was universally infiltrated, and in places ulcerating. The disease had also attacked the soft palate about the base of the uvula and the palatine arches.

The apices of both upper lobes of the lungs were infiltrated. The epiglottis was curetted and the larynx treated with lactic acid. The dysphagia was considerably relieved, and the patient went to the seaside for a while, where he materially improved. He had now returned with the disease spreading about the left palate and left tonsil, which was excavated, and Dr. Horne was desirous of receiving suggestions as regards further treatment. Although no tubercle bacilli had been detected in the tissue removed from the epiglottis, it was undoubtedly of a tubercular nature.

Correction.

In 'Proceedings' of May 11th, p. 85, Dr. Pegler's remarks should follow Dr. Grant's case of "Sigmatic Dyslalia," p. 86.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY

OF

LONDON.

VOL. VI.

1898–99.

WITH

LISTS OF OFFICERS, LIST OF MEMBERS, ETC.

LONDON:
PRINTED BY ADLARD AND SON,
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LARYNGOLOGICAL SOCIETY

OF

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Annales des Maladies de l'Oreille, &c. (Paris).
Revue de Laryngologie, &c. (Bordeaux).
Centralblatt für Laryngologie.
Archiv für Laryngologie (Berlin).
Monatsschrift für Ohrenheilkunde, &c.
Archivio Italiano di Otologia (Turin).
Bollettino delle Malattie dell' Orecchio, &c. (Florence).
Archivii Italiani di Laringologia (Naples).
Archives Internationales de Laryngologie, Otologie, et Rhinologie (Paris).

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American Laryngological, Rhinological, and Otological Society.
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JANUARY 6TH, 1899.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *November 4th*, 1898.

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

HERBERT TILLEY, M.D., WILLIAM HILL, M.D., } Secretaries.

Present—36 members and 3 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were elected members of the Society:

F. J. Dixon, M.B., B.C., Welbeck Street, W.
Frederick Spicer, M.D., Devonshire Street, W.

LUPUS OF THE LARYNX (WITH MICROSCOPICAL SECTIONS AND DRAWINGS FROM A CASE).

Shown by Professor FERDINAND MASSEI, Naples (Honorary Fellow of the Society). A girl æt. 10 was seen last year by Professor Massei suffering from typical lupus of the larynx. A year previous the case had been sent to him as one of syphilis, the cutaneous manifestations having been diagnosed as such by a competent dermatologist. In spite of energetic antisyphilitic treatment matters underwent no amelioration, and whatever change took place was for the worse. Professor Massei then decided that the affection of the larynx was lupus, and the cutaneous appearances confirmed this diagnosis. The lungs were normal. Sections of tissue removed from the epiglottis showed giant-cells around which were disposed

epithelioid cells in the manner characteristic of tubercle. Inoculations of guinea-pigs were, however, unfruitful, but recently the patient presented symptoms of pulmonary phthisis.

He proposes to do away with the distinction between tuberculosis and lupus, holding that they are identical, as shown in this case by the microscopical appearances and the recent development of consumption. The negative result of inoculation is not, in his opinion, a disproof, because it goes along with the extreme scantiness of the bacilli in lupus tissue, which is so well recognised.

(Professor Massei has presented to the Society the sections from this case, and they may be seen on application to the Librarian.)

Mr. WYATT WINGRAVE thought that the non-differentially stained specimen presented by Professor Massei was hardly sufficient evidence of the pathological identity of lupus and tubercle; and since there was much difference of opinion as to their respective histological details, a demonstration of bacilli would have proved of great interest and importance.

Sir FELIX SEMON said that he thought it was generally agreed that lupus and tubercle were essentially the same, but that the former was characterised by its chronic course and the paucity of tubercle bacilli, whereas comparatively opposite conditions held in tubercle.

MAN AGED 51 WITH HYPERTROPHIC LARYNGITIS OF DOUBTFUL NATURE.

Shown by Dr. STCLAIR THOMSON. The patient, J. H—, æt. 51, had been hoarse for eight months. There was no specific history; the lung-sounds were normal; and the patient confessed to having taken very freely of alcohol. He has been under iodide of potassium for over a month without any improvement. There is an irregular growth on the right processus vocalis; the right cord is decidedly impaired in its movement. There is thickening of the opposite (left) processus vocalis and general hypertrophic laryngitis. No glands are to be felt. The patient has not lost flesh. There is a good deal of chronic rhinitis.

Sir FELIX SEMON was not certain that the case was simply hypertrophic laryngitis; there was some defective mobility of the right vocal cord, and a small excrescence on the vocal process.

This suggestion of malignancy was also endorsed by Dr. BOND, who thought that the absence of any intervals of improvement (which were frequent in simple chronic laryngitis) rather favoured the idea of grave disease.

Mr. LAKE had seen the patient some time before, and on account of the rapid loss of weight and suspicious appearance had suggested exploratory laryngo-fissure.

Dr. STCLAIR THOMSON proposed to remove a portion of the growth from the right processus vocalis, and report to the Society as to its microscopical characters.

EPITHELIOMA OF LARYNX.

Shown by Dr. BARCLAY BARON (Bristol). Patient male æt. 64. About twelve months ago he found him suffering from extensive growth affecting the front parts of both vocal cords, especially the right and the anterior commissure. This was removed at several sittings by means of forceps and curette. The growths were multiple, not ulcerated, and there was no redness or swelling of surrounding structures, and the case was regarded as probably a non-malignant one. Some months ago he again came to the hospital, and the whole larynx was filled with warty growth, with redness and swelling of the right ventricular band. This was removed by a surgical colleague after thyrotomy, and proved to be epithelioma, and it has extensively recurred since the operation last June. Dr. Baron queried if this is not a case of transference of a benign into a malignant growth.

Sir FELIX SEMON rather questioned whether the papillomatous nature of the growth in the first instance was not more apparent than real. The warty appearance might be merely superficial, the separate papillomata growing from a common base. The man's age, again, was not in favour of a benign growth. Under all circumstances he thought the supposed transformation could not be classified otherwise than "extremely doubtful." He himself had hardly any doubt that the disease was malignant from the first.

SARCOMA OF NOSE.

Dr. BARON also showed a case of growth in the right nostril of a woman æt. 34 years. Three months ago she found some epiphora; an attempt was made to pass a probe through the lachrymal duct by her medical adviser, but he was unable to reach the nose. Since then there has been much pain over the eyebrow and roof of nose, some discharge from the nostril, and a gradual obstruction of it. She was seen in consultation, and the whole nostril found to be filled with a greyish growth which projected into the naso-pharynx. It bled freely

on probing, and removal of a piece with a snare caused very free hæmorrhage. She also said that she had bled freely three times in a fortnight. There was a soft elastic swelling at the inner angle of the eye. Microscopically the growth appeared to be a mass of round cells, and the clinical history and appearance were believed to point to sarcoma.

Mr. SPENCER did not think that there were definite evidences of sarcoma present. The mass of granulations bathed in muco-pus might have an inflammatory origin, *e. g.* be gummatous, or have arisen in one of the sinuses. He advised that the nose should be first of all cleared out by curetting under an anæsthetic with the head hanging low, and then be plugged. In a day or two, on the removal of the plug, it would be possible to examine the interior of the nose and naso-pharynx completely. The subsequent course of the case would then enable a diagnosis to be made.

The PRESIDENT agreed entirely with Mr. Spencer as to the course of treatment he had suggested, and thought the mass had more the appearance of a benign than a malignant growth. He thought it would be very difficult to differentiate microscopically between a chronic inflammatory mass of this kind and a small round-celled sarcoma.

Mr. WAGGETT thought the microscopic specimen could not be distinguished from a mass of granulation tissue.

Dr. HILL had a similar case under his care eight years ago; as the pathological report declared a portion removed for microscopy to be undoubtedly malignant, he handed the case over to Mr. Page, who cleared the nose out by Rouge's operation. Slight recurrence took place from time to time, but the patient was still living and well, and the speaker had long ago been compelled to recognise that the case was really one of granulomatous growth associated with suppuration from the sinuses.

Mr. ROBINSON thought that there was a possibility of the lesion being tuberculous, the nose becoming infected subsequent to the injury. The crusted, dry appearance, and its localisation to one cavity, did not seem to favour the view of its sarcomatous nature.

The PRESIDENT thought that the smoothness of the swelling outside, and the ulceration inside, seemed to point more to an infective disease than to a new growth.

NASAL CASE FOR DIAGNOSIS.

Dr. BARON also showed a young man who had a blow on the nose six months ago. Three weeks afterwards he noticed a swelling on the outside of the nose, and this has increased steadily. It is red and hard, and presents no fluctuation. There was no discharge until

about three weeks ago, when some pus came from the nostril, and Mr. Morton, under whose care the case was admitted at the Bristol General Hospital, took away a piece of necrosed cartilage. There is no history of syphilis, but he has taken antisyphilitic doses of iodide of potash for a month or so with no effect. There is some history of tubercle in the family, but the man is quite healthy excepting for the nose trouble.

The case was shown to get the opinion of the members as to the nature of the swelling, Dr. Baron believing it to be inflammatory, with necrosis and sequestrum of cartilage as the cause of it.

Cancer of Œsophagus with Paralysis of one Vocal Cord.

Shown by Dr. Watson Williams. W. D—, male, æt. 64, complained July 1st, 1898, of difficulty in swallowing, but early in the previous January he had noticed some difficulty in swallowing a piece of meat, which had increased gradually until he could only swallow soft food. He lost flesh considerably—nearly three stone in weight. In August, 1897, his voice had become slightly thickened and hoarse, and remained so since.

Laryngoscopic examination showed the right vocal cord in the cadaveric position, and pointed to a right recurrent nerve paralysis. There was no obvious cause for this, neither were physical signs in the chest indicative of organic lesions found. A No. 20 œsophageal bougie was easily passed into the stomach. No history of syphilis. Rest in bed and small doses of iodide of potash were followed by rapid improvement in swallowing powers and in his general health.

In five weeks' time marked inspiratory dyspnœa developed, increasing so rapidly that a low tracheotomy was performed with relief. He now expectorated quantities of mucus, and, rapidly sinking, died four days after the operation.

Post-mortem examination disclosed a circular perforation in the trachea two inches above the bifurcation, three quarters of an inch in diameter, and communicating with the gullet. The right posticus muscle was atrophied. The anterior gullet wall was invaded by an epitheliomatous growth, which involved also a post-tracheal gland. The right recurrent laryngeal nerve was involved in the growth and compressed. Old caseating tubercular deposits were found in both pulmonary apices, and the bases were affected with septic pneumonia.

Dr. Williams pointed out that the value of recurrent paralysis as a symptom of malignant disease of the gullet depends much on the presence or absence of signs of organic disease in the chest cavity, which might also produce a similar paralysis. The early improvement under treatment in this case certainly might have at first suggested a thoracic aneurysm. It is worthy of note that the right cord was probably paralysed five months before he suffered from dysphagia.

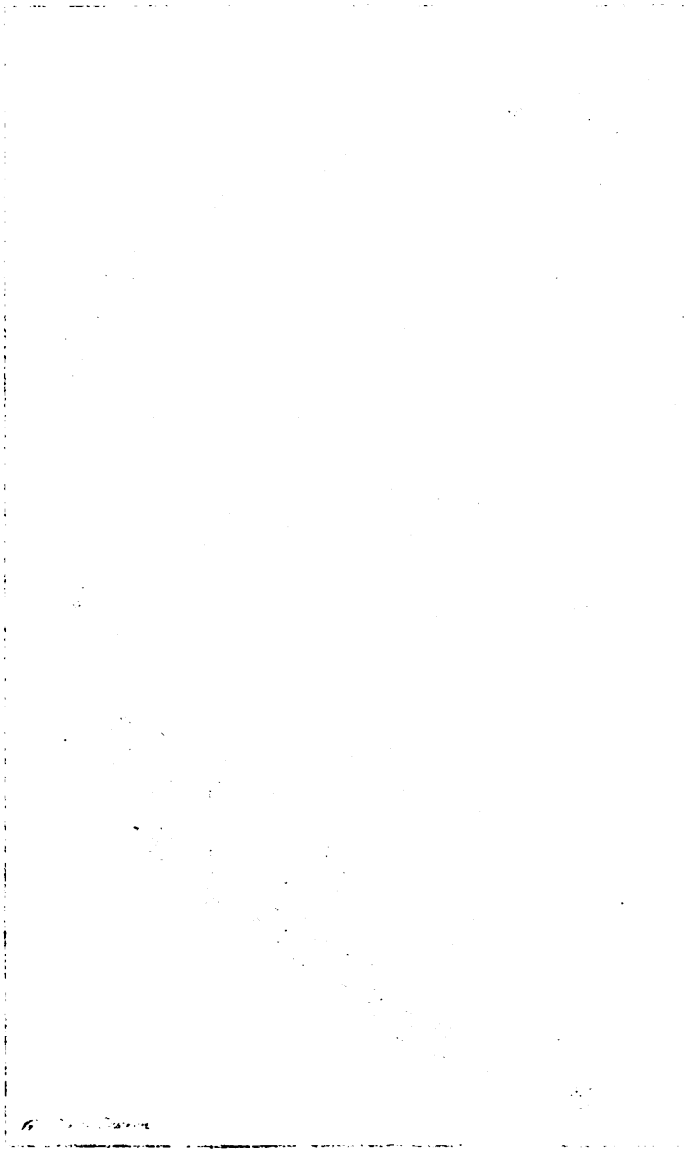
Sir FELIX SEMON thought that in all cases where a patient died with paralysis of a vocal cord the laryngeal muscles should be carefully examined for varying degrees of degenerative changes, so that we might gain further and more exact information as to the question whether in organic progressive disease of the recurrent laryngeal nerve the abductor muscle was the first to succumb. Dr. Friedrich's descriptions of such cases had been most valuable.

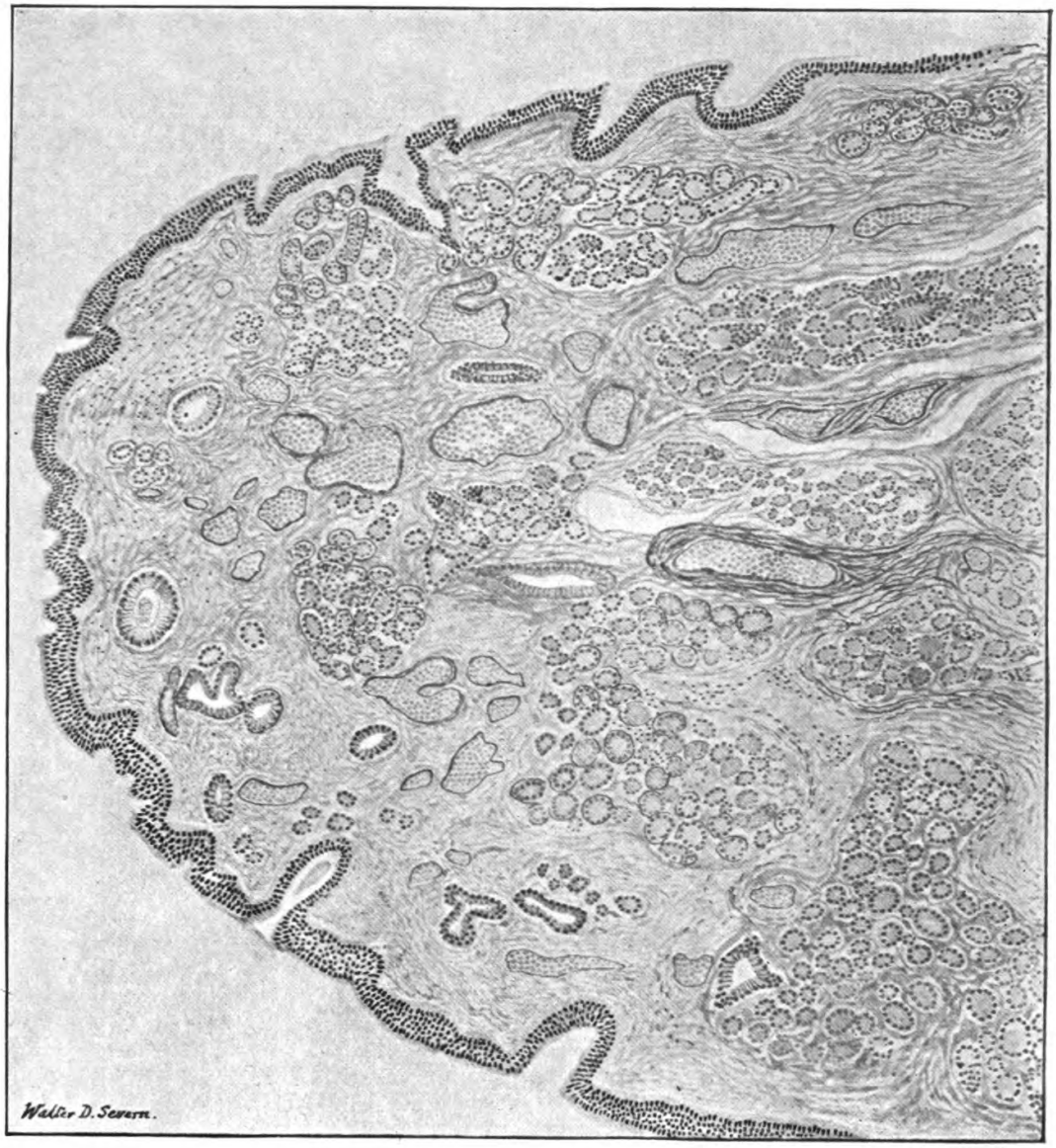
A CASE OF PAROXYSMAL SNEEZING ASSOCIATED WITH GREAT HYPERTROPHY OF TISSUES IN NEIGHBOURHOOD OF THE SEPTAL TUBERCLE (SHOWN AT JUNE MEETING).

Shown by Mr. ARTHUR CHEATLE. A man complained of nasal obstruction and violent attacks of sneezing. On the right side a pink soft mass, springing from the septum opposite the middle turbinal, extending downwards and forwards, having a broad base with slightly overhanging lower edge, quite obscured the middle meatus and reached down to the inferior turbinal. The same condition existed on the left side, but to a much less degree, the mass being pale.

With a cold snare a large portion of the mass on the right side was removed. Sections showed great hypertrophy of the normal tissue; numerous glands, giving an almost adenomatous appearance with large blood-spaces, and great increase of connective tissue.

Dr. PEGLER thought one would be scarcely justified in designating this case an adenoma of the septum, because, although the microscopic sections displayed an abundance of racemose glands, this was a common condition in mucous membrane hypoplasiæ of the septum and turbinals.





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MR. ARTHUR CHEATLE'S CASE.

Growth in Anterior Commissure has been Removed, but Paresis of Right Cord remains (Patient shown at March Meeting).

Shown by Dr. Pegler. The small commissural fibroma of left cord was removed with forceps six months ago, *i. e.* immediately after patient was shown to the Society.

All trace of the growth has now disappeared, but the abductor paresis of the opposite (right) cord remains unchanged.

The voice is much improved.

Case of Large Angioma of Larynx.

Shown by Dr. Bond. Patient male æt. 55. When a boy he used to shout tremendously. He has had hoarseness for about twenty-eight years; some twenty years ago he was under Sir M. Mackenzie, who found and treated the tumour in larynx. Since then the patient has occasionally attended at Golden Square. An account of the case was published by Dr. Wolfenden in 1888 in the 'Journal of Laryngology.' At various intervals patient has spat up blood, and when seen by me in March last was coughing up blood and phlegm freely.

He has a dark bluish tumour on right ventricular band, covering quite two thirds of it; there is a separate little offshoot above, and a third one on left ventricular band in front. The cords are apparently free.

Patient says that he used to be treated weekly with the galvano-cautery. It is a question, considering the severe hæmorrhage last March, whether one should not do a more radical operation, and the opinion of the Society on this point was desired.

Mr. Spencer supported the proposal of Dr. Bond to perform thyrotomy and freely excise the disease. He noted that the cord on the right side moved very little, and there was a small glandular enlargement in front of the carotid on that side. It was possible that the growth was tending to show malignant characters.

The President concurred with the suggestion of surgical interference.

? Epithelioma of Larynx.

Shown by Mr. Steward for Mr. Symonds. D. H—, æt. 55, attended at Guy's Hospital on August 5th, 1898, for partial loss of voice and pain in the throat and below the right ear. The loss of voice began in December, 1897, after an attack of influenza, and since that time has been gradually increasing. Examination showed an irregular thickening of the right vocal cord, which, however, was distinctly moveable. Iodide of potassium was prescribed. A fortnight later the right cord was found to be fixed, and some irregularity of the false cord was noticed.

On September 23rd the growth was distinctly larger, and some blood had been coughed up. A small piece of growth was removed, and reported, after examination by the pathologist, to be inflammatory. After this some improvement in symptoms took place, for on October 23rd the patient reported that he was free from pain, and that he could speak with less effort. There was, however, no change in the laryngoscopic appearances.

Drs. Spicer and Grant thought the case was malignant.

Sir Felix Semon could not, however, satisfy himself that the ulceration described by the first speaker was at all obvious.

Large Lipoma of Soft Palate.

Shown by Dr. Bond. Patient is a female æt. 49. She has a large semi-fluctuating tumour in soft palate on right side, extending on left beyond mid-line and on the right behind angle of jaw. Eight years ago he removed a large, many-lobed fatty tumour through external incision in parotid region. The mass removed weighed several ounces. The operation was followed by right facial paralysis, from which patient has almost recovered.

The original tumour was a parotid one; the present one has probably developed from some fragment left.

Six years ago her right breast was removed in one of the London hospitals.

The President thought that it would be possible to remove the tumour of the palate, which might easily shell out through a fair incision.

Tubercular Laryngitis after Removal of Large Interarytænoid Mass.

Shown by Mr. Lake. The patient, a girl of 21, had been under treatment for eight months. When first seen she had bilateral ulceration of the vocal cords, great bilateral swelling of the arytænoid cartilages, and a very large interarytænoid mass. The arytænoids were treated by double curettage in April, and had not been enlarged since, and the cords were quite healed. The mass removed from the interarytænoid fold was shown, as also were Mr. Lake's forceps for the removal of such growths.

Dr. Herbert Tilley thought that Mr. Lake was not only to be congratulated on the excellent result attained in this case, but also for bringing the instruments to such perfection and making it a comparatively easy task to deal with such cases of tubercular laryngitis. He has seen great relief afforded patients by removal of these œdematous masses, and had no doubt that they would see many more in the immediate future.

A Case of Membranous Laryngitis.

Shown by Mr. Lake. The patient, a man æt. 25, was the subject of a laryngitis of combined tubercular and syphilitic origin. He had loss of voice of eight weeks' duration. On October 17th a white membrane was noticed on the posterior surface of the epiglottis, which had recurred after removal.

In reply to Dr. Thomson, Mr. Lake said that no bacteriological examination had yet been made, but a further report was promised.

Paresis of the Right Facial Nerve and of the Right Side of the Palate following Tympanic Suppuration.

Dr. William Hill showed a female æt. 24 exhibiting this unusual condition. Right tympanic suppuration followed measles eight years ago; a polypus was removed about four years later, and after this operation the right side of the face was said to be "drawn up;" two years ago, however, this side "got weak," and the face was drawn up on the opposite side. For a year she has experienced some difficulty in swallowing, especially solids, though fluids have occasionally passed into the naso-pharynx; she has continuously "felt a lump" in her throat.

There is now, in addition to facial paresis, marked asymmetry of the palate, the arch being much higher on the left side; the right is flaccid, and the uvula is adherent to this side. The reflex, which is very active on the left side, appears to be absent on the right. There is reaction of degeneration in the right facial nerve, but for want of a suitable electrode this test has not yet been applied to the palate.

The view that the palate was partly supplied by the facial through the vidian and large superficial petrosal nerves has been taught by anatomists since the time of Sir Charles Bell down to the present decade; but neurologists have for several years, on clinical and experimental grounds, combated this teaching, pointing out that the true motor supply of the palate is from the medullary fibres of the spinal accessory. The case was therefore of great neurological interest, few reliable cases having been recorded, and it was desirable to ascertain the views of the members as to whether the asymmetry of the palate was actually due to motor paresis (and not to an acquired or congenital deformity); and if so, the further question had to be faced, whether the paresis of the facial muscles and of the palate were due to a common lesion within the temporal bone rather than representing an accidental association.

Dr. Dundas Grant was of the opinion that the median position of the dimple in the palate during phonation was a strong argument against the diagnosis of hemiplegia of the larynx. He considered the appearance, apart from the phonation, as inconclusive, and was inclined to think that the asymmetry then present was due to inflammatory changes in the pillars of the fauces, and not to nerve lesion.

Frontal Sinusitis.

Dr. Hill also showed a male æt. 40, on whom he had recently operated for chronic suppuration of the frontal sinus by the Ogston-Luc method. The chief points of practical interest in the case were: (1) the shortness of the skin incision along the brow; (2) the perfect æsthetic effect, as the scar was barely visible, and the previous displacement outwards of the eye had disappeared; (3) no drainage-tube was employed.

Dr. Herbert Tilley, in reply to a question as to what instrument was used to make a free passage into the nose, said that he had found a Krause's antrum trocar fulfil the object very well, the slight curve on the instrument being just that which was necessary.

Case of (?) Œsophageal Pouch.

Shown by Mr. Cresswell Baber. F. G—, a butler, æt. 62. First seen at the Brighton Throat and Ear Hospital on October 24th, 1898. For over a year he had had a peculiar sensation in his throat as if his uvula were too long, and he brought up a quantity of phlegm. Seven or eight months ago he first noticed that he returned lumps of undigested meat which had been taken the day before. This usually happens in the morning after breakfast, when they return together with fragments of that meal. There is no marked difficulty in swallowing, but occasionally he has to make two efforts before the act can be accomplished. Solids are more troublesome to swallow than liquids. He feels satisfied after a meal, and is conscious that he swallows most of the meal without any difficulty. No vomiting or pain. He has a "croaking" or gurgling noise in his throat, especially when lying down and at meals, which is followed by the bringing up of quantities of phlegm. He often has to leave the table because of the discomfort.

On examination the pharynx is irritable and congested, and uvula thick. Larynx congested, especially the cords; otherwise it is normal. Much white frothy secretion is seen coming up behind the arytænoids. External examination shows a doubtful fulness in the left posterior inferior triangle of the neck, but I have not examined him after a full meal. Pressure with the fingers above the clavicles, especially at the left side, produces a gurgling noise, and escape of gas by the mouth; and after he has swallowed some milk and bread, pressure in this region causes it immediately to return. Liquid taken alone is partly returned when he stoops sharply forward. Patient is well nourished, and has not lost flesh to any extent. His weight, which on July 26th, 1898, was 12 st. 9½ lbs., and on August 30th 12 st. 13 lbs., is now (October 31st) 12 st. 11 lbs. I have passed two large-size elastic bougies down, and they both became arrested about nine inches past the teeth. The ends could not be distinctly felt in the left posterior inferior triangle. Chest normal, except a narrow patch with slightly impaired resonance under the left clavicle.

Dr. StClair Thomson suggested that the case afforded a useful field for the employment of the Röntgen rays. He had not himself had such a case, but it had occurred to him that if two metallic bougies were passed down the œsophagus, one into the pouch and

the other into the stomach, and if an X-ray photograph were then taken of the neck and chest, we might get very useful information as to the situation and relationship of this pouch.

The PRESIDENT said that before operating to remove the pouch the patient should be carefully examined in order to ensure he was in a fit state of health, and that it should be clearly ascertained that there was no organic stricture of the œsophagus, a probe passing easily into the stomach as well as into the pouch.

AN EXCEPTIONAL CASE OF CLEFT PALATE.

Shown by Mr. MORLEY AGAR. The bony cleft was on the left side, and only showed the inferior turbinate in its whole length. There was also some deformity of the vomer.

Mr. ROBINSON was of opinion that this deformity was not very unusual. He explained it as a complete cleft from front to back, but to the left side of the mid-line, so that there was non-union on the left side of the maxilla to the pre-maxilla, and of the palatal processes of maxilla and palate to their fellows on the right side. The appearance posteriorly was due to the dragging well to the right of the soft palate and the sloping edge of the bones, and the right posterior choana thus coming into view.

NOTES OF A CASE OF ULCERATION OF THE SOFT PALATE.

Shown by Mr. PARKER. A. G—, male, æt. 32. Last Easter his throat became very sore—was said to be ulcerated. After ten weeks' treatment it got quite well, and remained so till a few days ago. He has always been a strong healthy man, and denies all history of syphilis. He had gonorrhœa thirteen years ago. He is married and has three healthy children, but he states that his wife has had two or three miscarriages.

On examination the soft palate and uvula are found to be covered with a ragged, straggling ulceration of a superficial character; between the patches of ulceration there is a peculiar nodular appearance, and there is a small areola of redness round the diseased parts.

The diagnosis lies between tertiary syphilis and tuberculosis. The former seems to be more probable.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *December 2nd*, 1898.

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

HERBERT TILLEY, M.D., WILLIAM HILL, M.D., } Secretaries.

Present—37 members and 10 visitors.

The minutes of the previous meeting were read and confirmed.

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

H. St.George Reid, 25, Old Burlington Street, W.

REPORT OF THE MORBID GROWTHS COMMITTEE.

Slide L.S.L. 16.—Section of growth removed from a female patient of Dr. Barclay Baron's, shown at meeting November 4th, 1898. The Committee report that the specimen submitted to them contains a mass of large polyhedral embryonic cells, which some would term an alveolar sarcoma, others spheroidal-celled carcinoma. Some of these cells are in an active stage of proliferation. The arrangement of the cells tends to show some trace of alveolation, and it is noticeable that there is an intra-cellular fibrous structure. In deeper portions of the section there are evidences of inflammatory change, some recent and some of longer standing. Blood spaces are seen without definite walls. In our opinion the growth belongs to a class which behaves in many respects like sarcoma, but showing slight and local malignancy.

Slide L.S.L. 17.—Sections of glands under sterno-mastoid to-

gether with portion of internal jugular vein, removed from patient shown by Dr. Bond May 13th, 1896, p. 86; November 11th, 1896, p. 4. Report on section January 13th, 1897, p. 40. Case "Sarcoma of Nose."

The Committee regret that owing to some mistake in the constitution of the fluid in which the growth was originally placed, the mass had almost decomposed before they received it, and only one small portion was at all suitable for sections. This portion was undoubtedly of malignant nature, but whether it was a spheroidal-celled carcinoma or an alveolar sarcoma the condition of the section rendered it impossible to decide.

Wall Charts for Teaching Signs of Suppuration in the Nasal Sinuses.

Shown by Dr. Dundas Grant. These charts were drawn up by Dr. Grant to illustrate his lectures in June, 1898, and were founded mainly, but with various modifications, on the classifications of signs as *presumptive, probable,* and *certain,* given by Lermoyez in his work on the treatment of diseases of the nose and sinuses of the face.

Section of Cyst removed from the Naso-pharynx.

Shown by Mr. Arthur Cheatle. A man æt. 19 came to the Royal Ear Hospital complaining of nasal obstruction. Besides some turbinal hypertrophy and a spur in the nose, a smooth pink mass, the size of half a walnut, was seen in the naso-pharynx immediately behind the septum and stretching from one Rosenmüller's fossa to the other. Under chloroform it felt tense, and was ruptured with the finger-nail before removal. A microscopical section through the mass showed a large and a small cyst, each lined with columnar ciliated epithelium, with a slight amount of adenoid tissue outside on the cut surface.

Preparations of Hypertrophied Tonsils.

Mr. Wyatt Wingrave exhibited sections of enlarged tonsils for inspection by the naked eye. They illustrated the conditions of simple hypertrophy unattended with any inflammatory changes.

The points of chief interest were the scantiness of the connective-tissue elements, the depth of the lacunæ, which reached to the "bed" of the tonsil, and the fact that one aperture was common to several lacunæ.

The tonsils before cutting had been soaked in collodion, which method binds the tissues together and prevents the lymph follicles falling out.

Sections of Lupus of Larynx.

Shown by Mr. Wyatt Wingrave. The sections were stained by the Ehrlich triple Biondi process, a method which had the great advantage of differentiating the three most prominent histological elements, viz. the small-cell tissue, the epithelial cells, and the sclerotic bands. Neither in this nor in other instances had he been able to demonstrate a specific bacillus.

Apart from the question of the bacillus, he considered that histological differences between tubercle and lupus were to be explained by the respective rates of inflammatory changes.

Microscopic Sections of Papilloma of the Larynx.

Shown by Mr. Wyatt Wingrave. From a case of Dr. Dundas Grant's. It was of the simple stratified squamous variety.

Microscopic Sections of Rhino-scleroma.

Shown by Mr. Wyatt Wingrave. From a case of Dr. Dundas Grant's.

Specimen of Pachydermia Laryngis.

Shown by Mr. Lake. The larynx shown was removed from a patient æt. 34, who had been hoarse, or, as the patient had described it, "had had a man's voice since the age of four years." His family history was good. He had suffered with phthisis for one year, but his larynx showed no traces of this.

In reply to Dr. Grant, Mr. LAKE said the hoarseness antedated the phthisis by about thirty years.

TUBERCULAR LARYNX FROM A CHILD AGED 6 YEARS.

Shown by Mr. LAKE. This was shown on account of the comparative rarity of this disease in childhood. When first seen the child had laryngeal stenosis due to subglottic swelling; later destructive ulceration set in, and he died nine weeks later.

REPORT ON A SPECIMEN OF MEMBRANE (EPIGLOTTIS) FROM A CASE OF MEMBRANOUS LARYNGITIS SHOWN AT THE LAST MEETING (NOVEMBER) BY MR. LAKE.

Three organisms were shown to be present in the cultivations, viz.:

(1) *Staphylococcus pyogenes albus.*

(2) A small diplococcus (morphologically identical with the gonococcus, but staining by Gram's method).

(3) A small-celled torula.

WALTER D. SEVERN.

RECURRENT NASAL TUMOUR FROM FEMALE AGED 23.

Shown by Mr. LAKE.

EMPYEMA OF ANTRUM CURED BY REPEATED IRRIGATIONS BY MEANS OF LICHTWITZ'S TROCAR AND CANNULA.

Shown by Dr. DUNDAS GRANT. Mrs. M— was seen on July 21st, 1898. There was dulness on transillumination, and a free exit of fœtid pus following the use of Lichtwitz's trocar and cannula.

For nine years the patient had been subject to "colds in the head," chiefly affecting the right nostril, but the history of a fœtid discharge only dates about four weeks before her application for relief. Possibly the chronic recurring discharges were due to attacks of suppurative inflammation in the right frontal sinus from which the antrum was secondarily "charged." Transillumination of the right frontal sinus shows less translucency than that on the left side. The signs of antral empyema, which were typical, entirely disappeared after eleven irrigations with Lichtwitz's instrument. The teeth were sound, and

hence the intra-nasal treatment was adopted in place of any of the buccal methods.

Chronic Empyema of the Antrum cured by Intra-nasal Treatment (Anterior Turbinectomy—Krause's Trocar).

Shown by Dr. Dundas Grant. M. A. L—, æt. 31, schoolmaster, seen April 22nd, 1898, complaining of offensive purulent nasal discharge which had lasted continuously for six months. Antral empyema was diagnosed by means of Lichtwitz's trocar and cannula. Three carious teeth were removed, and the discharge did not return for two days. Temporary relief followed irrigation by the latter instrument. Alveolar puncture and irrigation were then instituted, and the latter carried out till June 18th, at the first with temporary success, but with pain in the process and no actual cessation of discharge. The alveolar puncture was allowed to close.

Anterior turbinectomy was then performed, and under cocaine Krause's trocar and cannula introduced; through the latter the antrum was washed out and then insufflated with iodoform and finally iodol. Twenty-eight irrigations through the alveolus had been unsuccessful, but after twelve through the intra-nasal cannula the discharge and smell had entirely ceased.

The patient is now quite free from any symptoms of his antral disease, there is no pus on irrigation, and the dulness on transillumination has diminished.

Dr. Herbert Tilley thought that the great disadvantage of this treatment was that in the majority of cases the irrigation had to be done by the surgeon rather than by the patient himself—a matter of very considerable importance. The alveolar method, which was without this disadvantage, made it most suitable for the general run of cases as the first line of treatment; for once the patient had been provided with a suitable plug and had been shown how to use the syringe, he could carry on the treatment for himself.

In reply to Dr. Spicer, Dr. Tilley said that he did not for a moment wish to underrate the value of the more radical operations in protracted cases, and cases where it was probable antral polypi were keeping up the discharge. He had himself found them invaluable. His contention was, that in ordinary cases associated with carious teeth the treatment should commence by removal of the latter and insertion of a plug, removable for constant irrigation; that the lotion should be constantly changed, and not until these methods were found to fail should more radical operations be performed,—one great

disadvantage of which was that patients could not carry out the treatment themselves. He was surprised that Dr. Spicer had met with so few cases cured by the alveolar method.

Dr. PEGLER thought the operation of anterior turbinectomy, as performed by Dr. Grant in this case, would become a more general accessory procedure in the treatment of antral disease where a Krause opening was to be made. He had noticed that the inferior turbinal tended to become chronically inflamed and swollen in the presence of much purulent discharge, and in its turn aggravated matters by hindering drainage and keeping up sepsis, besides rendering the Krause's opening more difficult of access. Subsequent treatment by irrigation with a catheter through this opening was also much facilitated by an anterior turbinectomy.

In reply to Dr. Tilley, Dr. PEGLER said he could show cases in which the habitual passage of a vulcanite catheter through the Krause opening, during home treatment by the patient, had been carried out, after a little practice, without any great difficulty.

Dr. SCANES SPICER felt it his duty to join issue with Dr. Tilley on two points. Firstly, as to the assumed difficulty of patients washing out the antrum per nares through the operative artificial ostium maxillare. With a proper bent tube, and one or two demonstrations, the patient found no difficulty in doing this within a few days of the operation. He had recently sent a case out of hospital fourteen days after radical operation, and as she was going to Bristol for a month he asked her to present herself at Dr. Watson Williams' clinic, and the speaker believed that that gentleman would say there was not the slightest difficulty. In fact, since he had adopted entire nasal irrigation after operation, he had found that patients had far less difficulty and discomfort than with the tooth-socket tube irrigation. Secondly, he protested against the routine use of tooth-socket tubes and a plate for "two months" in well-proved cases of *chronic* empyema. This doctrine was retrograde, and directly in opposition to all recent English, Continental, and American advances, and should be discountenanced by a society of specialists. Cases of cure of *chronic* empyema by tooth-socket tubes were most rare, while he had come across several cases of supposed "cures" who had gone on wearing their tubes for ten, fifteen and more years, and were still doing so, and using irrigations one, two, or three times a day for the suppuration and smell. It therefore appeared to him better to adopt at once a radical method which was safe, rapid, and practically certain, instead of wasting time and money on a method which almost never succeeded.

Dr. STCLAIR THOMSON suggested that in the matter under discussion the feelings of the patient might be slightly considered, and that in his experience when the facts of the case were put before a patient, the larger majority preferred to have the alveolar opening only whenever there was a suitable empty tooth-socket on the same side. A long history of suppuration does not necessarily mean an intractable case, for in his case, referred to by Dr. Scanes Spicer, the patient had had symptoms for seven years and the empyema had been definitely diagnosed two years before operation was decided upon.

Dr. WATSON WILLIAMS had had a case under his care which

showed the ease with which a patient could syringe out her own antrum.

Dr. GRANT, in reply, quite agreed that the convenience of the alveolar operation was such that it could never be altogether done away with. At the same time he had seen cases in which it had done no good, and improvement only began when the alveolar opening began to close and other methods of treatment were initiated. On principle he contended that an opening between the mouth and nose was bad physiologically, and still worse bacteriologically. He had therefore tried what could be done by intra-nasal treatment. He showed an instrument for enlarging the opening made with Krause's trocar, and cited a case in which such an opening had persisted. Anterior turbinectomy had at the same time been performed, and the patient could pass a Eustachian catheter into the opening.

X-RAY PHOTOGRAPH OF FOREIGN BODY (SILVER TUBE) IN THE ANTRUM OF HIGHMORE.

Shown by Mr. CHEATLE. The patient was wearing a tube through the canine fossa for chronic antral suppuration; the top broke off, and the patient continued to wear it. One morning on waking it had disappeared. In order to see if it was inside the antrum, Mr. Low took the photograph, which clearly showed it lying across the cavity.

Dr. DUNDAS GRANT had in one case of opening the antrum through the canine fossa found a vulcanite tube which had broken off from its plate. This had been adopted after the alveolar operation, and was supposed by the patient to have dropped out.

Dr. WATSON WILLIAMS cited a case where a peg similarly got lost in the antrum, but passed out into the nose through the ostium maxillare without operative interference.

Dr. WILLIAM HILL recorded another case where the loss of a tube in the antrum was fortunate for the patient, as it necessitated opening the front wall of the sinus, which was found to be diseased, and a radical cure was made of the case.

SPREADING ULCER OF THE NOSE.

Shown by Mr. WYATT WINGRAVE. Charles T—, æt. 50, labourer, seen on Nov. 14th, 1898, complaining of pain over nose and stinking discharge of six weeks' duration. On examination, nostrils were full of fœtid crusts, which on removal showed perforation of vomerine region of nasal septum with granulation tissue in all directions.

He gave a history of syphilitic sore thirty years ago, with falling of

hair, but no other signs. Married twenty years; wife had two miscarriages, at the second and fourth pregnancies. He had usually enjoyed good health. Two months later a red patch appeared on the outside of each ala at junction of bone and cartilage; this rapidly broke down and the ulceration spread to cheeks and upper lip, the tip of nose remaining free. He suffered considerable pain, and the discharge was profuse and fœtid. He was treated with pot. iodide and bromide, also inunctions of mercury, with negative results.

Cultivations were taken, but no special micro-organism was found, and injections of mallein and tuberculin gave no response. He has not lost flesh to any very great extent. The temperature has sometimes been as high as 103°, but for last six weeks has kept about normal. At the present moment the disease is not spreading as fast as it was, and the pain is but slight. He continues to take biniodide of mercury, which he has been under for the last three months. The ulceration is now much more superficial than it was, and shows a tendency to heal.

He thought that the case possessed interest from its resemblance to one which was presented to the Society by Dr. McBride in 1896, and seen by Sir Felix Semon and Dr. Milligan, who were all in doubt as to its nature.

The cases were alike in their resistance to mercury and iodides, their negative evidence of glanders, and their clinical history. He thought at first that it might be an unusually rapid case of lupus, since the history of syphilis was decidedly equivocal, and scrapings afforded no evidence of tubercle bacilli.

Mr. SPENCER considered the case one of malignant ulceration, including under that term rodent ulcer. He would employ thorough erasion and the cautery, and later on cover healthy granulations with epidermal grafts.

Dr. LOGAN TURNER said that he had had the opportunity of constantly observing Dr. McBride's case of destruction of the nose and face, which had been referred to by Mr. Wingrave. The microscope, bacteriological investigation, and specific treatment had failed to establish any diagnosis. In spite of operative interference the ulceration had extended and death followed. Post-mortem examination revealed nothing of a definite nature. It differed from Mr. Wingrave's case in the deeper and more complete destruction both of the soft parts and of the bones. In his (Dr. Turner's) opinion the patient now shown presented rather the appearance of a case of lupus.

Mr. BOWLBY suggested that it might well be a form of rodent

ulcer, in which case the term epithelioma should not be applied, as they were not identical diseases.

In reply, Mr. WYATT WINGRAVE said that the fragments examined afforded no evidence of epithelioma or tubercle, and that no surgical treatment had been attempted. There was no response to the active mercurial treatment, which was thorough.

CASE OF SYRINGOMYELIA, WITH PARALYSIS OF THE RIGHT SIDE OF THE PALATE AND PHARYNX, AND OF THE RIGHT VOCAL CORD.

Shown by Dr. HERBERT TILLEY. The exhibitor expressed his great indebtedness to Dr. Risien Russell for the help he had given him in the examination of the patient's nervous system.

[Dr. Russell, at the invitation of the President, described the chief nervous symptoms of the case.]

C. S—, æt. 15 years, applied to the Golden Square Hospital, complaining of "hoarseness and inability to use her hands properly."

Patient's mother had "chorea" when seventeen years of age, and her mother's grandfather was the subject of fits, and died in an asylum. She was born at full term; labour difficult, and instrumental delivery with injury to the head resulted. Has always enjoyed fairly good health, but has always been subject to eczema of hands since quite young. Menses not established. Weakness of hands noticed first about two years ago, when she found she was unable to open her hands properly. Hoarseness seems to have existed before the latter trouble was noticed.

About two months ago she received a large burn on the hypothenar eminence of left hand, and knew nothing of it till the blister accidentally broke. She experienced no pain as the result of the burn.

Present state (*November* 28th, 1898).—Patient is a pale, well-nourished girl, with noisy breathing and a hoarse voice. Nystagmical jerks of both eyes are observed on lateral and upward movements; they are more marked when the eyes are directed to the right than when turned to the left, and the movements of the globus being lateral, with a certain degree of rotation added.

There is complete paralysis of the right half of the palate, pharynx, and right vocal cord, as opposed to a normal movement of the same on the left side.

All the neck muscles act well, and show no evidence of atrophy. The scapular and shoulder muscles, also those of upper arm, are intact, and all movements of the shoulder-joint and elbow are well executed. There is moderate wasting of the extensors and flexors of the forearms, with weakness of extension and flexion at the wrist—the defect being more marked in the extensors.

The fingers of both hands are in the "main en griffe" position, and there is marked atrophy of the small muscles of the hands on both sides, but more advanced in those of the left. The wasting of the thenar eminence and first interosseal space is more pronounced than elsewhere. The hand grasps are very feeble; separation and adduction of fingers feeble; inability to extend the second and third phalanges. Adduction of thumb possible, but feeble on both sides. Opposing power of thumb almost *nil.*

All muscles of forearm respond to faradism, but need a stronger current to evoke contraction than do those of the upper arm. No response of palmar muscles to faradism; dorsal interossei respond slightly. On right side, in addition to the response from the dorsal interossei there is very slight contraction of the palmar muscles. Markedly diminished reaction to galvanism is noted in the small muscles of the hands; no response in the palmar muscles (with the strength of current available, viz. one producing powerful response from normal muscles), including those of the thenar eminence on both sides. Dorsal interossei respond K.C.C. > A.C.C.

The trunk and back muscles are practically normal, but there is a pronounced lateral curvature of the spinal column, involving the whole of the thoracic vertebræ, and with its convexity to the right.

The lower extremities, both in nutrition and function, are normal.

Tactile sensibility is everywhere preserved, but there is blunting of painful impressions on both superior extremities; the analgesia, however, is not pronounced. There is complete loss of appreciation of thermal impressions all over both superior extremities, and there also appears to be a similar defect on the back of neck and trunk.

Thermal impressions seem to be normally perceived on the face, but there appears to be some slight defect on the neck and trunk down to the third rib on right side, and again from costal margin to about the level of the umbilicus; on the left side the defect appears to be more definite, and extends all the way down the neck and trunk to about the level of Poupart's ligament.

Knee-jerks are exaggerated, but no ankle-clonus can now be elicited as was possible a week ago.

Recent trophic disturbances are seen, and scars, the result of similar past affections in connection with skin of fingers; also some sores about the elbows, looking as if they were abrasion. Sphincters, thoracic and abdominal organs, present no clinical evidences of disease.

The PRESIDENT thought the case very interesting, as hitherto he had been unable to find any records of syringomyelia associated with laryngeal paralysis.

Mr. SPENCER pointed out that the nuclei in the lower third of the bulb giving rise to pharyngeal and laryngeal fibres were in this case affected, whilst the fibres arising from the upper part of the spinal cord, going to the sternomastoid and trapezius, were untouched. Doubtless in other cases both groups were affected. But the possibility of one group being alone attacked confirmed the view of a distinct origin.

HYPEROSTOSIS OF MAXILLARY AND OTHER BONES CAUSING NASAL STENOSIS.

Shown by Mr. BOWLBY. E. P—, æt. 43. She has noticed difficulty in nasal breathing and pain about eighteen months. She has been deaf to some extent for nineteen years, but has not got worse lately. Now complains chiefly of the frontal pain and difficulty of nasal respiration.

Present condition.—There is exophthalmos, especially on the left side. The left temporal fossa is occupied by a bony growth which is continuous with an enlargement of the left malar and superior maxillary bones. The left supra-orbital ridge is thickened. Both maxillary bones show overgrowth of their nasal processes, but the nasal bones themselves are not enlarged. There is a bony growth in the floor of each nostril, covered by smooth mucous membrane, and as large as a large almond. The turbinate bones also appear enlarged; the palate bones and the alveolar processes of the maxillæ are normal; the lower jaw is normal. Pulse 130. No tremors; occasional palpitations. Thyroid apparently normal. No definite evidence of syphilis, but has "had bad health" since marriage, has lost five out of six children, and had an "eruption on the face."

Mr. SPENCER asked Mr. Bowlby if he would try treatment by

thyroid extract on purely experimental grounds; it might do some good, and probably no harm.

A Case of Paresis of Left Side of Larynx.

Shown by Dr. Willcocks. J. T—, male, æt. 37, came under observation about the middle of November. The alteration in his voice began last April, accompanied by dyspnœa and noisy inspiration. For the last six weeks the voice has been worse. Patient had a penile sore followed by a rash about six years ago, and has also been a good deal exposed to vicissitudes of weather in his occupation.

The view of the interior of the larynx is much obscured by the epiglottis, which is very pendulous and almost immobile. The left arytænoid is much restricted in its movements on phonation, while the right side moves freely. There is no definite evidence of intra-thoracic pressure, such as aneurysm of the aorta, and there is no local evidence of disease in the larynx itself. The questions raised as to the nature of the condition were whether the partial paralysis on the left side was due to pressure on the left recurrent within the thorax (of which there is at present no definite evidence), or whether the restricted movement of the left arytænoid depended on some local mischief, such as adhesion, anchylosis, &c.

The Vice-President remarked on the difficulty that such cases as these presented as to whether the immobility was due to mechanical fixation or paralysis.

Dr. Lack had examined the case very carefully, and considered the appearances were those of recurrent paralysis and not of mechanical fixation.

Varix or Nævus of the Posterior Faucial Pillar.

Mr. Ernest Waggett showed a young man who had for a few weeks complained of pain and difficulty in swallowing.

A knot of dilated veins were to be seen under the mucous membrane of the left posterior faucial pillar, connected above with a small nævoid patch occupying the surface of the upper part of the corresponding tonsil. Attention had recently been drawn to the throat by frequent examination for throat lesions, necessitated on account of the occurrence of a suspicious sore on the penis. The symptoms

complained of dated from the occasion on which the patient for the first time became acquainted with the abnormality described, and his nervous demeanour warranted the symptoms being regarded as constituting a mere mental obsession. Presumably the abnormality was of congenital origin, or at all events one of very long standing, and, until recently, not noticed. No surgical procedure seemed called for.

Mr. WAGGETT, in answer to the Chairman, said that he was unaware that any lesion could be described as "a typical varix of the posterior pillar." He had shown the case as an unusual curiosity, and considered the condition to be very unimportant intrinsically, and one merely forming the basis of a pharyngeal obsession in a nervous patient.

A CASE OF FUNCTIONAL HOARSENESS IN A WOMAN AGED 37.

Shown by Dr. HECTOR MACKENZIE. The patient had been under observation for over six months. About the end of May she was sent up from the country to Brompton Hospital, supposed to be suffering from pulmonary and laryngeal tuberculosis. She had then been hoarse or aphonic for some months. She said her throat was painful, and that she had difficulty in swallowing. The history was strongly suggestive of tubercle. In June, 1897, she was said to have brought up a large quantity of blood. Her father died of phthisis when she was seven years old, and her mother died of asthma and lung disease. One was quite prepared, therefore, to find both pulmonary and laryngeal disease. On examining the larynx, however, one noticed the extreme tolerance the patient showed to examination, so that there was not the slightest difficulty in at once getting a thorough and complete view. This contrasted strongly with the great irritability usually exhibited in tuberculous cases. The movements of the larynx were irregular, and on attempted phonation the cords did not come together, while the ventricular bands tended to overlap them. In adduction the left arytænoid persistently occupied a position slightly posterior to the right. The mucous membrane was lax, but there was no sign of swelling or ulceration, and the cords were of a normal colour. No abnormal signs were found on examination of the chest.

From the appearances the conclusion was arrived at that the

laryngeal condition was functional. The faradic current was applied to the hands, with the result that the voice became at once quite normal. The voice remained normal for some weeks. The patient was greatly relieved in her mind by the restoration of the voice, and improved considerably in general health, putting on nine pounds in weight in six weeks. There has been a tendency for the hoarseness and aphonia to recur, but the voice has always been easily restored to a normal condition by the application of the battery. Unfortunately the patient lives at a considerable distance from London, so that treatment has been carried out at some disadvantage.

Dr. StClair Thomson was of opinion that the laryngitis was entirely functional. If the patient was put through certain vocal exercises with the laryngeal mirror in position, it was seen that the vocal cords were perfectly healthy and mobile, and that the ventricular bands were much hypertrophied. The patient, in fact, had developed what the Germans call "taschenbandsprache," and he thought that with suitable exercises she might be induced to desist from speaking with her ventricular bands, and return to the natural use of her vocal cords.

Dr. Grant suggested that she should constantly practise inspiratory phonation, which he had found useful in a similar case.

Papilloma of Tonsil.

Shown by Mr. de Santi. The patient, a girl æt. 19, suffered occasionally from enlarged tonsils. No other trouble. When examined a papillomatous growth was discovered on left tonsil. The tonsil and growth were removed together.

Malignant Disease of Nose in an Old Man.

Dr. Bond showed a case on whom radical operation on the nose and two operations for removal of glands had been performed, the patient having twice previously been shown to the Society and reports made on microscopic sections of tissues removed.

In May, 1898, the nose was clear of disease, but there was a large mass of glands in left side of neck the size of a hen's egg. This was cut down upon and removed with all adherent structures, viz. much of the sternomastoid fasciæ, the internal jugular vein, and the spinal

accessory nerve. The patient is now apparently free from malignant disease and in good health.

The case is of interest since—1st, the left side of palate and left cord have become paretic; 2nd, the remnant of left sternomastoid and trapezius have wasted; 3rd, the general condition of the patient is good, after suffering from undoubted malignant disease for some six years.

In reply to the Vice-President, Dr. BOND thought that the paralysis of the cord might be explained by the fact that the vagus was considerably pulled about during the operation, and of course it was possible that pressure was being exercised upon it by a deeper set of glands.

RECURRENT PAPILLOMA OF LARYNX IN GIRL OF 18.

Shown by Dr. BOND. This patient came to Golden Square about eight years ago with papilloma of larynx, which she seems to have had all her life. When first seen, in 1892, she had not, and was said never to have had, any voice. She was thought to be dumb, was said to have no laugh, and had considerable dyspnœa. Both cords were covered with papillomatous growth on the upper surfaces and edges, and there was a considerable amount below cords in front. The growths have been cleared away every few months during the last eight years. The patient has now a fair voice and the cords are almost clear, though it is some four months since the last operation. The case is of interest owing (1) to the great length of time during which the growths have persisted; (2) to the fact that the growths are recurring with less and less vigour as the patient gets older; (3) the fact that a child of ten could be thought to be dumb owing to the presence of these growths seems a novelty in laryngology.

In reply to a question by the Vice-President as to whether Dr. Bond had used any local applications, the latter said that perchloride of iron grs. vij ad ʒj had been used.

Dr. GRANT suggested the use of a 5 per cent. solution of salicylic acid and absolute alcohol.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ANNUAL GENERAL MEETING, *January 6th*, 1899.

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

HERBERT TILLEY, M D., } Secretaries.
WILLIAM HILL, M D., }

Present—45 members and 3 visitors.

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

Mr. Wyatt Wingrave and Mr. Milsom Rees were appointed Scrutineers of the ballot for the election of Officers and Council for the ensuing year; they reported the result of the ballot as follows:

President.—F. de Havilland Hall, M.D.
Vice-Presidents.—A. Bronner, M.D.; W. H. Stewart, F.R.C.S.Ed.
Treasurer.—Clifford Beale, M.D.
Librarian.—J. Dundas Grant, M.D.
Secretaries.—William Hill, M.D.; Lambert Lack, M.D.
Council.—Edward Law, M.D.; Walter Spencer, M.S.; F. W. Milligan, M.D.; A. Bowlby, F.R.C.S.; Herbert Tilley, F.R.C.S.

The following Report of Council was then read and adopted:

The Council are pleased to report the continued prosperity of the Society, as evinced by the increase in the number of its members and the enthusiasm thrown into the work of the ordinary meetings.

Thirteen gentlemen have been elected ordinary members during the past year, which including the nine honorary members brings the total membership of the Society to 135.

The meetings of the Society have been well attended, the average of thirty-five attendances for the ordinary meetings during the past year being the highest hitherto recorded.

A special meeting of the Society was held July 13th, 1898, to discuss—1. Whether it was desirable to limit the membership of the Society. It was decided to add the words "and as proficient in laryngology" to the present declaration on the nomination paper, and also that the name of each candidate for election should be brought before the Council before being submitted to the ordinary meeting for election.

2. Whether, in deference to the opinions expressed by certain provincial members, it was desirable to alter the day of the ordinary meetings. A letter was sent to each member of the Society asking his opinion in the matter, and in accordance with the wishes expressed by the majority of those who replied, it was decided to hold the ordinary meetings on the first Friday of the month in place of the second Wednesday as heretofore.

Bye-laws were passed giving effect to these alterations in the Rules, subject to confirmation at the next Annual Meeting (January 6th, 1899).

During the past year two gentlemen have resigned their connection with the Society, and we have to regret the loss through death of Mr. John Fallows, L.R.C.S.Ed., who perished in the wreck of the Mohegan.

The Society especially deplores the early death of Professor A. A. Kanthack, lately of Cambridge University. Professor Kanthack was one of our original members, and made many valuable contributions to our Proceedings. Before he determined to devote himself to pathology he turned his attention to laryngology, and, while in Berlin, studied with success some interesting points in the anatomy and pathology of the larynx. The results of his researches were published in 'Virchow's Archiv.' After he had given up clinical medicine and surgery he still continued his interest in matters connected with laryngology, to the good fortune of our Society, which loses in him one of its most active and able members.

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

The actual receipts for the year are £152 5*s*. This amount includes six subscriptions for 1899 and one for 1900.

There are still fifteen subscriptions (£18 18*s*.) outstanding for 1898, the majority of which are good.

The seven outstanding subscriptions for 1897 (£7 7*s*.) mentioned in last year's report have been paid during the current year.

The actual expenditure is £111 10*s*. 6*d*., which leaves a balance for the year of £40 14*s*. 6*d*. This, added to the balance from 1897 (£170 0*s*. 5*d*.), leaves in the Treasurer's hands a total balance of £210 14*s*. 11*d*.

BALANCE-SHEET, 1898.

Income.	£	s.	d.
Balance from 1897	170	0	5
111 Subscriptions at £1 1s. .	116	11	0
12 „ at £2 2s. .	25	4	0
1 Compounding Fee at £10 10s.	10	10	0
Total . .	£322	5	5
The income for the year is . . .	£152	5	0

Expenditure.	£	s.	d.
Rent and Electric Light (20, Hanover Square)	31	10	0
Adlard for Printing and Postage, May, 1897, to August, 1898	71	18	3
Strangeways (Photo-engravings)	1	0	0
Professor Kanthack (refunded for hire of microscopes)	1	10	0
Indexing volume, 1898 (Clarke)	1	1	0
Mathew (porter), 3 meetings (1897), 8 meetings (1898) .	1	18	6
Petty Cash—			
Rogers (Carbolic Acid and Spirit) . . £0 10 6			
Receipt books (Creswick) 0 6 6			
Bank Charges . . 0 0 6			
Baker (hire of microscopes) 0 12 0			
Dr. Tilley (secretarial expenses) . 0 11 3			
Hon. Treasurer's expenses (postage, &c.) 0 12 0			
	2	12	9
Balance in Treasurer's hands	210	14	11
Total . .	£322	5	5
The expenditure for the year is . .	£111	10	6

Audited and found correct, *January* 6, 1899. { PHILIP R. W. DE SANTI. L. HEMINGTON PEGLER.

The following embodies the Librarian's Report, which was then read:

I beg to report that since the last Annual Meeting I have received the following periodicals, and shall endeavour to have them bound in time for the next meeting:

Revue Internationale de Rhinologie, Laryngologie, et Otologie (Natier).
Revue hebdomadaire de Laryngologie, d'Otologie, et de Rhinologie (Moure).
Archivi Italiani di Laringologia (Massei).
Belletino delle Malattie, &c. (Grazzi).
Archiv für Laryngologie (Frankel).
Journal of Laryngology (D. Grant).
Laryngoscope (StClair Thomson).
Annales des Maladies de l'Oreille, du Larynx, du Nez, et du Pharynx (Gouguenheim).
Monatsschrift für Ohrenheilkunde (Gruber).
The Brooklyn Medical Journal (Vol. XII. from June).

Moure, Dr. E. J. De la Tracheo-thyrotomie dans le Cancer du Larynx (Travail de la Clinique de Moure).
Moure, Dr. E. J. Sur les Traitement des Sinusites (Travail de la Clinique de Moure).
Moure, Dr. E. J. Traitement de l'Ozène (1897).
Catalogus van de Boekerij der Nederlandsche Keel-, Neuw-, en Oorheelkundige Vereenigung, 1897 and 1898.
Brighton and Sussex Medico-Chirurgical Society Proceedings and Annual Report, 1897–8.
Gesellschaft der Ungarischen Ohren- und Kehlkopfärzte Jahrbücher, Band III.
Niederlandische Gesellschaft für Hals, &c., 1897–8.
Laryngologische Gesellschaft zu Berlin Verhandlungen, Band VIII.
American Laryn. Assoc. Transactions of the 19th Annual Meeting.
Eighteen Monographs in reprint from Professor Gradenigo.
Five Monographs in reprint from Professor Grazzi.
Several microscopical specimens have been added to the Society's collection, including Lupus of the Larynx (Professor Massei).
Volumes bound as completed.

The following bye-laws (*vide* Council Report) and suggestions from the Council were then discussed, and it was agreed that they should henceforth be regarded as rules of the Society :

(*a*) That the words "and as proficient in laryngology" be added to the nomination papers for future candidates. (Special meeting, July 13th, and Council meeting, October 7th.)

(*b*) That the names of candidates for the membership of the Society shall be submitted to the Council before being placed before the ordinary meeting for ballot. (Council meeting, October 7th.)

(*c*) That the ordinary meetings of the Society be held on the first Friday (instead of the second Wednesday as heretofore) in each month, from November to June inclusive (see Rule 19). (Council meeting, October 7th.)

(*d*) That in Rule 3 the reference to provincial members be expunged. (Council meeting, December 2nd.)

The Forty-sixth Ordinary Meeting of the Society was subsequently held, the President being in the Chair.

Chronic Nodular Laryngitis in a Boy aged Fifteen.

Shown by Dr. StClair Thomson. This case was shown as illustrative of the nodular laryngitis of children described by Moure of Bordeaux. This latter observer, however, had attributed the condition to the straining of the voice, especially in children with treble voices who were compelled to sing seconds. In the present case there was no such history of voice abuse. He was brought with a history of a few months' hoarseness, but

on further inquiry it appeared that he had been more or less hoarse since an attack of croup at the age of three or four. On examination it would be seen that there was a rounded thickening at the junction of the middle and anterior thirds of both vocal cords—the usual site of singers' nodules,—but in the present instance, instead of being situated on the free margin, the nodules were on the upper surfaces.

The cords were generally injected. Some adenoids had been removed in October last without relief, and since then he had been treated with insufflations of alum, sprays of iron, lactic acid, &c., without relief. Rest to the voice has been prescribed.

Dr. DE HAVILLAND HALL thought that at the present time Dr. StClair Thomson would probably feel inclined to alter the nomenclature of the case, as the appearances were those of a chronic laryngitis, the nodules not being distinct. The case, in Dr. Hall's opinion, resembled a chronic laryngitis due to nasal obstruction.

TWO CASES OF CHRONIC LARYNGITIS, ENTIRELY LIMITED TO THE RIGHT VOCAL CORD, AND PROBABLY TUBERCULAR IN CHARACTER.

Shown by Dr. STCLAIR THOMSON. One case was that of a young woman who had been hoarse for more than a year; the other was that of a man who had been hoarse for the last nine months. He had at one time lost flesh, but had latterly put on weight. In neither case were there any definite physical signs in the lungs, and there was no expectoration to examine. The temperature was not raised. In each case there was a red fleshy condition of the right vocal cord, and it was interesting to note, as confirmatory of Dr. Jobson Horne's pathological researches on this subject, that the free edge of the cord was but slightly affected, while the granulations on the cord appear to originate from the mouth of the ventricle of Morgagni. The diagnosis was arrived at by a process of exclusion. Both cases were decidedly improving under general treatment, although they lived in London.

Dr. HALL thought that the evidence in favour of a tuberculous laryngitis was not decisive in Dr. StClair Thomson's second case.

Dr. CLIFFORD BEALE observed that the limitation of the affection to one or the other side of the larynx must always be a strong point in diagnosis in cases of doubtful tubercular infiltration where evidence of other specific diseases was wanting.

Dr. HERBERT TILLEY agreed with Dr. Thomson in looking upon these cases as tubercular. The speaker had shown at a former meeting a man who had tubercular ulceration of the tip of the epiglottis which had been almost completely cured by lactic acid applications and curetting. He had had him under observation nearly twelve months, and when he saw him two days ago he noted a marked granular congestion of the left vocal cord and vocal process, the rest of the larynx being normal. There was well-marked tubercular mischief in both pulmonary apices.

Dr. STCLAIR THOMSON in reply said he had been led to the diagnosis of tuberculosis in these cases by the one-sidedness of the affection, the absence of symptoms of new growth or syphilis, the chronic nature of the complaint, and the situation and appearance of the fleshy granulations. It was hardly likely that a simple chronic catarrh would remain limited to one vocal cord for a whole year, and that it would not disappear completely under vocal rest, such as these patients had tried. Recovery—and these two cases were improving—was not necessarily opposed to this view, for tuberculosis of the larynx, as of other parts, got well, and in some instances even without treatment.

Sir FELIX SEMON said that whilst fully recognising the diagnostic importance of isolated congestion of one vocal cord—a point, in fact, which he had always emphasised himself—he should not go so far as to make a definite diagnosis from this appearance alone. In his opinion the discovery of such an isolated congestion ought to draw the observer's attention to the possibilities of tuberculosis, malignant disease, and syphilis, and no doubt in the majority of cases one of these affections would be found later to develop in the congested part; on the other hand, however, he looked back personally upon a small but definite number in which such an isolated congestion was not followed by any further untoward developments. He should not, therefore, pin his faith upon the discovery of the appearance named alone, but simply look upon it as a valuable warning signal.

CASE OF CURE OF CHRONIC EMPYEMA OF MAXILLARY ANTRUM BY RADICAL OPERATION.

Dr. SCANES SPICER showed this patient, operated on by him six weeks ago.

A. B—, æt. 23, eight years ago had attacks of pain and recurrent abscesses for two years over region of left upper first molar. Six years ago this tooth was removed, and there has remained a fistulous track high up on anterior wall of gum, discharging fœtid pus on and off ever since. In October, 1898, increase of swelling, pain, and fœtor in left nostril. No loose bone could be detected with a probe. Patient, actively engaged

in business, pressed for an immediate cure. Exploration was advised under an anæsthetic, and permission obtained to remove any sequestrum, or to deal with the antrum as might be deemed necessary.

On November 29th this was done. A large gap was found in the anterior bony wall of superior maxilla of irregular shape, and in the membranous structure filling this gap were small, loose, thin, bare scales of bone. The probe and finger easily passed into the antral cavity, which was filled with thick inspissated pus, cheesy débris, also polypi and granulation tissue, with indescribable fœtor. The cavity was thoroughly cleaned out, and the naso-antral bony wall found to be similarly absorbed; the finger passed into the antrum with the slightest pressure met the finger passed into the corresponding nasal fossa, breaking through the membranous portion in the inferior meatus region. The opening was enlarged with finger and curette so as to admit a large drainage-tube, which was cut off near the nostril, and the tube secured by silk threads tied behind each ear. The muco-antral opening was sutured (apparently not sufficiently so, as this incision has not yet healed).

The patient's doctor carried out all subsequent irrigation and drainage by this nasal tube, and after its removal in five days through the naso-antral opening.

Patient reports there has been no pus or fœtor since the end of the third week.

The case is interesting for the following reasons:

(1) It exemplifies the polypoid proliferation and caseation of retained pus, so usually found in chronic antral empyema.

(2) There was a co-existence of a rarefying osteitis of superior maxilla with necrosis of small scales of bone, rendering use of trephines, gouges, or Krause's trocar unnecessary to open and drain the antrum.

(3) The cure of fœtor and suppuration of eight years' standing was rapid, and performed well within the time allowed the patient by his governing board.

Specimen of Dead Bone, Polypi, and Débris removed from a Case of Chronic Empyema of Antrum cured by Radical Operation in Eight Weeks.

Dr. Scanes Spicer showed this specimen. The patient from whom it came, E. P—, female, æt. 18, had complained of unilateral nasal stench and evacuation of foul crusts for nearly eighteen months. This stench was relieved by the evacuation of a crust, and then gradually increased for two or three days, until another crust was discharged. All teeth were present and apparently sound. Diagnosis confirmed by transillumination. Patient's parents had brought her from the north of England for cure, and were staying in London for that purpose. Radical operation as in last case was advised and performed. The patient returned after eight weeks with no fœtor or suppuration, and several reports up to Christmas, 1898, state there is no recurrence of fœtor or pus as before.

The presence of the sequestrum (suspended in the bottle by a silk thread), and the polypi, &c., which filled the bottle at time of operation, indicate the extreme improbability of cure being effected by tooth socket tube.

Dr. Scanes Spicer also showed the temperature chart of another patient on whom he had performed the radical operation in St. Mary's Hospital for cure of chronic empyema of antrum, to illustrate that the modern form of operation was by no means the severe and dangerous procedure which had been stated. On no day had the temperature subsequent to operation exceeded the normal by a degree. The patient will attend at a subsequent meeting.

Further Report of Case of Sarcoma of the Nose shown at November Meeting.

Dr. Barclay Baron (Bristol) reported that he had sent a piece of growth removed from his case of sarcoma of the nose shown at the November meeting to the Morbid Growths Committee. They reported it to be an alveolar sarcoma, and showed sections of it at the December meeting. The growth rapidly increased

both within the nose and externally, displacing the eye outwards. At Dr. Baron's request, Mr. Charters Symonds kindly undertook its removal, full view of the growth being obtained by enlarging the opening in the superior maxilla made by the disease. The dura mater was found to be exposed in one place, the bone covering it having been destroyed, and it would, therefore, have been a dangerous procedure to attempt to curette the interior of the nose without seeing what was being done.

The patient made a quick recovery, and there is very little disfigurement.

Mr. Symonds, in describing the operation, said that when he first saw the case in the wards at Guy's Hospital it seemed to him to presently clinically the ordinary appearance of a sarcoma of the nasal fossa. The elastic projection at the inner corner of the eye which had been noticed in November had projected and displaced the eye both upwards and outwards. In respect to the various opinions expressed as to the nature of this swelling, he carefully exposed it and found it to be composed chiefly of soft growth. It was limited by the stretched periosteum, and between the two was some thick nasal mucus, an arrangement which would account for the sense of fluctuation. The incision was carried down to the ala of the nose and another outwards below the orbit, then with a keyhole saw a part of the nasal process of the superior maxilla, and of the floor of the orbit and anterior wall of the maxilla, were removed. The aperture thus obtained, together with that made by the growth, which had destroyed the lachrymal bone and a part of the ethmoid, gave a large opening into the upper part of the nasal cavity. Through this the entire growth was removed. A sterilised pad was plugged into the posterior naris. On removing the growth the dura mater, as Dr. Baron had mentioned, was exposed; this was not due to the forcible removal of bone, for the growth itself lay in contact with this membrane. That it was dura mater was clear from its bluish-white colour and its density; thus it was obvious that a large part of the ethmoid had been destroyed, and that the starting-point of the new growth was somewhere in the mucous membrane covering this bone. The mucous membrane round the area was cut away with scissors, including the middle turbinal, and the edges of bone around the site were also removed by cutting forceps. The maxillary sinus, which had been slightly opened, was freely laid bare by removing the inner wall. The wound was sutured, and the patient went home in a week. The eye returned nearly to the normal position, and the movements were unaffected and there was no diplopia. The microscopic examination which was made by the surgical registrar at Guy's Hospital, Mr. Fagge, confirmed the report of the Morbid Growths Committee that it was alveolar sarcoma. The structure was identical in all parts of the tumour: it may be added that the growth extended from the nostril to the pharynx, but did not occupy the antrum.

In his report Mr. Fagge stated that the microscopic appearances were those not uncommon in neoplasms of the nasal fossæ.

Mr. Symonds added that he usually, in operations upon the upper jaw, preferred, instead of the set procedure usually recommended, to use a keyhole saw, and surround the growth, leaving any portion that appeared to be quite healthy, for in this way more or less of the palate in some cases might be preserved.

Specimen of Peg removed from Maxillary Antrum through Ostium Maxillare.

Shown by Dr. Watson Williams.

Lupus of Nose.

Shown by Mr. Wyatt Wingrave. Female æt. 30 complained of nasal obstruction with discharge of five years' duration. Four months ago the floors of both nasal fossæ were found occupied by granulations, which extended as high as the middle turbinals. Large quantities were removed by sinus forceps and curette, only to be followed by rapid recurrence. They are much less numerous now, but have involved the turbinals. The cartilaginous septum is perforated, and there is some evidence of old pathological changes in the soft palate. The larynx is normal.

Owing to the large amount of granulation tissue, the existence of severe pain, and evidence of caries on probing, syphilis was suspected, but no history could be obtained, and she did not respond to specific treatment. The tissue on examination gave no evidence of tubercle bacilli, but presented the usual features of lupus.

She has lost one brother and one sister from consumption, and suffers from lung trouble herself.

Mr. Cresswell Baber and Dr. Thomson thought the appearances and fœtor resembled syphilis.

Dr. Watson Williams suggested that in the discussion of such cases the terms lupus and tubercle should be used synonymously, as they were essentially identical diseases, and differing only in their chronicity and mode of growth.

Dr. de Havilland Hall upheld this restriction of nomenclature.

Tubercular Laryngitis in a Dwarf.

Shown by Dr. Herbert Tilley. Patient is a female æt. 45, height 3 feet 2 inches. In February, 1898, she had an attack of influenza and bronchitis, since when she has had a chronic cough and hoarseness.

The larynx is very small, the vocal cords being only about 15 mm. long; both of them were ulcerated, also the right vocal process.

Tubercle bacilli had been found in the expectoration.

Two Cases of Epithelioma and One of Sarcoma of the Larynx treated by Thyrotomy, and keeping well two and a half years, one and a half years, and six months respectively after operation.

Shown by Sir Felix Semon. Case I (already described by the patient himself, Mr. C. Fleming, L.R.C.P., &c., in the 'Lancet' of October 16th, 1897).—Medical man, æt. 47, noticed in June, 1895, slight huskiness, which steadily increased. In November a whitish, pointed, sessile thickening was seen in the middle of left vocal cord. The cord itself congested, its movements free. In May, 1896, voice much worse, no other symptoms. Posterior part of left vocal cord generally thickened, slightly œdematous, no distinct growth visible, movements of cord still free. Two months later conditions unchanged. Proposal of exploratory thyrotomy supported by Mr. Butlin. Operation on July 21st, 1896. Left vocal cord was found to be tumefied in its entire length, and was removed with an area of healthy tissue around it. Mr. Shattock pronounced the growth as a typical squamous-celled carcinoma in the early stage, with little horny transformation. Convalescence took place without any complications, and the patient resumed his practice within a month from the performance of the operation. Since then perfectly well. Voice very good. On laryngoscopic examination a marked cicatricial ridge is seen in the position of the former left vocal cord.

Case II.—Naval officer, æt. 57, sent by Dr. Clay of Plymouth on March 30th, 1897, on account of increasing hoarseness. Both

vocal cords very irregular, considerably thickened and congested, particularly in their anterior two thirds. Their movements free. Differential diagnosis between chronic laryngitis and malignant disease doubtful. The latter suspected on account of the unusual amount of thickening, and expectoration on one occasion of slightly blood-tinged sputum. Two months later hardly any change. Consultation with Mr. Butlin, who shared my suspicion of malignancy. Intra-laryngeal removal of some small projecting pieces of the general thickening for microscopic examination. Mr. Shattock's report on the largest of these ran as follows:—"I took the greatest pains to cut the section of the small flat piece of tissue at right angles to its slightly uneven and granulated surface. The result was wholly successful, and then I saw at once that the growth is a squamous-celled carcinoma. It is so marked that there can be no two opinions about it. The growth has a slight tendency to be horny, *i. e.* less malignant than other forms." Operation on May 31st, 1897. Thorough removal of both vocal cords, scraping of bases. Uninterrupted convalescence. Two months afterwards granulation tumour in anterior commissure, which was removed intra-laryngeally. Patient has enjoyed good health since operation, but the voice of course has been reduced to a whisper, as *both* vocal cords had to be removed, and as the cicatricial ridges which have been formed do not compensate for their loss.

Case III.—Private gentleman, æt. 69½, sent by Dr. Branfoot, of Brighton, on July 15th, 1897, on account of gradually increasing hoarseness, which had already lasted several months. A reddish, irregular, mammillated, broad-based growth occupied the greater part of the much congested right vocal cord, beneath which it seemed to pass into the subglottic cavity. Mobility of cord, if at all, certainly not much impaired. Differential diagnosis doubtful between fibroma and malignant new growth. Microscopic examination (Mr. Shattock) of intra-laryngeally removed fragment showed the tumour to be a sarcoma, nowhere undergoing fibrous transformation, but in part the seat of leucocytic infiltration, and altogether apparently of a highly malignant type. Thyrotomy on July 21st, 1898. The thyroid cartilage was completely ossified, and had to be divided by sawing. The larynx having been opened, it was seen that the growth was

partly pedunculated, but in part infiltrated the anterior part of the right vocal cord. The growth and the anterior half of the right vocal cord were removed and the basis scraped. The posterior part of the right vocal cord was stitched to the right ventricular band. The whole wound was immediately closed after operation, and only a small drainage-tube left in its lowest part. This, too, was removed on the second day after operation. The temperature rose in the evening of the first day to nearly 101°, and came only very gradually down until the normal was reached on the sixth day. In all other respects uninterrupted progress. The patient returned home a fortnight after operation, and ever since has been perfectly well. His voice has an almost normal character, and is still improving in strength.

Mr. SPENCER asked for information on three points: (1) What antiseptics were used. (2) Whether the thyroid cartilage was always sutured. (3) Whether the muscles of the neck were sutured together before closing the skin wound.

Sir FELIX SEMON (in replying to Mr. Spencer) said that his methods of operation had been described in the 'Lancet' of 1894, and in the 'Archiv für Laryngologie' for 1897; that he always rubbed iodoform into all the tissues before closing the wound; that he sutured the thyroid cartilage by means of catgut or silver ligatures; that he now closed the wound in its entire length, withdrawing the sponge cannula immediately after the operation, and only left in its lowest part a drainage-tube; that he was not quite certain whether this modification represented a real improvement, as he thought he had observed that the temperature kept up longer than when the lower third of the wound, as previously, was left open for three or four days, and that he might possibly revert to the latter method. He had only once had to suture the *muscles*, and this was in a case of *tubercular* disease of the larynx, in which the wound had become infected. He added that the appearance of a tumour in the anterior commissure of the vocal cords was—to conclude from his own experiences—rather suggestive of the formation of a granuloma than of a recurrence of the malignant growth; and secondly, that a recent communication of Professor Chiari's in the 'Archiv für Laryngologie' had shown him that the idea of painting the laryngeal mucous membrane with a 20 per cent. cocaine solution to diminish bleeding and reflex irritation had not originated with him, as he had thought, but that he had been forestalled with regard to this by the late Professor Billroth.

Specimens.

Dr. Milligan showed the following specimens:

1. Lymphangioma of Vocal Cord.
2. Laryngeal Papilloma.
3. Naso-pharyngeal Fibro-sarcoma.
4. Large Exostosis removed from Maxillary Antrum.

Multiple and Diffuse Papillomata of the Larynx.

Dr. Jobson Horne showed a case of multiple papillomata occurring in the larynx of a woman æt. 22. Change of voice had been noticed by the patient's friends for upwards of eighteen months, gradual in onset,—at first only a roughness of voice, which had developed into complete hoarseness. Difficulty in respiration had been experienced after physical exertion, especially after going up and down stairs, and after prolonged talking. Latterly the patient has been distressed by nocturnal attacks of dyspnœa on first lying down, but had not been disturbed by them in the course of the night. It was on account of these attacks that the patient first sought advice.

Laryngoscopic examination showed a subcordal mass of papillomata attached in the neighbourhood of the anterior commissure, which when driven upwards during phonation occupied more than half the glottis. Diffuse papillomata also covered both cords.

The subcordal mass was removed, and the attacks of dyspnœa had ceased, and some improvement had taken place in the voice.

The growth under the microscope was found to be a simple papilloma.

Tubular Epithelioma of the Nose.

Dr. Bronner (Bradford) showed a microscopic specimen of a tubular epithelioma of the nose. The growth was of the size of a large pea, and had been removed from the nasal mucous membrane just above the anterior part of the lower turbinated bone of a man of forty-seven nearly ten years ago.

There was a history of slight nasal obstruction and frequent slight hæmorrhage from the nostril. The growth had been removed by scissors, and the base then thoroughly burnt with the galvano-cautery. There has been no recurrence. The report of the Clinical Research Association was :—"The growth is malignant, of an epithelial type; it may be classed with the tubular epithelioma. At the periphery beneath the mucous membrane tubules with a definite lumen can be seen.

Mr. BUTLIN thought it would be very difficult to decide whether it was an adenoma or carcinoma, and suggested that sections should be made by the Morbid Growths Committee.

CASE OF RIGHT RECURRENT PARALYSIS WITH PARESIS OF TRAPEZIUM, STERNO-MASTOID, AND PALATE, WITH SLIGHT PTOSIS AND FACIAL PARALYSIS, ALL ON THE SAME SIDE.

Shown by Mr. R. LAKE. This patient, an intelligent man æt. 36, was sent to me for an affection of the larynx. The following history was obtained. Eleven years ago he was stabbed over right eye, and had subsequently Jacksonian (?) epilepsy, the last attack twelve months ago. No history of syphilis. He has had a cough since August, 1898, and loss of voice for three weeks, dysphagia, and food going the wrong way for two months. His right shoulder is lower than the left; wasting and want of power are noticed in the trapezium and sterno-mastoid, some paresis of palate; reflex present on both sides, the same with pharynx. Left pupil large, and only reacts slightly to accommodation, but not to light. Slight right ptosis and loss of power in the right labial muscles. No Romberg's symptoms. The patient has been taking 90 grains of iodide of potash daily, and had mercurial inunctions every other day for the past six weeks. The dysphagia is getting worse; the voice is now, and has been for the last week, nearly normal.

GROWTH OF LEFT VOCAL CORD IN A MAN AGED THIRTY-TWO.

Shown by Mr. C. A. PARKER. *History.*—Voice began to be slightly husky about the middle of August last. The huskiness varied at first, but has been getting gradually worse during the

last eight weeks. The patient is a tea inspector, and he is constantly inhaling tea dust. There is no loss of flesh and no history of syphilis.

When first seen on October 14th there was a large growth of left vocal cord, especially affecting the anterior half of the cord, where there appeared to be a superficial slough. From its appearance it seemed to be a simple papilloma. The cord was then moving freely.

On October 28th the anterior portion of the growth was removed and examined microscopically by Dr. Hewlett, who reported it to be a papilloma. Since then the growth has recurred to a great extent, and now looks more an infiltration of the cord than a growth attached to the cord; meanwhile the movement of the cord has become impaired.

The case is before the Society for suggestions on the diagnosis and treatment. It seems at present to be something more than a simple papilloma, and in spite of his age (thirty-two years) one is inclined to think it may be a case of early malignant disease.

He has taken 10 grains of iodide of potassium three times a day for six weeks without the slightest improvement.

Sir FELIX SEMON thought it looked very like malignant disease, and advised thyrotomy.

Mr. DE SANTI expressed similar views.

AFTER HISTORY OF A CASE OF RECURRENT PARALYSIS OF VOCAL CORD.

Dr. WILLCOCKS, who showed the patient at the December meeting, reported that he had since had pneumonia, and died suddenly of intra-thoracic hæmorrhage, pointing with little doubt to aneurism which during life had presented no physical signs.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *February 3rd*, 1899.

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

WILLIAM HILL, M.D., LAMBERT LACK, M.D., } Secretaries.

Present—31 members and 3 visitors.

The minutes of the previous meeting were read and confirmed.

The PRESIDENT briefly thanked the members of the Society for the honour they had conferred on him in electing him to preside at their meetings. He promised that he would spare neither time nor energy in furthering the interests of the Society, and in endeavouring to maintain the high standard of his distinguished predecessors in the chair.

The President announced that at the Council meeting just held it had been decided, owing to the large number of clinical cases shown, to increase the number of the electric lamps. To facilitate the reporting and enhance the value of the proceedings a shorthand writer would attend at the next meeting. It was decided further that one meeting, viz. May 5th, should be entirely devoted to a discussion on "Asthma and its relation to diseases of the upper air-passages."

The following gentlemen, their names having been previously submitted to the Council, were nominated for election at the next meeting:

H. Fitzgerald Powell, M.D.(St.And.), F.R.C.S.Edin. Practice, Laryngology and its branches.

Mark Purcell Mayo Collier, M.S., F.R.C.S. Practice, Laryngology and Surgery.

St. George Caulfield Reid, M.R.C.S. Practice, General and Special.

Dr. Lack was elected a member of the Morbid Growths Committee in place of the late Dr. Kanthack.

The following cases and specimens were shown.

Slight Defective Abduction of the Right Vocal Cord.

Shown by Mr. H. Betham Robinson. F. E—, æt. 37, came on December 22nd, complaining of increasing weakness of his voice in singing for some three months, with some pain on the right side of his neck. There was no sore throat and no cough, but occasionally he had night sweats.

His occupation is that of clerk, but he sings a good deal. No history of syphilis.

His father had disease of the knee-joint after an injury ten years before; for this it was excised and subsequently amputated, from which operation he succumbed.

On examination there was slight impaired abduction of the right cord with some injection of both cords; there was no other intra-laryngeal lesion. On the right side of the neck, below the posterior part of the right ala of the thyroid cartilage, was some fulness and slight tenderness on pressure. There was no evidence of any nerve lesion. The treatment was iodide of potassium and benzoin inhalations.

On January 19th his condition seemed decidedly better as far as the external fulness was concerned, and he remained in the same state when shown.

The lesion was regarded as an extra-laryngeal infiltration mechanically interfering with the action of the right cord through

involvement of muscle or hindrance of proper movement at crico-arytænoid articulation. This, in spite of its subsidence under iodide of potassium, was regarded as probably tuberculous.

Dr. DUNDAS GRANT considered that the defective movement of the right cord was due to mechanical fixation.

Mr. MILSOM REES thought that the appearance of defective abduction arose from a distortion of the larynx, the epiglottis being twisted.

The PRESIDENT remarked the right cord showed evidence of inflammatory changes; and

Mr. ROBINSON, in reply, said that both cords were congested when the case first came under observation.

TUMOUR OF RIGHT VOCAL CORD. CASE AFTER REMOVAL.

Shown by Mr. H. BETHAM ROBINSON. F. G—, æt. 48, was exhibited at the meeting on June 8th, 1898, with a small sessile swelling on the right cord at the junction of its anterior third with the posterior two thirds. It was convex, of a whitish colour, and compressible. Its removal was advised. This was accordingly done effectively with Grant's forceps under cocaine about ten days later. The tumour was very soft, and smashed up in the forceps, exuding a mucous fluid; thus no microscopical examination could be made. Its nature was either a cyst containing mucus or a myxoma.

The patient had now complete absence of symptoms, and on examination his right cord would be pronounced normal.

The PRESIDENT congratulated Mr. Robinson on the excellent result.

PARALYSIS (? COMPLETE) OF LEFT CORD.

Shown by Dr. FURNISS POTTER. The patient, a man æt. 48 years, came under observation on the 3rd of January last, complaining of hoarseness, which had come on gradually seven weeks previously. History of a "sore" twenty years ago, but none of rash, sore throat, or other sign indicating constitutional infection. Always had good health.

On examination the left cord was seen to be fixed and practically immoveable in a position rather external to a line midway

between the extremes of adduction and abduction. The left side of the soft palate was markedly paretic, there was some diminution of sensation, chiefly along the lower border; the tongue when protruded deviated to the left side; no affection of trapezius, sterno-mastoid, or orbicularis oris. There were slight lateral nystagmoid movements of the eyes; the knee-jerks appeared to respond rather too readily. Examination of the chest gave negative result. Patient had been taking ten-grain doses of iodide of potassium for the last month, but with no appreciable effect.

Sir FELIX SEMON asked why Dr. Potter hesitated to call the case complete recurrent paralysis. He regarded it as a perfect case, the left cord being in the typical cadaveric position.

Dr. HERBERT TILLEY thought that such cases as these tended to uphold clinically what had been experimentally proved by Horsley and Beevor, viz. that the nerve-supply of the palate, contractors of the pharynx, and probably the muscles of the larynx, was the spinal accessory. This was the fourth case of the kind the speaker had seen within two months, and he thought it was very doubtful if the facial nerve innervated the palate at all, as had until recently been taught in our schools.

CASE OF ULCER OF NASAL SEPTUM.

Shown by Mr. BOWLBY. Female æt. 32, married, and with several healthy children. No history of tubercle or syphilis, and no evidence of either. Had some swelling of the septum nasi about a year ago. This remained covered by normal mucous membrane for six or eight months, and recently has become ulcerated. There is now an ulcer about the size of a large pea at the upper part of the cartilage of the septum. It is not painful. There is no bare bone and no other disease of the nose. The ulceration progresses very slowly in depth, and not at all in extent. No tubercle bacilli have been found.

Dr. DUNDAS GRANT considered the perforation more irregular in outline than the typical perforating ulcer, and more suggestive of tubercle or lupus. This idea was confirmed by the patient's tint and the injurious influence of cold weather.

Dr. STCLAIR THOMSON agreed that the ulceration was situated too far in the nose to be a simple traumatic perforation from the irritation of dust or nose-picking. He thought that against the suggestion of syphilis was to be placed the consideration that the disease had lasted

a considerable time without the progress which is to be found in specific affections. The characteristic odour of nasal syphilis was also absent. He thought the indolent thickened margin and the situation both suggestive of tuberculosis. He had shown a similar case at the Clinical Society, where in portions of the removed granulations he had discovered typical giant-cells. In his case it had been objected that tubercle bacilli were not found in the sections, although carefully sought for. But as his patient had been treated with tuberculin and reacted strongly, he thought his diagnosis fully confirmed. Tuberculin might be used in the present case both for diagnostic and curative purposes.

Mr. WAGGETT said that the history of previous bilateral swelling and the presence of the much thickened and inflamed edges differentiated the ulcer in Mr. Bowlby's case from what was generally known as the perforating ulcer. The latter was characterised throughout its course by an atrophic process.

Dr. SCANES SPICER thought that the ulceration was probably syphilitic in nature, in spite of the absence of a characteristic stench.

The PRESIDENT said it was certainly not a case of ordinary atrophic ulceration. He had observed such cases from the commencement, and in one case had been able to predict a perforating ulcer. There was never previous thickening of the mucous membrane, but always atrophy.

SPECIMEN OF ABSCESS OF THE LARYNX.

Shown by Dr. DE HAVILLAND HALL. The larynx shown was removed from a female æt. 17. The patient was admitted into the Westminster Hospital on December 17th, with acute Bright's disease and lobar pneumonia of septic origin. Shortly after admission she became hoarse, and suffered from dysphagia. A satisfactory laryngoscopic view was impossible on account of the patient's condition. She died December 24th. At the necropsy about an ounce of dark green fœtid pus escaped from around the larynx, the cartilages of which were quite necrosed; the abscess had recently perforated the larynx through a small aperture. Both lungs were pneumonic. There were old thin pericardial adhesions. The cardiac valves were normal with the exception of the mitral, round which was a ring of large coarse vegetations. In the right lobe of the liver was a hydatid cyst, the size of an orange, containing hydatid membrane and thick olive-greenish viscid pus. The rest of the liver was febrile. The spleen and kidneys showed the ordinary changes of toxæmia.

INFANT EXHIBITING A PECULIAR GRUNTING INSPIRATORY SOUND.

Shown by Dr. WILLIAM HILL. The noise was practically continuous, being just as well marked during sleep as at other times, but there was an occasional intermission during one or two respirations. The grunt was not affected by retracting the palate, and was, he believed, produced in some part of the larynx and not in the trachea. He had not passed a Schroetter's tube into the larynx, but such a measure would serve to differentiate between a tracheal and laryngeal sound. He thought the case belonged to the group described by Dr. Gee and Dr. Lees, and more recently by Dr. Lack, and he accepted the latter's explanation (which was an amplification of Dr. Lees' theory of the influence of the epiglottis) that the vestibular structures were here exceptionally lax, and collapsed during inspiration. This could be seen by the aid of the mirror. The sound was unlike those produced in the glottic region, and there was no reason to suspect stenosis from paralysis, or from any intra-laryngeal swelling.

The PRESIDENT did not consider the case agreed in all particulars with those described by Dr. Gee as cases of respiratory croaking in infants.

Sir FELIX SEMON thought that in this case the stridor was produced in the trachea, or at any rate below the larynx. He alluded to some recent papers pointing to enlargement of the thymus gland as the possible ætiological factor in such cases. He thought intubation would certainly settle the point as to whether the stridor arose in the larynx.

Mr. MILSOM REES remarked that the stridor ceased when the child cried, and asked if it continued in sleep.

Dr. LACK looked on the case as one of the milder forms of the affection commonly known as congenital laryngeal obstruction, and due, as in all such cases, to collapse of the vestibule aided by curling of the epiglottis. Where there was very marked obstruction the inspiratory sound was "like a chicken crowing," and occasionally associated with slight expiratory stridor. In less marked cases like Dr. Hill's the stridor was of a "purring," "grunting" character, with no expiratory sound. In all cases of tracheal obstruction due to pressure of an enlarged thymus *expiratory* stridor only was present, or at any rate much more marked than *inspiratory*.

Dr. HILL said the stridor continued during sleep. He would give the child chloroform and ascertain if the stridor continued then, and intubate with a long tube so as to exclude a laryngeal origin for the sound. Personally he thought it appeared to arise from the parts above rather than below the larynx.

Case of Papillomata of Larynx.

Shown by Mr. Richard Lake. Patient has been hoarse for five years, but worse since an attack of typhoid fever last year. There is now a large papilloma in the anterior commissure springing from the right vocal cord, and also one of moderate size on the left vocal process.

Man æt. 51, shown at the November Meeting as a Case of Hypertrophic Laryngitis of Doubtful Nature, which is now seen to be Tuberculous.

Shown by Dr. StClair Thomson. The history of this case is described in the 'Proceedings' for November, 1898, p. 2. At that period the patient presented no evidence of pulmonary tuberculosis, and some suspicions were expressed that the case was malignant, and it was advised that a portion of the growth should be removed for microscopic examination. This was done, but with a negative result. The patient was put upon large doses of iodide of potassium. An ulcer, very suspicious of tuberculosis, appeared on the epiglottis, and the patient rapidly wasted. Further examination showed commencing phthisis, and the expectoration, which had previously been absent, revealed numerous tubercle bacilli. The case was now evidently one of tuberculosis, and was shown as illustrative of the difficulties which this affection in the larynx might present. From this point of view the case was similar to the one shown by Mr. Stephen Paget at one of the meetings last year.

Dr. Clifford Beale asked if the œdema occurred suddenly in this patient, remarking that he had commonly observed its rapid onset in similar cases where iodide of potassium was prescribed. Once present, however, it remained, and thus differed from acute œdema.

The President suggested that the iodide could be used like tuberculin, as a diagnostic test for tubercle.

In reply, Dr. StClair Thomson said the development of œdema of the arytænoids was as Dr. Clifford Beale suggested; it occurred quite suddenly in one week.

Large Naso-pharyngeal Polypus.

Shown by Dr. Herbert Tilley. The polypus was removed from a woman æt. 45. The post-nasal space was filled by the growth, and it extended by a nipple-like process below the level of the uvula, producing, especially at night, a feeling of suffocation. It was removed with Löwenberg's forceps, and the resulting hæmorrhage was slight.

Sir Felix Semon inquired if the polypus had undergone cystic degeneration. In his experience, almost all nasal polypi which protruded into the post-nasal space contained larger or smaller cysts, whilst such were not nearly so frequently found in the myxomatous polypi situated in the nose itself.

Dr. Hill thought this was, properly speaking, a case of nasal, and not post-nasal polypus, the growth apparently arising from the interior of the nose. Further, he objected to the term myxoma being applied to nasal polypi.

Sir Felix Semon said he had used the term inadvertently from old custom.

Dr. Lack said he had quite recently removed a nasal polypus protruding both from anterior and posterior nares, and very firm, with no cystic degeneration. The specimen was very similar to Dr. Tilley's in shape and size.

Dr. Spicer agreed that nearly all polypi springing from both anterior and posterior ends of the middle turbinate contain cysts, often eight to ten small ones. He suggested that large cysts are often dilated ethmoidal cells.

Mr. Waggett wished to corroborate Sir Felix Semon's statement that cysts were generally evident in polypi removed from this position. Moreover small glandular cysts were to be found in the large majority of all nasal polypi.

In reply, Dr. Tilley said that he removed the polypus with Löwenberg's forceps passed into the post-nasal space. He had used the term naso-pharyngeal in an anatomical sense, and not as indicative of the pathological nature of the new growth. The polypus contained one or two large cysts, and measured five inches in its longest and three and a half inches in its shortest diameter.

Epitheliomatous Ulceration of Naso-pharynx.

Shown by Dr. Herbert Tilley. Patient is a man æt. 55. He complains of difficulty in breathing through the nose, and an unpleasant discharge into the mouth, also general weakness.

The palate is seen to be immobile and almost vertical in direction, obviously due to something in the post-nasal space. Its free borders are so thickened and congested that only a small aperture just sufficient to admit the index finger to the naso-pharynx is present. On introducing the finger the ulceration is very evident, and the discharge peculiarly offensive, reminding one of that which is so characteristic of advanced epitheliomatous disease of the tongue. There is an enlarged gland under the upper part of the left sterno-mastoid. A mixture of iodide of potash and mercury perchloride during the last week has had no visible effect on the disease.

Dr. StClair Thomson had had a similar case in a patient æt. 34. He had considered it a case of late adenoids, although the growth appeared rather congested. Operation was attended with profuse hæmorrhage. Patient was seen a few months later with recurrence of growth and enlarged glands in neck. He died shortly after, and the diagnosis of epithelioma of Luschka's tonsil was confirmed by necropsy and microscopical examination.

Mr. Milsom Rees had recently had a similar case.

Case of Empyema of the Antrum cured by Alveolar Irrigation after Failure of Intra-nasal Treatment.

Shown by Dr. Dundas Grant. In this case an endeavour had been made to treat the condition by irrigations by means of cannulas introduced into the antrum through the inferior meatus according to Lichtwitz's method, but without bringing about any continuous cessation of the discharge. The condition obviously arose from disease of several teeth, the stumps of which were thoroughly removed. The alveolar puncture was then resorted to, and the patient irrigated her antrum night and morning without difficulty, with the result that extremely rapid improvement took place, and there was every prospect that eventually a cure would be effected. Dr. Grant brought forward this case to show that his advocacy of intra-nasal methods did not prevent him from recognising the value and unequalled convenience of the alveolar puncture in suitable cases.

Sir Felix Semon thought the Society should be very grateful to Dr. Grant for bringing this case forward, as a contrast to the one

shown at the last meeting. Sometimes one method, sometimes another, was to be preferred; there was no royal road to success.

Dr. HILL and the PRESIDENT suggested this case was of dental origin, and therefore alveolar puncture was successful when intra-nasal failed.

In reply, Dr. GRANT stated that he had in that Society formulated the proposition that antral empyemata of dental origin should be treated through the alveolus, those of other origin through the nose.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

48TH ORDINARY MEETING, *March 3rd*, 1899.

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

WILLIAM HILL, M.D., LAMBERT LACK, M.D., } Secretaries.

Present—27 members and 1 visitor.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were unanimously elected members of the Society:

Mark Purcell Mayo Collier.
St. George Caulfield Reid.
H. Fitzgerald Powell.

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

Henry J. Davis, M.B.Camb., M.R.C.P.London.
Peter Abercrombie, M.D.Glasgow.
Alfred B. Lazarus, M.B., C.M.Edinburgh.

The following cases were shown:

CASE OF LARYNGEAL PARALYSIS SECONDARY TO STRICTURE OF THE ŒSOPHAGUS.

Shown by Mr. BOWLBY. Man æt. 50. Suffers from difficulty in swallowing and loss of voice. His symptoms began

twelve months ago, when he had a very slight difficulty and pain at about the middle of the sternum on swallowing. Six months ago he suddenly lost his voice, and has had partial aphonia ever since. Swallowing has gradually become more difficult, and for three months he has been unable to take anything more solid than soaked bread.

Present condition.—On the left side of the neck there is some fulness, and a mass of hard, matted lymphatic glands can be felt reaching from the clavicle upwards to the level of the cricoid cartilage. On passing an œsophageal bougie a stricture can be felt at a distance of seven inches from the teeth. Laryngoscopical examination shows that the larynx is natural, except that the left vocal cord is fixed in a position midway between abduction and adduction. In front of the processus vocalis the free edge of the left cord is concave. Nothing abnormal in the chest. Pulses equal. Pupils equal.

I have seen paralysis of the vocal cords in cases of œsophageal stricture on several occasions, the left cord being more often involved. I think it may be compressed either by the original growth or by enlarged and infiltrated glands. In the present case the concavity of the cord is very marked, a condition probably due to paralysis of the internal tensor.

Dr. Clifford Beale described a case he had just seen which was almost similar, but at a somewhat more advanced stage. The patient had been for some time under observation, the first evidence of mischief being obstruction of the larynx. On the left side of the trachea there was a swelling which was acutely tender. Under large doses of iodide of potassium the swelling had considerably diminished, and the pain absolutely disappeared. The larynx showed complete abductor paralysis, the cords lying in the cadaveric position. When first seen she spoke with a clear voice. As the patient was subject to adductor spasm, tracheotomy had to be performed. It was now possible to examine freely, and all down the neck on the left side of the œsophagus a hard infiltration could be felt. Under chloroform the top of the growth could be made out with the finger. There was no evidence to indicate how long the paralysis of the cords had lasted, as the voice had not been affected, and up to the time he had first seen her there had been sufficient breathing space.

Sir Felix Semon would not undertake to say off-hand whether, in his experience of œsophageal stenosis, the right or the left vocal cord was more frequently affected, but he could recall several cases of œsophageal obstruction in which the right vocal cord had been paralysed. It was possible that the latter cases made a greater impression

on their minds, since in cases of left-sided paralysis an aneurism was more often the cause than œsophageal mischief. With reference to the flaccid and excavated appearance of the left vocal cord, and the question whether that was due to participation on the part of the superior laryngeal nerve, or whether implication of the recurrent was alone sufficient to explain it, he believed that the latter fully sufficed, because, if the internal tensor became paralysed, the result, in his experience, was the excavated and flaccid appearance of the vocal cord exhibited by Mr. Bowlby's patient. It has been recently stated that if the recurrent laryngeal nerve was completely paralysed, the crico-thyroid muscle would, being no longer opposed by any antagonistic muscle, from mere inactivity undergo degeneration and atrophy. This statement, he was convinced, was purely theoretical. He need only point to cases of abductor paralysis in tabes, such as shown in this Society, in which the affection had lasted for ten or more years, and yet the patient had been able not only to speak with a perfectly normal voice, but even to sing. If that period was not sufficient to produce paralysis of the crico-thyroid from inactivity, he wondered what time was required for the purpose. Besides, Dr. Friedrich, of Leipzig, and Dr. Herzfeld, of Berlin, had found on post-mortem examination the crico-thyroid perfectly normal in cases of complete and long-standing recurrent paralysis. He would suggest that every opportunity be seized in such cases of making a post-mortem examination and instituting a thorough macro- and microscopic examination of the crico-thyroid, and publishing the results of the observation.

Dr. DE HAVILLAND HALL could see no anatomical reason why, in cases of malignant disease of the œsophagus, one vocal cord should be more frequently affected than the other. He thought he had himself seen more cases of right than of left-sided paralysis, but, as Sir Felix Semon had remarked, right-sided paralysis probably made more impression on their minds than left-sided, which was so comparatively common that they were not surprised to find it, whereas a case of right-sided paralysis put them on the *qui vive* to ascertain its cause. As for the place of involvement of the nerve, he found that on pressing the enlarged gland of the neck the man had a distinct attack of spasm of the glottis, and there was marked stridor. This, he thought, the left cord being paralysed, must have been through the afferent fibres and down the vagus on the right side.

CASE OF LUPUS OF NOSE.

Shown by Dr. EDWARD LAW. Female, æt. 33, came to the hospital three years ago suffering from lupus of the skin of the left ala nasi, with a few granulations inside the nasal orifice. Perfect cicatrisation took place after scraping, &c., and no recurrence was noticed for eighteen months, when granulations appeared on the floor of the left nasal fossa and extended up to

the middle turbinal, with nodules on the posterior margin of the septum. Curetting, and applications of lactic acid brought about a satisfactory result, and the patient was discharged apparently cured. A few weeks ago, a posterior rhinoscopic examination revealed a small swelling in the soft palate, immediately behind the posterior margin of the septum.

Case of Nasal Polypi complicated by Well-marked Bilateral Septal Obstruction.

Shown by Dr. Edward Law. Patient, æt. 31, came under observation at the end of last year on account of difficulty in nasal respiration, one or other side being constantly blocked. There is a history of the nose having been broken whilst playing football sixteen years ago, and of a similar accident five years ago, "when there was some difficulty in keeping the three pieces in their proper position."

Examination showed an irregularly deflected septum, with well-marked bilateral prominences at the lower margin of the nasal bones, and an unusually large, long, and thick spur running parallel to, and in union with, the inferior turbinate on the left side. The whole septum is much thickened, and there are polypi in each nasal cavity behind the obstructions. At first it was impossible to obtain a posterior rhinoscopic image on account of the great irritability which accompanied the naso-pharyngeal catarrh. This disappeared after the discontinuance of tobacco, malt liquors, and attention to diet, &c. The posterior extremities of both inferior turbinals are somewhat hypertrophied. The case is interesting, and the opinion of members is requested as to the methods and extent of operative interference.

A discussion ensued on operative interference in cases of stenosis of the nose in general.

Sir Felix Semon said he had recently had a series of cases in which the tendency to adhesion, which was so marked a peculiarity after operations in the nose, had been even more prominent than usual. In one case in which he had removed, by sawing and cutting, a projecting part of the turbinate bones and the septum, every means

he had tried to keep the passage open had failed. The patient had been unable to bear plugging with gauze or wadding; neither could she stand gutta percha, celluloid, or silver. Ivory was the only thing she could bear. He had tried every astringent and sedative he knew of, and had employed cocaine so as to contract the mucous membrane. Nothing availed; everything irritated and gave pain; and each time the plugging was left off adhesions formed. He had sent the patient to her home, and there the parts grew together again, so that he had anew to operate. She was now wearing an ivory plug. When it was taken out she breathed as freely through one nostril as the other, but, although there was a distance of 2 mm. between them, the opposite surfaces touched and united when the plug was left out for six hours. He would like to know if anyone could suggest what to do in such a case. At present he was merely applying pure paroleine, and there was no pain now.

Dr. WILLIAM HILL said that within the last few months he had operated on a case seven times. First he had cut away a piece of the turbinal and a small bit of septum. On removal of the plug, a clot or a scab would form and a bridge appear. In this case he had cut with scissors the turbinal on the outer side, and destroyed the bridge quite six times. He had used the soft rubber plug, which he believed was least irritating, though not very aseptic, and it had been borne well. He believed that if they simply went on persistently with a suitable plug, healing must in course of time occur.

Dr. WAGGETT said he had had a similar case that gave great trouble. He had come to the conclusion that the prolonged use of plugs after operation was disadvantageous, in that it caused a local anæmia of the injured parts and prevented healing. The parts could be kept asunder without pressure by inserting a sheet (not a plug) of celluloid, which took up little room and left quite enough space for the escape of discharge from the surfaces of the ulcers. The celluloid should be removed daily, and the nose syringed.

Mr. SPENCER said it was the continuance of the local treatment that was the difficulty, owing to the pain caused, especially in the hyperæsthetic cases. In Dr. Law's case there were two very thick ridges of half cartilage, half bone, close down upon the floor of the nose. To treat such a case by Bosworth's saw on either side would be exceedingly difficult, the nose was so narrow. Every case should be treated, if possible, under cocaine, but there was a more complete method of treatment, namely, to remove, under an anæsthetic, the whole of the inferior turbinal, either by knife or scissors, and at the same time, if the nose were excessively narrow, to dilate it till it was thoroughly free Dr. Hall had sent a young man to him in whom there was marked hyperæsthesia. The anterior part of the inferior turbinal had been removed by a practitioner, but an adhesion to the septum had formed. A plug had been put in, but the pain prevented its retention. Under a general anæsthetic, the whole inferior turbinal bone was removed, the nose was plugged for a day, then douched, and under this treatment had healed, leaving a free passage.

Dr. SCANES SPICER said he felt sure Dr. Law's case was one of those in which, having obtained permission to remove whatever was necessary

to radically clear the nasal obstruction, a general anæsthetic should be given and the thing done thoroughly. It might be necessary to remove the spurs on both sides and to tackle the middle (for the case was complicated with polypi and purulent sinusitis) as well as the inferior turbinates. That, of course, would mean ten days or a fortnight's confinement to hospital; but such a case as this was best and quickest treated in this radical fashion. Referring to Sir F. Semon's case, of late years he had had no troublesome adhesions after nasal operations until last December, when, through not continuing long enough personal attention to the nose, he had seen two. One patient, having been in London for ten days, was allowed to return home too soon after operation; a "cold" supervened, a bridge formed, and she had to return to London, and it took over a fortnight to conquer the bridge. In the second case exactly the same thing happened. He had worked at this case for two months, and the patient was not yet out of the wood. In obstinate and irritable cases he believed the proper plan was to give the patient a complete rest and allow the bridge to consolidate, simply lubricate with soothing unguents, and get all inflammation down; then, later, attack the non-inflamed bridge. In such a case as Sir Felix Semon had described, a temporary policy of masterly inactivity, such as recommended, would in the end prove most efficient and shortest. It was possible that in these cases freer removal of adjacent parts should have been done, and would have prevented this bridging. For his own part the speaker felt his errors had been invariably in the direction of removing too little rather than too much.

Dr. DE HAVILLAND HALL said that nothing short of the heroic measures taken in the case instanced by Mr. Spencer would have succeeded, the condition being one of long adhesion in narrow nostrils. The result was exceedingly satisfactory.

Dr. DONELAN said he had had much trouble with an adhesion associated with a good deal of hyperæsthesia. There was eczema of the auditory meatus, for which he was using Burow's solution of acetate of lead and alum. He at last tried this in the nose, separating the adherent surfaces with lint soaked in it. The hyperæsthesia was at once relieved, and the adhesion was soon overcome. He further referred to the occasional ill effects of turbinectomy, and mentioned a case in which necrosis of the upper jaw and facial paralysis had followed that operation.

Dr. DUNDAS GRANT said that he had performed inferior turbinectomy for the purpose of getting rid of an adhesion with satisfactory result; but in one case, where there was no previous adhesion, plugging after complete removal of the inferior turbinate body was followed by such inflammatory reaction that an adhesion formed. In one case of adhesion between the left turbinate and the septum in a medical man he had removed the anterior extremity of the turbinate; but that did not prove sufficient. The patient then asked him simply to remove the band, and he would try to keep it open by means of a nasal bougie made of the silk-wove material used in urethral bougies. This the patient cut short, and went about with it *in situ* all day. He was now cured. It was sometimes a question whether adhesions required to be

interfered with. In a case in which the nasal obstruction was so marked that he could only remove the polypi at the posterior part after sawing away a spur on the septum, an adhesion formed which seemed to cause no discomfort, and the relief from the partial operation was so great that he was exercising a "masterly inactivity." Use of cocaine had two effects, anæsthetisation and contraction. But a spray of 4 per cent. of antipyrin would bring about contraction of longer duration. It was, however, rather irritating, and he preceded it by a spray of 5 per cent. eucaine. With that combination an enormous amount of comfort was afforded without risk. In reply to a remark by Mr. Atwood Thorne, that bridges did not seem to him to form unless both terminal and spur were operated on at one time, and his suggestion that they should be dealt with at different times, Dr. Grant replied that there had been cases of adhesion which had arisen without any operative interference at all.

Dr. Edward Law, in replying to the discussion, said that unless the adhesion mentioned by Sir Felix Semon was a very broad one, he should certainly let it heal, and not tamper with it for six or twelve months. One had occasionally to break down adhesions in order to pass the Eustachian catheter, and he had been surprised at the ease with which the surfaces could be kept apart compared with the adhesive tendency manifested after any operations in the nose. This freedom from adhesion in the case of the division of bridges of long duration was probably accounted for by the adjacent mucous membrane being in a more or less normal condition.

Case of Complete Adhesion of the Soft Palate to the Posterior Wall of the Pharynx.

Shown by Dr. de Havilland Hall. The patient, a married woman of 33, was quite unaware of her condition until informed of it, but she noticed that she could not blow her nose like other people. She has never suffered from sore throat or skin affection. The left central incisor, upper jaw, is notched and pegged. Eyes not affected. Patient had one child 12 years ago, and has had no miscarriage. She is an only child, and states that her mother had miscarriages. The case is clearly one of inherited syphilis.

Foreign Body impacted in the Naso-pharynx for Four Years.

Shown by Dr. D. R. Paterson. This was a metal regulator for rubber tubing frequently used with infants' feeding bottles.

It was removed from a child aged six years, who came with the history of otorrhœa of the left side and fœtid discharge from the left nostril. There was inability to breathe freely through the nostrils, and something could be distinguished in the posterior nares on looking through the left nostril. Under an anæsthetic a hard mass was felt above the soft palate, fixed immediately behind the posterior choanæ, and on removal was found to be the foreign body thickly coated with phosphates. A history was obtained that when the child was fifteen months old, and was playing with a regulator, it suddenly showed difficulty of breathing, which was relieved by suspending with head downwards, though from that time the nasal breathing became obstructed and the child suffered in health. At various times bougies were passed by different medical men into the œsophagus with a view of disabusing the parents of the notion that there was a foreign body in the throat, and it was for relief of the aural and nasal trouble that advice was lately sought.

Mr. Parker related what might be called a surgical freak. A boy had come to him complaining of obstruction of the nose. By the aid of the posterior mirror he saw a large grey mass in the posterior nasal space, but, unable to determine what it was by inspection, he had put his finger up. This did not reveal the nature of the body; but just then the boy gave a great heave, and from the back of his nose came a piece of drainage-tube about two inches long and half an inch in diameter. The boy had had an abscess in his neck two years previously, in connection with which the drainage-tube had been used.

Case of Laryngeal Vertigo.

Mr. Atwood Thorne showed a man, æt. 51, who came to Dr. William Hill at St. Mary's Hospital, on January 5th, 1899, complaining that "whenever he had a fit of coughing he felt giddy and lurched towards his right front." He has been subject to paroxysms of coughing on and off for two years, but the condition has been getting worse lately. He has never fallen, but has to catch hold of something to prevent his doing so.

He is slightly deaf, and for the past two months has had noises "like heavy traffic" in his head.

He has polypoid hypertrophy of both middle turbinates, some lymphoid hypertrophy at the base of the tongue, and some

slight swelling in the interarytænoid space. There is some pulmonary emphysema. No other cause for vertigo being ascertained, the case is brought forward as one of laryngeal vertigo.

Fifteen minims of dilute hydrobromic acid have been given three times a day, and the man describes himself as rather better.

While at the hospital the man has never had an attack, forced coughing not having affected him in any way.

Dr. LAW thought it was possibly a case of *aural* vertigo. The patient complained of deafness and tinnitus; the tympanic membranes were retracted. He thought that catheterisation would reveal the Eustachian tubes to be over patent. The man had probably for some time given his ear repeated concussions either by coughing or blowing his nose. He should be recommended not to blow his nose violently, and some remedies should be given to relieve his cough.

Dr. HILL said the man had been under him for aural treatment. He at first had assumed the case to be one of aural vertigo, but finding the patient had signs of exhaustion sinusitis before one of the attacks, he then was inclined to think it was a case of *nasal* vertigo. Afterwards it was found that the attack *always* came on in connection with some laryngeal irritation and cough, and narrowed down in that way; he believed it was really an instance of laryngeal vertigo.

Dr. DUNDAS GRANT said although the theory of aural vertigo had been propounded by some authors, he was indisposed to accept it, if only because of the extreme rarity with which vertigo followed inflation of the middle ear, a result he himself had never seen. In a case of very definite laryngeal vertigo, or rather syncope, as it was better called, there was a strong gouty tendency, after treatment for which he believed the vertigo disappeared.

Dr. STCLAIR THOMSON suggested that it might be *cardiac* syncope. The patient's pulse was very small and quick, and slightly irregular. The man himself said that when he bent forward to lace his boots he felt inclined to fall on his nose.

CASE OF TUBERCULOUS INTERARYTÆNOID GROWTH.

Shown by Mr. J. S. LUCAS for Mr. Lake.

The patient, a female æt. 33, has been hoarse for four months. For the last eight weeks she has been under treatment, and the throat has been painted with formalin in 3 per cent. solution. She has improved greatly, but still complains of pain if the throat is not painted daily. The swellings in the interarytænoid region are rather unusual, being very irregular.

Two Cases of Extra-laryngeal Cyst.

Mr. Waggett showed two young men exhibiting cystic formations in the thyro-hyoid region.

In the one case a cyst the size of a hazel-nut was found lying upon the thryo-hyoid membrane on the left side. In the second case a tumour, partly cystic, and about the size of a walnut, was present on the left side over the thyro-hyoid membrane and extending down over the corresponding ala of the thyroid cartilage. This was probably a cyst developed from the pyramidal lobe of the thyroid gland.

Mr. de Santi thought the first case a bursal cyst, extra-laryngeal and unconnected with the thyroid. It might be necessary to make a deep dissection, but he thought Dr. Waggett could cut down and remove it. He could not get "blowing out."

Dr. StClair Thomson asked whether the possibility of so-called pneumatocele had been considered, as the tumour could be distended by blowing with closed lips.

Mr. Waggett had at first considered the second case to be one of pneumatocele. He had, however, convinced himself that the slight enlargement which occurred on coughing was due to venous engorgement. On external pressure a slight prominence occurred in the region of the left aryepiglottic fold, but it was quite impossible to cause any diminution in the size of the tumour by prolonged manipulation. He felt certain that the cyst in no way communicated with the lumen of the air-passages. Mr. Waggett agreed with Mr. de Santi in thinking the first case to be one of bursal cyst. As it caused no inconvenience he did not propose to operate.

Case of Multiple Laryngeal Papillomata in a Child æt. 3½ Years, completely removed in three sittings by Endo-laryngeal Method under combined General Anæsthesia and Local Cocainisation, and without Tracheotomy. Result: Full Restoration of Voice and Normal Breathing.

Dr. Scanes Spicer showed this case. Boy, æt. 3½, lost his voice after a cold at the age of seven months, and has always spoken since in a breathy whisper; there is no sound in his laugh or cough, and his breathing is noisy, especially at night. He is highly intelligent, but shy, and can say anything

in his peculiar whisper. His tonsils are enlarged, and there is post-nasal adenoid hyperplasia. Laryngoscopic examination not practicable without anæsthetic.

February 1st.—Dr. Fred. Hewitt administered gas, ether, and chloroform, and patient was placed in intubation position in nurse's lap. The condition was:—Large median, cauliflower mass, whole length of glottis, flapping freely in air current, and attached somewhere on right side; right cord embedded in multiple, pale, warty growths; left cord perfectly healthy and mobile. The median mass only was removed by antero-posterior cutting forceps, as the larynx was irritable, and preparations had not been made to tackle the growths on that occasion.

8th.—No return of voice, but breathing much quieter, especially at night. Anæsthetic was given again as before, and the larynx was sponged with a few drops of 20 per cent. cocaine solution, and well mopped out. This was done two or three times until the larynx was tolerant of the probe and forceps. Eight or ten large clusters of growths were then removed, blood being mopped away at times. After this the tonsils and adenoids were removed.

16th.—The patient still speaks in a whisper, but there is sound in the cough and laugh. Anæsthetic given again and cocainisation as before. Small growth removed and larynx seen to be absolutely free. Recovering from anæsthetic a curious croupy inspiration was observed, which was especially marked when anyone was in the room, but subsided when patient was left alone. The sound of voice did not return for some days, and only gradually. Apparently determined effort was requisite to produce the voice, and it had a raucous, monotonous character devoid of inflexion.

This case is interesting as a further proof of the practicability of removing laryngeal growths in young children by the method described by the writer some years ago. He then had had four such cases, later one more, and, until the present one, no case of the kind for five years. This case has been far more rapid than any of the others, and the operator has been much indebted to Dr. Hewitt for many suggestions in connection with the anæsthetic and position. It is also a point of much interest that the

voice did not return at once, though there was no mechanical impediment to adduction. This might have been due to slight bruising during operation, or it might have been a result of the threefold co-ordination of breath, articulation, and adduction never having been established at the time when the child lost its power of adduction.

Sir FELIX SEMON thought the result most satisfactory, and one upon which Dr. Spicer ought to be congratulated. He had himself seen the child before the operation. It was then in a very bad condition, perfectly aphonic, and with loud laryngeal stridor, and a suggestion of tracheotomy had been made.

Dr. WILLIAM HILL said Dr. Spicer's results put the question of treatment of papillomata in children of three or four years of age on quite a new basis. Instead of putting off operation till the patient was seven or eight, Dr. Spicer cleared out the larynx at any age. He had himself seen two cases in which the finger nail was used at his suggestion to remove some of the growths.

Dr. SCANES SPICER said the growths were removed under the guidance of the mirror. The longest time occupied at a sitting in his earlier cases was two hours. There was a good deal of trouble in connection with the chloroform. Very little cocaine solution was used. He followed up the spray immediately with a dry cotton-wool mop, giving it a brisk turn round so that no cocaine was swallowed, and a local anæsthetisation was thus procured, which supplemented the chloroform and allowed the field to be operated on without exciting reflex contraction and closure. In the present case Dr. Frederic Hewitt had given the chloroform, and had much facilitated the operations.

CASE OF PACHYDERMIA OF THE LARYNX, PROBABLY DUE TO CHRONIC RHINITIS.

Shown by Dr. DUNDAS GRANT. Man, æt. 21, was first seen by Dr. Grant on the 25th February, when he complained of huskiness of the voice which had persisted for two months subsequent to a cold, also frequent coughing and hawking. He attributed the condition to an attack of diphtheria nine years before. It appeared that on at least two occasions such hoarseness had followed colds and had lasted for several months. On examination of the larynx there was found a dry congestive condition of the vocal cords, with a pale irregular fringe on both vocal processes. The thickness on the vocal processes was

irregular, and the processes appeared on phonation to dovetail into each other.

In the nose there was hypertrophy of the inferior turbinated bodies and increased muco-purulent secretion. There was no history of specific disease nor of excessive use of the voice. The patient is otherwise in excellent health, and the condition, if not absolutely typical of pachydermia, seems to approximate to it extremely closely. The treatment proposed is the removal of the hypertrophied portions of the inferior turbinated body and application of the alcoholic solution of salicylic acid to the larynx.

Dr. DE HAVILLAND HALL doubted whether the case could be called one of pachydermia. It did not extend far enough along the processus vocalis. He had seen pachydermia in alcoholics who were also voice users. Sir Felix Semon having remarked that he had seen it most frequently in clergymen, Dr. de Havilland Hall further remarked that one of his cases was that of a clergyman in whom lipomata on the nape of the neck had led him to suspect alcoholism.

Dr. DUNDAS GRANT thought his case approximated closely to pachydermia, though not of the typical shirt-button type, and was a hyperplasia of the epithelial tissue.

CASE OF PAPILLOMA OF THE LARYNX PREVIOUSLY SHOWN IN AN ELDERLY MAN. COMPLETE REMOVAL.

Shown by Dr. DUNDAS GRANT. Man, æt. 60, came under my care on the 28th October on account of hoarseness and loss of voice of a year's duration. The growth in this case was removed by means of Grant's forceps, and on microscopical examination presented the characteristics of a soft papilloma. The stump underwent some regrowth, but the alcoholic solution of salicylic acid was applied and the forceps again used, leaving only a slight roughness on the site of the growth. This was treated with local application of salicylic acid two or three times a week, and at present the voice has reached its normal condition; the edge of the cord is nearly smooth, though its colour is still abnormally red.

Case of Multiple Papillomata.

Shown by Dr. Dundas Grant. A woman æt. 59 came under my care on February 23rd on account of hoarseness and loss of voice of two years' duration. On the edge and upper surface of the right vocal cord was a sessile mass of a soft, warty appearance, which was, from its mobility, apparently of soft consistency, the papillation of the surface being particularly marked. This extended to the anterior commissure, where there was a roundish outgrowth. The left vocal cord was reddish and irregular at its edges, but was partially concealed by the growth from the other side. The movement of both sides of the larynx appeared to be normal, the voice was almost lost, and was more whispering than hoarse. By means of Grant's forceps a large portion of the growth was at once removed, but no particular effect on the voice was produced. Three days later, further removal was effected by means of the same instrument, but the growth at the anterior commissure could not be reached, probably on account of the length of the beak of the forceps employed. This was, however, removed completely by means of MacNeill Whistler's forceps. On the 1st of March the larynx was free from any large mass of growth. There still remained a slight fringe on the right cord, and there was seen below the middle of the left one a pale smooth sessile growth of very small dimensions. A 5 per cent. solution of salicylic acid was then applied between the cords. At this date the voice seemed as toneless as ever, but with a little insistence the patient was induced to utter hoarse but fairly loud sounds. It seemed as if the habit of whispering had become established, and that even after removal of the new growth in the larynx this would have to be overcome by practice.

Case of Large Gumma in Posterior Pharyngeal Wall.

Shown by Mr. Arthur Cheatle. A woman, æt. 37, came to the Royal Ear Hospital ten days ago, complaining of difficulty of swallowing, and "a lump" in her throat. A smooth swelling,

an inch and a half in breadth, situated slightly to the left of the middle line, reached from high up in the naso-pharynx downwards to the level of the top of the larynx. It was soft and fluctuating in the centre, hard at the edges, where it faded into surrounding parts. There was a history of numerous miscarriages and some stillbirths. Resolution was taking place under iodide of potassium and perchloride of mercury.

Case of Fixation of Left Vocal Cord with Fibrillar Movements.

Shown by Mr. W. G. Spencer. The patient, æt. 62, served in the navy, but having suffered from repeated attacks of rheumatism, he was invalided. His voice has not been good for years, and he has had attacks of aphonia. During the last four months he has been very hoarse or completely aphonic. The left vocal cord is fixed as regards voluntary movements. The arytænoid cartilage is fixed and drawn forwards, forming a ridge. The cord itself is unaltered, but continually exhibits fibrillar movements. Some congestion of the larynx has become less under treatment.

Dr. Herbert Tilley suggested that the curious appearance presented was due to tilting and fixation of the arytænoid cartilage, and that there might be some trouble (possibly rheumatic) in the crico-arytænoid joint. The twitching movements of the tissues covering the fixed arytænoid reminded him of a similar condition seen in a case of syringomyelia, with palatal and left abductor laryngeal paralysis, shown to the Society by Dr. Horne (June 9th, 1897).

Sir Felix Semon referred to a former paper of his on the subject, which described a case in which there was also complete tilting of the arytænoid cartilage, with fixation of the cord and the formation of a ridge in consequence of the drawing of the parts. In that case there appeared to be congenital anchylosis and luxation of the crico-arytænoid joint.

Case of Recurrent Papillomata of Larynx.

Shown by Mr. C. A. Parker. The patient, a man æt. 25, was first seen three years ago, when he had been hoarse for four months. The larynx was then found to be almost entirely filled

with papillomatous growths. The growths were removed, with great improvement to the voice. At intervals of a few months the patient has returned with recurrence of the growths, which have been removed on about twelve occasions. The patient has not been seen until now for fourteen months. The voice is impaired, and he has pricking pain on swallowing. The whole of the anterior part of the larynx seems to be filled up with growths, the posterior wall alone is free.

A Skiagram of Foreign Body in the Œsophagus.

Mr. de Santi showed a skiagram of a halfpenny tightly wedged in the œsophagus, opposite the level of the top of the sternum.

The patient was a child of 2 years 11 months, who had swallowed a halfpenny eleven days before Mr. de Santi saw him.

The mother of the child stated she had carefully examined the stools passed, but had seen no halfpenny. Beyond having occasional attacks of vomiting there had been no symptoms.

When brought to Mr. de Santi the mother stated the child complained of pain in the right iliac fossa. On examination the child cried on that locality being pressed.

Mr. de Santi ordered the air-passages to be skiagraphed. The halfpenny was then clearly seen in the œsophagus. Under chloroform the top of the coin was with difficulty felt with the tip of the index finger. It was extracted by means of the coin-catcher, although tightly wedged.

The child made an uninterrupted recovery. The interest of the case lay: (1) in the length of time the coin had remained impacted in the œsophagus, *i. e.* twelve days; (2) the absence of any localising symptoms, such as pain, dysphagia, or dyspnœa; (3) the presence of pain around cæcum, suggesting lodgment of the coin in that neighbourhood; (4) the absence of any inflammation or ulceration in the neck where the coin was wedged.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

49TH ORDINARY MEETING, *April 7th*, 1899.

A. BOWLBY, Esq., F.R.C.S., in the Chair.

WILLIAM HILL, M.D., LAMBERT LACK, M.D., } Secretaries.

Present—22 members and 5 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were unanimously elected members of the Society:

Henry J. Davis, M.B.Camb., M.R.C.P.Lond.
Peter Abercrombie, M.D.Glas.
Alfred B. Lazarus, M.B., C.M.Edin.

The following cases and specimens were shown:

CASE OF PACHYDERMIA LARYNGIS.

Shown by Mr. C. A. PARKER. A. C—, male, æt. 32, was first seen five years ago, suffering from well-marked and typical pachydermia laryngis, the greater swelling being on the right vocal cord. At first it yielded to none of the ordinary methods of treatment, but finally it was reduced by means of electrolysis, small portions also being removed by means of forceps. Two

years ago the pachydermatous swellings had almost entirely disappeared, and the voice had much improved, but considerable general thickening of the larynx remained. Since then he has had several attacks of laryngitis which have yielded to treatment. Three months ago, however, he returned with a marked pachydermatous thickening on the posterior third of the right vocal cord and a corresponding swelling on the left. This is again yielding to astringent applications locally, and iodide of potassium internally, but it is still well marked, and there is a great amount of general thickening of the mucous membrane of the whole larynx with laryngitis.

There is no history of syphilis. He drinks about one pint of beer a day, and he does not use his voice to any unusual extent. As a boy, up to the age of seventeen years, he sang in a choir, and was able to take very high notes.

The long duration and the obstinacy of the case led me to bring it before the Society in the hope of suggestions as to future treatment.

Case of Paresis of the Right Vocal Cord.

Shown by Dr. StClair Thomson. When the title of this case was sent in to the Secretary the right cord was perfectly fixed in the cadaveric position. It was now seen, however, to be moving fairly well. The case was interesting from the variability of the symptoms. The patient was a man aged thirty-four, who contracted influenza last autumn, and has been hoarse since November. When first examined in January last he was seen to have paresis of both internal tensors. This was confirmed at a second visit, and by several observers. At the end of a few weeks, although the patient felt his voice stronger, there was found to be complete abductor paralysis of the right vocal cord. There was nothing to account for this in his neck, chest, or general symptoms.

There was no history of syphilis, but as his wife had had several miscarriages he was put upon specific treatment. The laryngeal condition improved at first, then relapsed, and was now again rapidly improving.

Mr. Bowlby mentioned the case of a gentleman, æt. 48, who after influenza nearly lost his voice and had attacks of difficulty of breathing, having to gasp for breath after coughing. Examination revealed paresis of the abductors of both cords. At the end of three months this condition gradually passed away under no special treatment, and the patient had since been perfectly well. Paresis of some of the muscles of the larynx was not a very uncommon thing.

Specimen of Large Thyroid Cyst.

Shown by Dr. Herbert Tilley. The cyst measured ten and a half inches in circumference, and weighed eleven and a quarter ounces. It was removed from the left lobe of the thyroid gland in a female, aged thirty-five, who was suffering from difficulty of breathing owing to displacement of the trachea to the right.

Specimen of Old-standing Bronchocele, becoming Malignant and causing Pressure on the Œsophagus and Trachea.

Shown by Mr. de Santi. The patient was a woman æt. 60, and had had a bronchocele for some twenty years. For a few weeks before applying to the hospital she had had dyspnœa which increased and caused much trouble. On examination a large fibrous bronchocele was found; there was marked inspiratory dyspnœa, and no view of the larynx could be got. The bronchocele not only extended laterally, but also downwards behind the sternum. It had not increased much latterly.

A median incision was made and a large part of the centre of the tumour removed. This gave complete relief for eight months. The growth microscopically was benign.

The patient was readmitted for severe dyspnœa and dysphagia eight months after the first operation, and some more of the thyroid was removed. The trachea was not seen. Relief was obtained, but the patient died three weeks later from sudden cardiac syncope.

The specimen showed that the trachea was much deflected to the right, and was not only scabbard shaped but also flattened antero-posteriorly. The œsophagus was also much narrowed

and deflected to the right. The enlargement extended mesially down to the left innominate vein.

Microscopically the thyroid showed no malignant characters, but the mediastinal glands in the neighbourhood showed commencing carcinomatous changes. Mr. de Santi referred to the difficulties such cases presented as regards tracheotomy, and stated that it was by no means uncommon to find these old-standing bronchoceles becoming malignant after many years, although orginally innocent.

Mr. BOWLBY said the case illustrated exceedingly well the impossibility of removal of these tumours. It was a common experience, as far as malignancy was concerned, to find it commencing in a previously enlarged gland.

Dr. HERBERT TILLEY asked Mr. De Santi if he could say whether in this case the malignant disease started in the parathyroid structure, because in a lecture on goitre recently given by Mr. Horsley he had pointed out that such was often the case, a probability enhanced by the vascular and epithelial nature of this structure.

Mr. BOWLBY said that was not his experience. He had seen malignant disease start in the substance of the thyroid itself, not in the parathyroid.

Sir FELIX SEMON had seen several cases start in the thyroid itself after the original goitre had remained unchanged for twenty years or more.

CASE OF PRIMARY EPITHELIOMA OF THE RIGHT TONSIL WITH EXTENSION TO THE TONGUE AND CERVICAL GLANDS.

Shown by Mr. DE SANTI. The man, æt. 37, had first noticed swelling in the right tonsil at Christmas, 1898, and had seen a doctor who said nothing was the matter with him. He was again seen later when he was told he had tonsillitis and given a gargle.

Now there was well-marked cachexia. A foul ulcer was seen in the right tonsil. The base of the tongue was involved and bound down, and there was inability to open the mouth wide. The right cervical glands were typically enlarged and hard. The case was inoperable and of very rapid growth.

Mr. BOWLBY thought there could be no doubt as to the diagnosis, and that operative treatment was impracticable.

Swelling in Inter-arytænoid Region.

Shown by Dr. Furniss Potter. The patient was a man æt. 31, a meat salesman and voice user, who had suffered from hoarseness for about two months previously, and had had a cough with expectoration for an indefinite period—could not remember how long. On examination there was general hyperæmia of the larynx, the cords being thickened and slightly reddened. In the inter-arytænoid space was a pyramidal-shaped swelling, grey in colour as if covered with mucus.

According to patient's statement he had been a teetotaler for the last three years, but previously had indulged freely in alcohol. There was no history of syphilis. No loss of flesh. Examination of sputum for tubercle bacilli yielded a negative result. No definite abnormal physical signs in chest.

Sir Felix Semon thought care should be exercised in the use of the expression "growth in the inter-arytænoid fold," as it was the experience of practically everybody that benign growths in that region—he referred to real new formations—were amongst the greatest rarities of laryngological literature. Was Dr. Potter's case not much more likely to be an instance of inflammatory thickening, and in such circumstances was the use of the term "growth" justifiable?

Mr. Bowlby agreed with Sir Felix Semon, and asked if Dr. Potter would be willing to alter the title of the case. The term "growth" so definitely conveyed the idea of tumour formation as apart from inflammatory swelling that it was unfortunate to use it in a case like that before them.

Dr. Potter said he had had some doubt in describing the condition as a "growth." Perhaps "excrescence" or "swelling" would be more applicable.

Dr. William Hill thought the condition was not like an ordinary swelling or infiltration, if by that was meant something mound-shaped. It seemed to him rather of the shape of the typical tubercular *growth* in that position than of a mere tubercular swelling.

Case of Lupus of Nose and Pharynx.

Shown by Dr. Watson Williams. About two years ago patient, æt. 21, had a violent blow on the nose at football. The nose bled freely, and shortly afterwards became more or less persistently blocked on the left side. Crusts and discharge shortly after came from the left nostril, and after an interval of

about six months from the right nostril also. About this time a bicycle fell on his nose, producing the depression of the bridge so suggestive of syphilitic disease. There is no history of syphilis, nor any family history of tuberculous disease. Latterly the throat has been dry, and the voice husky.

The cartilaginous septum has completely disappeared, but I find no evidence of necrosis of the bone. The inferior turbinal and the remains of the septum appear to be superficially infiltrated with lupus.

The soft palate has been partly eaten away, and the remains of the uvula shows lupus nodules, with clean superficial ulceration in parts.

The posterior pharyngeal wall and the vocal processes in the larynx show lupus infiltration.

I was suspicious of a syphilitic infection, and put the patient on large doses of iodide of potassium, and also on mercury; but he developed iodism, while the local conditions only progressed. The local application of lactic acid 50 per cent. does not appear to control the disease. I have applied nitric acid to the pharynx and soft palate, and I propose to curette away as much of the infiltrated tissue as seems justifiable, and apply nitric acid.

Mr. Bowlby thought the suggestion, based on the statement of the patient, that the condition was the result of injury an exceedingly unlikely supposition. He believed it a case of syphilitic disease.

Dr. William Hill pointed out that the disease actually had extended to the larynx, there being an ulcer in the inter-arytænoid region, and there was also considerable destruction of bone in the nose, which was against the diagnosis of lupus.

Dr. StClair Thomson also believed it syphilitic. A blow would have to be a very straight one in the middle line of the nose to flatten it out as it had flattened this one. He did not think lupus, though it might destroy the nose very extensively, produced such retraction as this case showed; and the pharyngeal condition confirmed this view. Dr. Watson Williams had previously shown a case of true tuberculosis of the septum which had been treated with tuberculin, and he would suggest the idea of testing this case in that way before going in for any extensive treatment. If that procedure gave a negative reaction it might be advisable to treat the patient actively with inunctions of mercury before taking surgical measures.

A Case of Laryngeal Disease for Diagnosis.

Shown by Dr. W. H. Kelson. E. B—, a girl æt. 15, came complaining of loss of voice; duration two years; onset gradual.

Family history.—Parents alive; no history of consumption in family, but father has had bad throats, and sisters and brothers have had bad throats and eyes. Patient suffered from abscesses in the neck as a child. Three years ago suffered from interstitial keratitis, and as the eyes recovered deafness came on and loss of voice.

Condition on admission.—Patient is fairly well nourished. Auscultation of chest showed nothing abnormal; corneæ hazy. Central incisors rather pegged. Scars of old glandular disease in submaxillary regions.

Larynx.—Pinkish growths, having their origin apparently from the ventricles, obscure the view of the cord on both sides; portions of the growth have a warty appearance, other parts are smooth; the larynx is not at all tender on external manipulation.

Three months after admission: the patient has had two grains of Hydrarg. c̄ Creta in pill every day, and small portions of the growth have been removed with some improvement of the voice.

Present condition of the larynx: on the right side the growth has much receded and a slightly thickened cord is plainly visible. On the left side there is still much growth and only occasional glimpses of the cord can be obtained. The left side also does not move so freely as the right, and the arytænoid outline is not quite so sharply defined.

Sir Felix Semon thought it probably a case of syphilitic perichondritis with fixation of the crico-arytænoid joint and partial luxation of the arytænoid backwards, the processus vocalis springing more forward than was natural. With the other evidences to that effect, the explanation that it was a case of congenital syphilitic disease was a very likely one.

Mr. Spencer also thought it due to congenital syphilis.

Mr. Bowlby agreed with this opinion, and remarked that it was not a common experience to find the swelling clear up as it had done on the right side, leaving a perfectly free cord.

Case of Polypoid-looking Growth springing from the Right Supra-tonsillar Fossa.

Shown by Mr. Arthur Cheatle. A female patient æt. 21 had complained of discomfort in swallowing for a month.

On examination a smooth, pale growth, about one and a quarter inches in length, was seen projecting from the supra-tonsillar fossa and hanging over an enlarged tonsil but quite distinct from it. Sections of the growth will be shown at the next meeting.

A Case of Old Syphilitic Disease in the Nose of a Woman aged thirty-six.

Shown by Dr. Donelan. There was extensive destruction of all the intra-nasal structures. He desired the opinion of the Society as to whether a patch of thickened and inflamed skin on left side of nose was not an added tuberculous infection. There had been no change in this patch under anti-syphilitic treatment, though in the ten days it had been under observation the intra-nasal disease had been completely arrested.

Mr. Bowlby thought this case probably syphilitic. The term "lupus" might be employed indicating that it was a syphilitic lupus, but he did not think it at all like a tubercular affection.

Sir Felix Semon suggested that a tuberculin test might be applied.

Case of Miliary Tuberculosis of Fauces, &c.

Shown by Dr. Lambert Lack. Patient, a female æt. 26, is very anæmic and wasted. She has suffered from a cough for about two years; has been wasting for six months; and for the last six weeks has complained of sore throat.

On examination, the mucous membrane of the fauces and adjacent part of tongue and pharynx on the left side is reddened and slightly swollen. The surface is covered with minute, superficial, clearly-defined ulcers, with ashy grey, sloughy bases. At the periphery of the affected part the ulcers are distinct, and

vary in size from a pin's head to a millet seed. In the centre the ulcers are partly confluent.

The upper part of the larynx, the epiglottis, ary-epiglottic folds, and arytænoids are greatly swollen, and covered with superficial worm-eaten ulceration. The cords, as far as they can be seen, are normal. The voice is clear but weak. There is active phthisis at both apices with cavitation at the right.

At the first glance the condition of the fauces much resembles herpes.

Mr. Bowlby said the condition was not at all a common one, and described the case of a young man, æt. 24, who came to him complaining of a tickling cough and some trouble in the back of the throat, but was supposed to be otherwise in tolerably good health. The affection was well marked, though not so far advanced as in Dr. Lack's case. It appeared to be a case of miliary tuberculosis, and heralded a very considerable extension of the disease, from which the patient died in three months time.

Dr. Herbert Tilley described an identical case, that of a man æt. 65, which was under his care last year, and in which there was laryngeal tubercle as well. The condition extended right on to the hard and soft palate, the base of the tongue also appearing superficially ulcerated. After a short while the patient died. Before coming to the hospital he had been practically starved because of the pain in swallowing. Nothing relieved the dysphagia so much as orthoform, a little of which blown on his pharynx and palate enabled him to swallow anything given him with perfect comfort for some twelve hours after the application.

Sir Felix Semon spoke of a case he was at present treating for laryngeal tuberculosis in which orthoform was proving of great use. The maximum effect of the application, according to the patient, was experienced in an hour; it lasted for about three hours. The susceptibility of different patients to its influence seemed to vary. Orthoform was not poisonous, and in that respect more advantageous than cocaine; it could in an emergency be left in the hands of untrained people with impunity. Its effect was also more continuous. For the application to be effective there must, in his hitherto limited experience, be a breach of surface. In cases of simple infiltration he had so far found it had no effect whatever. It was a useful application in cases where only palliative measures could be adopted. It had been lately recommended in Germany as an excellent thing in vasomotor coryza; but in two cases in which he had tried it, it had been absolutely ineffective.

Dr. MacGeagh had also obtained good results from the use of orthoform in tubercular disease of the larynx, the effect lasting for two hours.

Dr. StClair Thomson said he had tried orthoform to relieve the dysphagia after removal of the tonsils, but with no success. The pain in that case seemed to be more traumatic.

Dr. LACK had found orthoform extremely useful in preventing the neuralgia which occasionally followed the dressing of wounds, as in the case of the mastoid or maxillary antrum when the cavity was packed.

CASE OF LYMPHO-SARCOMA (?) OF TONSILS.

Shown by Dr. LAMBERT LACK. The patient, a man æt. 46, has noticed a small swelling on the left side of the neck for six years. The swelling has been increasing ever since, but during the last twelve months it has grown more rapidly. Patient has always been subject to attacks of acute tonsillitis.

Present condition.—Both tonsils are enlarged, the left being very large, projecting beyond the mid-line, and very broad. It is firm, not densely hard, and is not ulcerated. There is a large, hard mass of glands in the anterior triangle on the left side, firmly fixed to the angle of the jaw and the surrounding muscles &c. A few small glands, also fixed, in a similar position on the right side. The left side of the tongue is paralysed and completely atrophied. The larynx is pushed over to the right. The pupils are unequal, the right being the larger. The man is in good health, has no pain, can swallow easily, and complains only of the swelling in the neck.

Mr. BOWLBY thought it a case of malignant disease, more probably lymphosarcoma than carcinoma, and that it was inoperable. The glands seemed to be more movable, rounded, and circumscribed, less hard, and causing less infiltration of the tissues and contraction around than in carcinoma. After a lymphomatous mass had existed for years it often took on more rapid growth, and in some cases was, in others was not, amenable to arsenic.

Mr. SPENCER said that the glands seemed hard and the infiltration of the hypoglossal nerve suggested that a good deal of the enlargement of the tonsil was secondary or inflammatory, and that there must be a deep-seated ulcer behind the tonsil which had extended to the glands. Unless it be the very malignant, infiltrating, and bleeding forms, lymphosarcoma caused a large tumour in the throat, and had been easily removed. It also generally occurred in women. From the infiltration of the hypoglossal nerve he should have thought the disease carcinoma.

CASE OF CYST OF THYRO-HYOID BURSA.

Shown by Dr. FITZGERALD POWELL. Patient, a man æt. 40, states that seven or eight months ago he caught cold, after which he

felt a small swelling on the outside of his throat which, after a time, completely disappeared, but on again catching cold the swelling returned and has gradually got larger ever since.

There is no tenderness on pressure and no pain and the tumour gives rise to no inconvenience.

On presenting himself at the hospital, a round, movable, fluctuating tumour, the size of a pigeon's egg, was felt to the left of the thyroid cartilage. It moved up and down on swallowing, and apparently was attached above to the hyoid bone.

I considered this to be a cyst of the thyro-hyoid bursa.

Mr. BOWLBY thought that, on account of its lateral position and its feel, it might turn out to be a cyst of the pyramid of the thyroid gland on the left side. Bursal cysts he believed to be more in the middle line. In the case of bursal cysts passing up behind the hyoid, it was better to leave them alone unless they caused much trouble. He was inclined to advise removal in the case of this laterally placed cyst, although it did not at present give much inconvenience.

Dr. PEGLER asked if members had met with successful results of operations in such cases.

Mr. BOWLBY said he had successfully operated on a patient who had been three times previously operated on for a sinus left after removal of a bursal cyst. He had seen other cases cured after operation, but they were certainly very troublesome.

Dr. FITZGERALD POWELL asked whether tapping or injecting should be employed when these cases were not operated on.

Mr. BOWLBY thought it would not be wise. The cyst should either be left alone or simply removed.

CASE OF LARYNGEAL ULCERATION.

Shown by Dr. FITZGERALD POWELL. Patient, a man æt. 23, complains that in December of 1898 he caught a severe cold in his throat, accompanied by cough and loss of voice, from which he had, however, quite recovered under treatment by his medical attendant.

In March, 1899, the loss of voice again occurred, and has continued to get worse up to the present. He says he has no pain or expectoration and no difficulty in swallowing. He has not lost weight or flesh, but, on the contrary, has gained both.

Laryngoscopic examination reveals considerable swelling and redness of the whole of the larynx, particularly the ventricular bands, cords, and inter-arytænoid region, the swelling extending

on to the under surface of the arytænoids themselves. The vocal cords are much thickened and irregular, and about the centre of the right cord is a dirty-looking greyish patch of ulceration and another at the posterior end of the left cord. The arytænoids are red in colour and are not œdematous.

There is no history or evidence of syphilis, and careful examination fails to reveal any tubercular disease in lungs or elsewhere. His voice has slightly improved under treatment by iodide of potassium and soothing inhalations.

Dr. HERBERT TILLEY thought the case was a tubercular one, and suggested that the patient's evening temperature should be taken for a fortnight. It was possibly true there were no physical signs in the lungs, but.in cases of tubercular disease of the larynx where physical signs in the lungs had been slight the evening temperature often gave a good clue as to the nature of the disease.

CASE OF PERVERSE ACTION OF VOCAL CORDS.

Shown by Dr. HERBERT TILLEY. Patient is a female æt. 23, of markedly neurotic temperament who sought hospital relief for loss of voice of five weeks' duration.

Inspiration was accompanied by laryngeal stridor, and every few seconds the patient made a curious barking noise which could be scarcely called a cough. Examination showed that the vocal cords were adducted during inspiration. The passage of a laryngeal brush through the glottis practically cured the symptoms.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

50TH ORDINARY MEETING, *May 5th*, 1899.

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

WILLIAM HILL, M.D., LAMBERT LACK, M.D., } Secretaries.

Present—33 members and 9 visitors.

The minutes of the previous meeting were read and confirmed.

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

Charles Heath, F.R.C.S., 3, Cavendish Place.

DISCUSSION ON ASTHMA IN ITS RELATION TO DISEASES OF THE UPPER AIR-PASSAGES.

The PRESIDENT in a few introductory remarks said that it had been decided to devote this meeting to a discussion upon "Asthma in its relation to Diseases of the Upper Air-passages." This subject in many respects was a purely medical one, and illustrated the importance of the laryngologist being not only a surgeon but an able physician. He was glad to announce that Dr. Percy Kidd had consented to open the discussion with the medical aspect of the case, and that Dr. P. McBride would follow, and treat the subject from the point of view of those who practised more especially in the diseases of the upper respiratory tract.

Dr. PERCY KIDD said: In accepting the invitation of the Council to

assist in opening the present discussion, I felt more than the traditional hesitation professed on such occasions from the conviction that there must be many members of the Society who have had a larger experience of the subject in certain of its aspects. But hearing that my task was to be shared with Dr. McBride I took courage, for I had the assurance that any deficiency on my part would be more than made good in his address. In order to promote discussion and not to occupy too much time I shall endeavour to make my remarks as short as possible, avoiding any attempt to discuss the literature of the question, and dealing mainly with matters of which I have had personal experience. According to the generally prevailing view, asthma is essentially a neurosis, in which the respiratory system is predominantly engaged, though reflex relations with other organs are often manifested. In speaking of asthma I refer only to what is commonly described as bronchial asthma, no mention being made of cardiac or renal asthma. It is well known that nasal symptoms, sneezing, hypersecretion, and obstruction of the nares, are not uncommonly met with in connection with asthma, and great attention has been devoted to this relation since Voltolini succeeded in curing a case of asthma by removing nasal polypi. The pathology of the asthmatic seizure is still somewhat uncertain, the theories most in favour ascribing the dyspnœa either to spasm of the bronchial muscles, or to vasomotor dilatation of the blood-vessels of the bronchi. A considerable advance in our knowledge was undoubtedly made when the close relations of bronchial and hay asthma became recognised, for a strong side-light was thereby thrown on the pathology of the asthmatic paroxysm. In view of the phenomena of hay fever one can hardly doubt that vascular dilatation plays a very important part in the production of asthma, whatever the influence of spasm may be, and the tenacious pearly sputum of asthma with its peculiar spiral threads is quite as easily explained according to this view as by the assumption of a special form of bronchiolitis.

To return to the subject of the relation of nasal disease to asthma. It appears to me that the frequency of this association has been much exaggerated, particularly by Bosworth, who says, to quote his own words, that " a large majority, if not all cases of asthma are dependent upon some obstructive lesion in the nasal cavity." It is assumed by this writer and others that nasal symptoms in asthma are invariably the result of some definite local lesion, and that asthma is a reflex result of the morbid condition of the nose. It cannot be denied that nasal symptoms may precede, accompany, or alternate with attacks of asthma, but the evidence forthcoming in support of the view that the two groups of phenomena necessarily stand in the relation of cause and effect is not altogether convincing. It cannot be said that there is anything characteristic in the nasal changes found in asthmatic subjects polypi, periodical swelling of the mucous membrane of the inferior turbinal and other parts, hypertrophic rhinitis, œdematous swelling over the cartilaginous septum, and various obstructive deformities, such as spurs and deviations of the septum. These conditions are common enough, and yet it is quite the exception to find them associated with asthma. According to my experience, the state

of the nasal cavity in asthmatic persons is generally substantially sound. The strongest proof of the influence of nasal disease upon asthma consists in the relief to the paroxysms of dyspnœa that sometimes follows surgical treatment of the nose.

In some cases (I should say, a very few) the amelioration is so marked as to suggest that the asthma was a reflex result of the nasal disorder. But in most instances any improvement that ensues is temporary and incomplete. If we remember what marked mitigation of the asthmatic seizures may follow an unimportant modification of drugs, a change of residence, or some powerful emotion, we shall be loth to credit any slight improvement to surgical operations on the nose. One of the worst cases of asthma I have seen obtained more relief from a course of compressed air-baths than from any other measure, including hypodermic injections of morphia. It is hard to resist the suspicion that the success of the compressed air-bath was largely due to psychical influences, and some of the apparent triumphs of nasal surgery are perhaps susceptible of a similar explanation.

To sum up my own experience. I have seen two or three cases of asthma associated with polypi, and in two of these removal of polypi was followed by manifest relief to the asthmatic condition. Unfortunately the patients were lost sight of, and their subsequent history is unknown to me. A moderate degree of swelling of the inferior turbinal, more particularly of its posterior extremity, was met with in a few asthmatic subjects. But in only one instance was there any noteworthy obstruction to nasal respiration, and except in the case of this patient, I have not felt justified in proposing cauterisation or removal of the swollen tissues. The patient referred to remains under observation and has been recommended to undergo appropriate local treatment, the uncertainty of the result *quâ* asthma having been explained to him. Periodical swelling of the inferior turbinal may have existed in some cases from the history of passing nasal obstruction given by the patients, but I have had no opportunity of verifying this surmise. I do not remember to have seen any instance of gelatinous swelling of the anterior septal region, or of any marked development of spurs, in this connection. No cases of asthma with adenoid vegetations in the naso-pharynx have come under my observation. Of localised areas of hyperæsthesia in the nasal cavity I have no experience to offer. It may seem that this account reads very like a confession of inexperience. But it must be borne in mind that the cases to which I refer presented themselves on account of asthma primarily, whereas asthmatics that apply for relief to specialists in the domain of laryngology and rhinology, are likely to comprise an unduly large proportion of cases of pronounced nasal disease. The clinical history of cases in which sneezing and other symptoms of hay fever alternate with, or are succeeded by, spasmodic dyspnœa may be regarded as supporting the reflex nasal origin of asthma; and the same view may be taken of asthma induced by the smell of the cat, horse, dog, powdered ipecacuanha, violets, roses, &c. But, as Semon and Watson Williams point out, where the attacks ensue on the inhalation of irritant particles like pollen and ipecacuanha, it is not impossible that asthma may be the result of a bronchial

rather than a nasal reflex, some of the fine powder reaching the lower air-passages as well as the nose. It is generally admitted that for the production of hay fever at least two factors are required, viz. an external irritant and a morbidly sensitive nervous system. Some writers consider that a further element, a pathological condition of the nasal mucous membrane, is also necessarily present, a statement which I cannot accept as correct for all cases. I am inclined to believe that too much is now-a-days expected of the nose, and the result is that the happy individuals that would be certified as possessing an ideally healthy nose are comparatively few. If rhinological examination is conducted according to this counsel of perfection, we need not be surprised that most if not all patients with nasal symptoms are found wanting.

The following conclusions appear to be justified. In some cases asthma is relieved by the removal of polypi, though the explanation of this effect is still very obscure. Hay asthma may sometimes be benefited by treatment of morbid conditions of the nose and naso-pharynx, an experience of which, at present, I can claim no personal knowledge. The prospects of improvement in such circumstances as in the case of polypi seem to be very uncertain, but in the presence of definite nasal stenosis local treatment is not only warranted but advisable. In the ordinary form of asthma uncomplicated by hay fever or polypi, nasal symptoms are not uncommon, but the nose is generally healthy and requires no local treatment, though a spray of cocaine is said to give relief in some cases. Here the nasal symptoms may be regarded as merely part of a general vaso-motor neurosis of the respiratory tract. The history of some instances of hay asthma, in which spasmodic attacks persist in the winter although the nasal symptoms are then in abeyance, shows how important is the neurosal element, quite apart from the existence of peripheral irritation of the nares.

Dr. McBride said: In addressing an audience of specialists it would be out of place—it would almost be an impertinence—to consider the relation of asthma to the upper air-passages from an historical point of view. The names of Voltolini, Hack, B. Fränkel, and many others will at once occur to you all as pioneers whose teachings have been of great value in calling attention to a connection which is admitted by all thoughtful physicians and specialists of to-day. Again, it would be equally out of place to ask you to follow me through the immense mass of literature which relates to reflex neuroses, of which asthma is probably the most important. This literature is in its main facts, no doubt, familiar to all here. As you are aware, it is abnormal conditions of the nose which have been most generally found to cause asthma, and it has seemed to me, therefore, best to begin my remarks with the heading—

Nasal Asthma.

The most generally known form is undoubtedly the variety which occurs in the course of hay fever and allied conditions. You are all familiar with the chain of events in these cases—the symptoms of coryza induced by the pollen of grasses and flowers, dust, and the like,

or more rarely by emanations from animals, chemicals, and a variety of other causes, followed in certain persons by asthma which differs in no respect from the affection as commonly described in our medical text-books. In this chain of events we have an illustration of nasal asthma in its most familiar form, and it is generally admitted that hay fever requires for its development a neurasthenic, or at least a neurotic condition which acts as a predisposing cause. Of course you are all aware that in a proportion of cases we find more or less marked abnormalities in the nasal passages, but I am quite sure that in a very large number of instances these parts are, excepting during the attacks, for all practical purposes normal.

I take it that the course of events is as follows: the specific irritant touches the mucous membrane, which, in order that the other phenomena may result, must be hyperæsthetic; erectile swelling then occurs followed by hypersecretion. In certain persons a reflex asthma is set up by the nasal irritation. It is well known that hay fever is to some extent dependent upon race, thus Anglo-Saxons are more prone to be affected than persons of other nationalities. It seems also to be influenced very materially by social position, for I presume that most of us have observed it either chiefly or entirely among the better or, shall I say, wealthier classes. Speaking for myself I have seen numerous cases, but with one or two exceptions they have always occurred in private patients.

A less common but still a relatively common form of nasal asthma is that which seems to depend upon the presence of nasal polypi. In these cases the nostrils are usually not completely occluded, so that the presence of the growths may escape observation unless attention be directed to this point. I have now seen a considerable number of people who suffered from asthma, and in whom nasal polypi existed. Where this combination occurs I consider that we may very reasonably expect to benefit the former by removal of the latter. It is somewhat difficult to explain why small polypi should be more liable to cause asthma than large growths, but probably the former being more mobile are for this reason more likely to irritate the mucous membrane.

In certain cases of hypertrophic catarrh and deviations, or outgrowths from the septum, we also meet with asthma which may be benefited by local treatment. Sometimes the pathological condition is obvious and so marked as to interfere with nasal respiration, and thus give rise to local discomfort. In such cases there can be no great difficulty in determining upon the proper line of treatment. In other instances, however, deviations from the normal are slight—so slight that perhaps we should not be justified in calling them pathological. Gentlemen, I know I am treading on thin ice when I say that we have as yet no satisfactory definition of a normal nose. We know very well what the anatomically correct organ should look like—the nasal septum should be straight and have no outgrowth, the middle and inferior turbinated bodies should be of a certain size, shape, and colour. This is the ideal, but we rarely find it, just as it is uncommon to find perfection elsewhere in this world. I have introduced this matter in order to lead up to the fact that we are often called upon to

make rhinoscopic examinations of asthmatics, and frequently find nothing, which if discovered in another person we should be justified in stigmatising as pathological. I think I may say without offence that rhinologists all over the world are divided into two classes. One holds that it is most desirable for a man's nose to be symmetrical, not only externally, which we all admit, but also internally. Gentlemen of this persuasion make it their business to straighten every septum which is not mathematically straight, to remove any excrescences which they find disagreeable to the examining eye, and finally to reduce the turbinated bodies to such size as seems proper to them. Those who belong to the opposite camp tend to limit treatment to cases in which the condition of the nose is such as to produce nasal symptoms appreciable as nasal by the patient. I fancy that most of us here hold with the second class, and I need hardly say that my own views are decidedly conservative with regard to nasal surgery. At the same time if these conservative views in their entirety be brought to bear upon nasal asthma they may prove misleading, and, moreover, if your patient falls into the hands of a nasal specialist who believes no nose normal, he may effect a cure where you have failed.

I do not wish to say that I have met with nasal asthma in an absolutely normal nose, but it appears to me that in some asthmatics nasal treatment is permissible and even desirable, where the conditions are such that on other grounds operative measures would certainly not be indicated. Thus, if the bronchial attack be preceded by sneezing and nasal hypersecretion, the application of the electric cautery may be beneficial, just as it is in some cases of hay fever, even if at the time of application the parts are fairly normal. I take it that in some of these cases this treatment is beneficial by destroying nerve-endings through which reflex vasomotor changes are produced, while in others good results are obtained by the formation of cicatrices, which bind down the erectile tissue and thus prevent swelling. I do not think, however, that in all cases the paroxysm is preceded by nasal symptoms, even where nasal treatment may do good. I have, however, found that in a considerable proportion of asthmatics there can be detected on the nasal mucosa spots which, when touched with a probe, produce cough. My experience has been that in almost every patient who shows this phenomenon, the application of the electric cautery to these sensitive areas will produce marked amelioration, amounting, in some instances, to a practical cure. These cough spots may be met with in any part of the mucous membrane, but are most commonly situated on the inferior turbinated body, while occasionally the reflex area may be encountered while passing a probe between a projection from the septum and the outer wall. I have said that I consider the presence of this reflex cough as an indication in favour of intra-nasal treatment, but I have not found that when it is absent such treatment is always useless, although in the one case we are entitled to express a conviction in favour of the probability of benefit, while in the other operative measures must be looked upon as more or less experimental so far as the asthma is concerned. I cannot help thinking that the clinical value of this symptom has been overlooked, although I have repeatedly

called attention to it for many years. In this connection a very interesting question confronts us, may it not be possible to benefit asthma in certain cases by applying the cautery to a normal nostril? The fact that we speak of a nasal reflex asthma implies that we admit something like the following chain of events: a stimulus travels from the periphery to a centre, and there sets up molecular changes, which result in a paroxysm of asthma. Observe we admit that an irritant applied to the nasal mucosa may effect molecular changes in a centre which is responsible for asthma. It almost follows as a carollary that we can influence this centre from the nose, and I very much question whether many asthmatics—even those with normal noses—might not be benefited by the use of the electric cautery, not as a destroyer of tissue, but as a counter-irritant.

It may, perhaps, not be amiss to glance for a moment at the prognosis of nasal asthma. I do not think it is ever safe to promise the patient a cure, because every thinking rhinologist will admit that the nose is rarely, if ever, the only cause of asthma. In cases of polypi, however, we can usually do much good by removal of the growths, and when we have the introduction of a probe into the nostrils followed by cough, the probability of benefit is much increased. In ordinary hypertrophic catarrh, and in the case of spines or deviations, the last-named symptom becomes of even more significance.

Asthma caused by other Parts of the Upper Respiratory Tract.

While nasal asthma is comparatively common, it is in my experience rare to have this neurosis produced by other parts of the upper respiratory tract. I am aware that cures have been reported after removal of enlarged tonsils and after destroying granulations upon the posterior pharyngeal wall, but I do not remember to have met with such cases myself. On one occasion only have I found asthma apparently cured by removing adenoids from a young boy. I have thought it well, thus, at the risk of appearing egotistical, to confine my remarks to an expression of personal experience and views. To discuss the subject by any other method would have occupied much time without any commensurate advantage.

In conclusion, I would venture once more to express my conviction that while the upper air-passages may be the exciting causes of asthma, its occurrence depends upon some individual predisposition. We can therefore hardly speak of cures by local treatment of the nose and throat without modifying the expression, and we must not forget to use such general remedies and modifications of regimen as have been found useful by physicians generally.

Dr. J. C. Thorowgood expressed his thanks to the Society for allowing him to be present as a visitor, and to be able to listen to such interesting papers, whose wisdom he admired. He thought with the last speaker that it was quite right not to promise the patient cure from asthma, and he remembered a case in which he had been consulted where, by following this plan, he had been able to prevent troublesome consequences. Speaking from his own experience, he

could not agree with Dr. McBride that asthma was not very often associated with adenoid growths; he had come across cases where the removal of adenoid growths had much mitigated the attacks of asthma, and in one case the patient had been almost free from asthma owing to the removal of these growths. He was quite convinced that there are certain areas in the air-passages which, when touched, give rise to paroxysms of asthma—this had occurred on the removal of polypi; one had to be particularly careful not to excite these centres in highly neurotic patients. In alluding to the effect of asthma on the circulation, he mentioned a case in which, other remedies having failed, chloral gave marked relief. Being a dilator of the vessels, theoretically chloral ought to answer if, as he believed, the asthma was due not to vaso-motor dilatation so much as to violent spasmodic contraction of the vessels.

Mr. WAGGETT believed that it was very seldom that a causal relationship between true spasmodic asthma and nasal disease could be established on a strictly logical basis. Although he had many opportunities of meeting with these cases he could remember but one instance in which the nasal origin of the trouble was proved with any real certainty. The case in question was that of a man of forty, who complained of distressing attacks of asthmatic character which had persisted for twelve years in spite of medical treatment. The attacks occurred at all times of the day but more particularly after lunch, and lasted about an hour or so. To quote the patient's own report: "They commenced with tightness amounting to severe pressure across the bridge of the nose; suffocating feeling about the throat, and apparent inward pressure from the ears. There was distinct tightness of the chest—very little wheeze—but difficult breathing with much effort to clear the throat; generally, too, there was dryness of the throat, and, on the whole, the feeling was that one would fall down." On examination a very large septal spur was found pressing tightly against the right inferior turbinate in its middle part, the nose, in other respects, being unusually patent. The spur was removed and the attacks immediately ceased. Eight months later the patient returned, stating that the attacks gradually recommenced about two months after the operation and were again very distressing. A large bony bridge was discovered stretching between the inferior turbinate and the site of operation. This was removed and the attacks at once ceased. Five weeks ago the patient reappeared, stating that the attacks recommenced about four months after his previous visit. A narrow bony bridge was again found in the former situation. This was removed and the patient reported himself as being, for a third time, relieved of his attacks. The general conditions of the patient as to occupation and place of residence had remained unaltered throughout the course of the case. On no occasion could an attack be induced by experimental irritation of the nasal fossæ. The interest of the case, which was one of diffuse neurosis embracing the symptoms of true spasmodic asthma, lay in the sequence of events, the cardinal point being the disappearance of the special symptoms on three occasions as a sequel to three almost identical intra-nasal operations. Even in this case a causal relationship between the neurosis and the

nasal lesion could not be absolutely established, as no evidence was forthcoming that the reappearance of symptoms coincided in point of time with the bridge formation. The speaker was compelled to believe that true nasal asthma was a rare disease, and inasmuch as it was often spoken of as an everyday occurrence, he thought it would be valuable if members would take this opportunity of furnishing statistical data.

Dr. MacIntyre (Glasgow) said, while he could fully understand the desire to obtain exact statistics we had to remember one difficulty. The patients who came back to us were very often those in whom the treatment had been unsuccessful, judged from the standpoint of being cured, whilst those that got relief were not so easily traced. Judged from every standpoint, however, he thought that from his own experience he could recall a few cases of which it would be justifiable to use the term cured. These were a very small minority, and, like others, his experience had been such as to induce him to speak of relief rather than cure where success was claimed for treatment. He thanked both gentlemen for the manner in which they had introduced the subject, knowing the difficulties in opening such a debate. On the one hand, while there might be over-enthusiasm and too great a tendency to surgical procedure, nevertheless the openers of such a discussion had a certain responsibility in presenting their views, because it was possible to throw such an amount of doubt upon the matter as to damp the enthusiasm and ardour of those who are inclined to investigate this difficult and as yet experimental branch of surgery. Further, it was exceedingly difficult before beginning the treatment of a case to give an exact prognosis, notwithstanding the fact that in a certain number of cases, as a matter of experience which could scarcely be conveyed in language, the surgeon felt more hopeful than in others. Asthma might be induced from an irritation of the nasal membrane, but other causes might exist in the same patient. He gave instances of the difficulty of arriving at a prognosis by quoting two cases in which patients had been sent for surgical treatment in the nostrils, and in one of which it was ultimately found that the irritation was due to a sarcoma at the base of the skull, and a second was ultimately traced to a neoplasm in the mediastinum. There was one point which had not been spoken of as yet, and that was the information which might be got from a study of the action of the diaphragm, which was not always the same in cases of asthma, but which could now be observed. At present he was engaged in a series of investigations not yet published bearing upon this, and it was not at all impossible that, in some cases at least, light would be thrown upon the subject by the differential diagnosis which might be got by means of the X rays.

Dr. Herbert Tilley said that his experience was very similar to Mr. Waggett's, and he thought that only a minority of cases of asthma would be found amenable to surgical treatment of the nose. Cases of inherited asthma had received no benefit from intra-nasal treatment at his hands, and his experience in these cases was, perhaps, larger than is usual, because both in his own and his wife's family asthma was an unfortunate constitutional legacy. He had recently operated on a young sister-in-law who had commenced her asthmatic

career—the paroxysms coming on at night or even in the daytime after violent exercise, *e. g.* cycling uphill or horse-riding. He removed a post-nasal growth, and later on the anterior ends of both inferior turbinates because they were producing marked nasal obstruction, and the patient was always suffering from sneezing fits and severe colds. Here was a case which seemed to be an excellent test case for intra-nasal treatment. It was now nearly two months since the treatment was carried out, the patient expresses herself as delighted with the comfort of free nasal respiration, but the asthma attacks are "about the same, if anything a little better, but the medicine (Potassium Iodide, stramonium and arsenic) keeps the attacks off as long as it is taken." He thought that such would be the experience of others in inherited cases, as also in gouty asthma; at the same time he would not deny that occasionally cases might be immensely relieved by intra-nasal treatment, on the same principle that epileptic attacks had been completely cured by removal of nasal polypi, but such cases would be a minority. The speaker described his own personal experience of asthma, which was typical of "place asthma," *i. e.* in certain parts of England he was almost sure to get an attack about 2 o'clock in the morning, the attacks lasting some two hours and then completely passing off. In London he was always free, and if returning from the country with an attack upon him, nothing produced such splendid relief as a journey by the underground railway. Recently going down the Channel he had had two severe attacks whilst in his cabin below deck, the attacks passing off immediately he went on deck. He considered his case was probably gouty asthma, as his father was a martyr to the latter disease. His asthma attacks were not preceded by any nasal irritation or catarrh, and in spite of the suggestion of his friends he scarcely thought it worth while at present to undergo nasal treatment. With reference to destroying the sensitive areas in the nasal mucous membrane referred to by Dr. McBride, he had almost discarded the galvano-cautery for this purpose, because trichloracetic or even glacial acetic acid seemed to possess more penetrative and permanent properties. The only cases in which he could consider he had *cured* asthma by surgical treatment were those in children where the disease was associated with large tonsils, post-nasal growths, and accompanying bronchial and nasal catarrh with much secretion—these were very favourable cases, but he could not say the same for cases of genuine spasmodic asthma in the adult.

In reply to Dr. MacIntyre Dr. Herbert Tilley said that he thought it was scarcely scientific in a test case to give iodide of potassium whilst surgically treating the nose, because they all knew what relief that drug alone would give.

Dr. Scanes Spicer considered that Dr. McBride had very judicially reviewed the question under discussion. On the present occasion he would desire to remark on two points mentioned in Dr. McBride's opening, *i. e.* (1) the word "experiment" as applied to a surgical measure; (2) the term "a normal nose." As to the word "experiment," the public is apt to be misled by ambiguous terms. The word experiment is ambiguous. Most persons regard it, used surgically, as equivalent to a vivisection or laboratory research, and as implying

something rash and risky—a kind of "kill or cure" procedure. This idea is widespread. The consequence is that a critic who describes a suggested procedure as "an experiment" tends to excite a prejudice against it and to prevent dispassionate consideration, whereas all the critic is justified in predicating is, that the procedure is not certain to "cure radically" every case—which, indeed, is true of all therapeutic measures. Unless, indeed, he desires to be understood as meaning by the word a procedure of which the result is sure and unvarying, as in a chemical or physical experiment. Since, then, the idea that any given surgical procedure is not an infallible cure for every case can be expressed in unambiguous English terms, and those not calculated to excite prejudice, the speaker thought that the use of the word experiment in clinical therapeutics was inappropriate and unwise, and should be discouraged. He regretted that it had, in this connection, crept into Dr. McBride's excellent book. With reference to "a normal nose" no definition had yet been agreed upon. Could any nose be called normal in which the patient was conscious of suffering or discomfort? Thus, although no spur, polypus, or other gross lesion might be found on examination, the nose may regularly be obstructed at night and cause insomnia, restlessness, &c., as a consequence of the nasal discomfort; that is to say, a nose which may appear normal during the day when patient is erect, becomes insufficient at night when he is horizontal. And here a protest should be entered against a widespread notion that spurs should be operated on *quâ* spurs and as deviations from a theoretical symmetrical ideal. Such a procedure should be strongly discountenanced. The correct indications for attacking a spur are: (1) that it acts as an impediment to the due physiological intake of air, with consequent alteration of normal air tension on the nasal mucosa and in the pneumatic accessory spaces; (2) that it is in abnormal contact with other intra-nasal structures, either permanently, or periodically on mucosa turgescence, and leads to irritative and reflex disturbances. Hence, a large spur may often be ignored if in a cavity otherwise roomy, whereas a small one in other relations and situations demands attention. It is this insufficiency of passage and presence of abnormal contacts which form the true criteria of interference. Hence, a nose which presents no obvious pathological changes, and may so be regarded in one sense as normal, is abnormal, if from arrested evolution its channels are inadequate to admit the air demanded by the organism of which it is a part. His own experience had convinced him of the positive and great benefits derived in many cases of "asthma" from thorough nasal treatment, which was not to be expressed in terms of polypi and galvano-cautery. A few patients were prepared to maintain they were cured, while the majority obtained great relief; but the speaker's cases were not, with very few exceptions, drawn from the class of fossil asthmatics which would gravitate to the chest physicians, and were in nearly all instances less confirmed cases of spasmodic dyspnœa, in which other troubles—usually nasal—were as prominent as the asthmatic condition.

Dr. P. Watson Williams (Bristol) reported one case in which intra-nasal treatment, in conjunction with general treatment, had

apparently resulted in practically a complete cure, as for three years the patient had been free from asthma. The patient came to him five years ago with constant asthma, which had persisted more or less for eighteen years. She was having at least two paroxysms every twenty-four hours, as they came on both day and night. The mucous membrane of the nose was very hyperæsthetic, but there were no particular spots of special irritability, nor did sneezing, cough, or asthma occur on probing. The mucosa over the septum and turbinals was œdematous, and to such a degree overlaid the middle turbinals as to be polypoid. The polypi were snared and the bases and surrounding sodden area cauterised. Violent attacks of paroxysmal sneezing alternated with the attacks of asthma, and the patient experienced marked temporary relief from the use of a cocaine spray. There was therefore good reason to believe that the intra-nasal irritation had a close connection with the asthma in this case.

We do not know for certain what is the actual condition of the bronchi in asthma, but it seemed to him that there is sufficient ground for believing that the paroxysm is due to excessive contraction of the bronchial muscular coat and of the bronchial arteries. He was unable to accept the view that it is due to vascular dilatation. Radcliffe Hall, cited by Walshe, considered the use of the bronchial muscular coat was by its "tonus" to counteract the effect of coughing. But is it not possible that it, like the alæ nasi and vocal cords, may rhythmically dilate and contract with deep inspiration and expiration, and that in asthma the normal "tonus" is heightened, and while imperfect *dilatation* occurs during inspiration, the *contraction* phase is excessive during expiration? There is expiratory, not inspiratory dyspnœa; consequently the air in asthma, and in bronchitis too, distends the chest. It is difficult otherwise to understand why dyspnœa is expiratory and the chest gets distended. If there be such a closely associated physiological action between the movements of the upper and lower respiratory tracts, we can readily comprehend how in some cases there seems such close interdependence in their *morbid* relationship.

When we come to discuss this relationship between intra-nasal disease and asthma, we are confronted at the outset by the difficulty in deciding what constitutes a morbid condition of the nasal passages. He had no manner of doubt that in a very large percentage of asthmatic patients the nasal passages present conditions which cannot be regarded as ideal, and when we have excluded all septal deflections and spurs, turbinal hypertrophies, polypi, general hyperæmias, &c., there will be only very few cases left to participate in the other very numerous intra-nasal defects which civilised humanity is heir to. Moreover, we have ample testimony that *removal* of these defects—especially, in my experience, removal of polypi and cauterisation of markedly hypertrophic turbinal bodies—will be followed in a very large proportion of cases by more or less prolonged amelioration, or even cessation, of asthmatic attacks. But it was very difficult to decide how far the nasal affection is the cause of the asthma, even in those cases in which intra-nasal treatment has proved successful in relieving the asthma.

When one bears in mind the association of asthma with various

neuroses and with gout and renal disease, the very *frequency* with which nasal disease is associated with asthma should make one suspicious that there was something more than simple cause and effect in their relationship. Dr. Watson Williams thought that most frequently the intra-nasal affections, such as hypertrophic rhinitis, water-logged mucous membranes, and perhaps even sometimes œdematous polypi (he took but little notice of minor septal deformities), are the *consequence* and not the cause of the asthma, and sometimes there may be no evidence whatever of their existence until after the asthmatic paroxysms have recurred for years. Yet such experience as he had had made him very unwilling to leave untreated any obvious intra-nasal defects in an asthmatic patient which could really be a cause of irritation or an embarrassment to nasal respiration; since the removal of any contributory factors towards the occurrence of the paroxysms, although they might not be the essential cause, will often materially aid our efforts in other directions to combat the disease, whilst occasionally the happy results that follow the intra-nasal treatment seem conclusive proof that therein lay the essential cause of the malady.

Dr. THEODORE WILLIAMS could recall one case of asthma cured by the removal of nasal polypi, but from the discussion which had taken place he gathered that the Society was not in favour of operating on the nasal cavities in order to cure asthmatic attacks, a conclusion of some comfort to himself, as he doubted whether he had recommended operations as often as he might have done. For the medicinal treatment of genuine spasmodic bronchial asthma generally, he found iodide of potassium in eight to ten grain doses three times a day combined with stramonium, henbane, or belladonna of great advantage, and if these failed, compressed air baths, such as were used at the Brompton Hospital, gave great relief.

Dr. W. PERMEWAN thought the distinction between "great relief" and "cure" was an extremely narrow one; cure was a large word, and not very properly used in a question of this kind. In the majority of cases relief was very great, and unmistakably the result of treatment was to give relief.

Sir FELIX SEMON: How long lasting?

Dr. PERMEWAN: Until necessity arose for further intra-nasal treatment. Of the variety of nasal diseases polypi were by far the most important, and he agreed with those who deprecated the indiscriminate use of the cautery. He thought that a normal nose, considered from a surgical point of view, was one which offered no point of attack to the surgeon. He believed that asthma was the result of a nasal condition, and that he was perfectly justified in healing the nose though he could find objectively nothing to attack. He emphasised the importance of respiration through the nose; if a patient's nose was blocked up with polypi, and he is unable to breathe through it; that is the factor which starts asthmatic paroxysms, and not a reflex centre. The speaker thought one was justified in promising the patient more than one could accurately say was the whole truth; this was an important element in dealing with neurotic patients; but of course this practice might be abused. There were two sides to this question—

the "practical" and the "scientific," and while the exact sequence of cause and effect might be open to criticism from the scientific side, from the practical side there could be no doubt as to the propriety of nasal treatment in cases of asthma.

Dr. DUNDAS GRANT thought that Dr. Theodore Williams ought to have been more impressed by the result of the first case he mentioned, where nasal treatment had been of such great service and might with advantage have been carried out at a much earlier stage. Dr. Grant thought the discussion was too pessimistic on the one hand and too sanguine on the other, and that the truth was far from these extremes. He then related the history of a case in his early practice in east London. The patient was a chronic sufferer from bronchial asthma, and a very remunerative client. He urged the removal of nasal polypi importunately; finally the man consented and was practically cured. He had seen the mere act of treating the nose for asthma make the condition for the moment worse though ultimately curing it. He had had a fair proportion of cases in which bronchial asthma had totally disappeared after nasal treatment. This was natural enough when one considered the class of cases likely to come into the hands of the nasal specialist. It was the duty of a physician, if treatment by drugs failed, to submit the case to the observation of someone accustomed to explore the nose, and capable of giving a reliable report as to whether or not an operation on the nose should be carried out. There should be a judicious combination of the medical and surgical treatments so as to give the patient a double chance of cure. Dr. Grant found the gouty diathesis well marked in a number of the cases which had been referred to him, an opinion confirmed by the beneficial effect of the administration of salicylate of soda, a drug which he thought might with advantage be more frequently employed in the treatment of asthma. The galvano-cautery in some cases acted beneficially by pinning down the turgescent mucous membrane, but its beneficial effect was often no doubt due to its action as a counter-irritant. After the application of the galvano-cautery he was in the habit of applying deliquescent trichloracetic acid, which appeared to him to diminish the inflammatory reaction. Antipyrin in a 4 per cent. spray reduced the swelling, but it was irritating and it ought therefore to be preceded by the application of eucain which acted, so far as anæsthesia was concerned, like cocain, and was in other respects freer from objection. Glycerine extract of supra-renal capsule applied in the form of a spray was often valuable as a vaso-constrictor.

Dr. CLIFFORD BEALE, in speaking of continued nasal treatment for asthma, described a case recently observed in which several operations had been performed from time to time until most of the interior of the nose had been removed. The attacks of asthma, relieved for a time after each operation, had regularly recurred. There was no evidence to show that the attacks arose from any sensitive point in the upper air-passages, whereas there were abundant morbid changes in the lower air-passages, which might equally well be assumed to be the starting point of a reflex spasm. In the heart, also, one might look for such causes. Some years ago he had a run of such cases. Four boys, all occupied in work that involved considerable heart strain, and all

about fourteen years of age, suffered from what appeared to be genuine asthmatic attacks, which were relieved by antispasmodic inhalations and rest. In these there was no reason to suspect any nasal reflex, but the attacks were far more likely to have found their origin in the over-strain of the immature heart. He quoted the observation of Dr. Moritz Schmidt to the effect that the nasal cavity if carefully searched with a probe might sometimes be found to present sensitive points, the irritation of which set up respiratory spasm. He thought that unless some definite evidence could be obtained that the source of irritation was in the nose, any operation except for the relief of obstruction was hardly justified.

Dr. WILLIAM HILL could not agree with the last speaker that it was "unjustifiable" to apply intra-nasal treatment unless a cough reflex was obtained; we had a plain duty to do the best we could for our patient, who rightly expected us to try not only every medical means, but also every surgical procedure which held out a reasonable chance of affording relief. A cure, in the strict sense of the word, could not, of course, be promised, nor often even expected, but a fair measure of relief, amounting in some instances to a practical cure, might, in his experience, be looked for in considerably more than half the cases where asthmatic symptoms were associated with obvious disease in the nose. If practitioners neglected intra-nasal treatment because they could not promise their patients an absolute cure, they not only ran the risk of being scored off by more enterprising neighbours, but, what was more serious, they laid themselves open to the charge of not having done their duty and their utmost for their patient. It was necessary to speak thus strongly because he feared that visitors at this debate, especially physicians who did not practice rhinology, would take away a very wrong impression of the attitude and experience of those who had dealt with a considerable number of cases of asthma with associated nasal disease. Not only was it necessary that a thorough examination of the nose should be made, in order that nothing abnormal might escape observation, but if intra-nasal treatment appeared to be indicated it was essential that this should be carried out in a very thorough way. Half measures were worse than useless, as they not only either failed to relieve at all, or led to early relapse, but unfortunately brought undeserved discredit on what was often a valuable remedial measure. He could not agree with Dr. Kidd's conclusions, but it was easy to understand difference of opinion here, as that physician, whose experience of asthma in general was large, frankly admitted that he had seen and treated very few cases indeed where there was a co-existing nasal factor. He desired to associate himself with the views of Dr. McBride, who had admirably summarised the scientific and clinical aspects of the subject, and whose practical suggestions on treatment all would do well to follow. Dr. Hill had not himself tried intra-nasal cauterisation where there was no obvious morbid condition in the nose, but he had made a note of what the opener of the discussion had said on that subject. In conclusion he thought he was considerably below the mark in asserting that marked relief might be expected in 50 per cent. of cases of asthma *plus* nasal disease, provided the nasal treatment was carried out with requisite

thoroughness; overlooking a small morbid area might make all the difference. He had no doubt it was our duty to advise our patients to submit to these surgical procedures, which were, after all, not formidable ones.

Sir FELIX SEMON, in a short historical retrospect, referred to the publication by the late Prof. Hack in 1884, entitled "Radical Cure of Hay Fever, Asthma, &c.," in which that author endeavoured to establish the existence of an intimate connection between affections of the nose and asthma. Long before that time, however, cases had been noted by good observers, such as Voltolini, Bernhard, Fraenkel and others, in which the mere removal of nasal polypi, not undertaken with any view to cure co-existing asthma, had been followed by that result, *i. e.* the asthma attacks—which had formerly been very troublesome, either entirely disappeared, or became less intense after the removal of the polypi—returned or became intensified with the recurrence of the polypi, and improved again after renewed removal. This was a very clear proof that asthma may be positively produced from the nose, and it was certainly a grave fault to altogether deny such a possibility. Nor were nasal polypi, although in the speaker's experience by far the most obvious, the only cause of nasal asthma; other forms of nasal obstruction could produce this effect, such as great tumefaction of the nasal mucous membrane, considerable deviation or excrescences from the septum, &c. In no class of cases, however, was the connection more clearly established than in cases of nasal polypi. In the speaker's experience, relief might be given by nasal treatment in such cases,—occasionally even when the asthma had been in existence for a long time, although the number of cases of the last-named category in which he had obtained satisfactory results was extremely small. Altogether the number of cases in which a short-lived success had been obtained was in his own experience infinitely greater than the number of those in which a long-lasting relief had been afforded. He himself had never been able to produce an asthmatic attack from the nose by exploring that cavity with the probe. In one single instance only had he been able to produce very violent paroxysmal cough by that method of investigation. With such experiences, he asked himself, what was one to tell a patient in whom asthma existed together with nasal disease? They had heard that afternoon diametrically opposed opinions in reply to that question. He invited them, however, to consider the enormous number of cases of asthma that had been treated since Hack's publication by intra-nasal interference. How small in proportion to these had been the number of those cases in which a real cure or, at any rate, a long-lasting improvement had been seen even by the warmest advocates of that treatment! In view of that fact, was one justified in promising any definite success to a patient? And what had struck him most in this discussion was that no mention had been made of those, in his experience most frequent cases, where *no results had been obtained at all!* Personally he divided these patients into three classes: (*a*) Lasting success obtained, exceedingly small percentage; (*b*) Temporary benefit, comparatively large percentage; (*c*) No success at all, very large percentage. Now considering that he had

to frankly confess that he was himself unable to make out beforehand, by any method of examination whatever to which of these three classes the individual patient would ultimately belong, what was the treatment in such cases but an "experimental" one? He stuck to this word most emphatically. He was in the habit of telling those patients suffering from asthma, in whom considerable nasal abnormalities existed: "Undoubtedly in a number of cases such as yours, in which the nose is treated, relief has been obtained; whether in your own case relief will be permanent or temporary, or whether there will be no relief at all, I cannot tell you beforehand. If your suffering are great, and if you should like to undergo this treatment, I consider your case a legitimate one for it, but you must understand that it is purely experimental." He had not found that his patients misunderstood so simple a statement.

Dr. StClair Thompson suggested the addition of a fourth class to Sir Felix Semon's classification, viz. those who were considerably damaged by the intra-nasal treatment. He had met these cases, who had suffered from a too forward policy of the nose and throat, at foreign health resorts, trying to get back their lost mucous membrane. He thought that in some cases of asthma the nasal conduction may be causal, but in many cases it was consequential.

Dr. Lambert Lack thought the undoubtedly frequent relation of asthma to nasal disease was not a simple reflex. He was very surprised to hear Dr. McBride's statement, on which he laid particular emphasis, that an irritant applied to the nasal mucosa may effect molecular changes in a centre which is responsible for asthma. In his experience he had never met with a single case in which irritation of the nose, as by probing, had produced an asthmatic attack, and he would much like to know if any other member had met with such a case. Dr. Thorowgood and others who supported this theory quoted instances in which cough had been produced. This Dr. Lack thought a not very uncommon result of nasal irritation, but he could not admit that a true asthmatic attack could be experimentally excited in such a way. He could add one case to those which had been cited, in which asthma was closely related to adenoid growths. The patient was a child, the subject of inherited asthma and gout. Removal of the adenoids was followed by complete freedom from asthmatic attacks; eighteen months later the asthma returned, and on examination there was found to be recurrence of the adenoids with nasal obstruction. Operation for the relief of the nasal obstruction was again followed by complete cessation of the asthma.

The President said they might be reasonably satisfied with the result of this discussion, which was of great interest; to a certain extent, the atmosphere was clarified. They had heard extreme views from both sides—those who thought no good was to be obtained, and those who believed that most benefit is derived from the adoption of intra-nasal treatment. Personally, he took the middle course, and he was quite certain that he had seen in a very fair proportion of the cases considerable and permanent relief; he mentioned the case of a lady whose polypi had been removed, and who had spent the winter in the Riviera, who had severe asthma, from which she had been

practically free for the last year. He thought they would all agree with the remark made by Goodhart that the "chronic asthmatic was almost as hard to cope with as the chronic epileptic," and they must not expect to work miracles or they would be disappointed. They should look to getting hold of the cases at an earlier stage, when relief is more easily given, especially in the case of adenoids.

Dr. PERCY KIDD said that his remarks had been misunderstood in some respects. He said that if there was obvious disease of the nose, local treatment was advisable, though the uncertainty of the result as regards the asthma should be clearly explained to the patient.

Dr. MCBRIDE said that owing to the kind reception his remarks had received, there was little left for him to reply to. With regard to the question of adenoids and asthma, he said that he had often seen cases where the patients were said to be asthmatic, but on inquiry it was generally found that the difficulty in breathing was due to the local causes. He had, however, on one occasion, as mentioned, immensely relieved a truly asthmatic child by removing adenoids. Questions had been asked as to the cure of asthma, but he considered that asthma, like epilepsy, could hardly be considered cured so long as the patient lived. He mentioned several cases illustrating the fact that asthma can be much benefited by local treatment of the nose, both in polypi and hypertrophic conditions. With regard to Dr. Beale's remarks, he begged to observe that he had never seen asthmatic paroxysms produced by touching the mucous membrane, but he would again refer to the great importance to be attached to the presence of a cough reflex in cases of suspected nasal asthma. With regard to Dr. Theodore Williams' remarks, Dr. McBride thought that they showed that laryngologists must be singularly devoid of the power of expressing their meaning clearly—it would not, of course, be proper to suggest another alternative. He failed altogether to see how Dr. Williams could have arrived at the conclusion that most of the speakers thought local treatment useless in asthma, and it would be a thousand pities that his remarks should be published as a serious contribution to the debate. Dr. McBride had no doubt that his words were spoken in jest, but every reader of the report might not be aware of this. With regard to Dr. Lambert Lack's criticism, he would refer him (1) to the fact that reflex nasal asthma was generally admitted to exist; (2) to the experiments of Lazarus which had been confirmed by Sandmann. It has thus been shown that irritation of the nasal mucous membrane can produce spasm of the bronchi and that such spasm ceases after section of the vagi.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

51ST ORDINARY MEETING, *June 2nd*, 1899.

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

WILLIAM HILL, M.D., LAMBERT LACK, M.D., } Secretaries.

Present—32 members and 5 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentleman was unanimously elected a member of the Society:

Charles Heath, F.R.C.S., 3, Cavendish Place.

The following cases and specimens were shown:

CASE OF UNILATERAL PARALYSIS OF PALATE, PHARYNX, LARYNX, &C.

Shown by Dr. HERBERT TILLEY. The patient, a female æt. 29, had been complaining of hoarseness and dryness of throat with difficulty of swallowing for three months. There was an accumulation of saliva in the throat and some difficulty of swallowing solid food, and occasional regurgitation of fluids through the nose. Patient had probably had syphilis. Exami-

nation showed the left half of the soft palate, left half of the pharynx, and left vocal cord paralysed, the last being in the cadaveric position.

Sensibility was much diminished on the paralysed parts. The upper part of the left trapezius and the left sterno-mastoid showed unmistakable signs of commencing degeneration. There was no paralysis of the tongue or the facial muscles, and no evidence of any other cranial nerves being affected.

The exhibitor remarked that during the past four months he had met with four similar cases, and these tended to prove clinically, what Horsley and Rethi had shown experimentally, that it was the spinal accessory nerve which innervated the muscles of the larynx, the pharynx (partly), and the soft palate.

A Case of Disseminated Sclerosis with Paresis of Left Half of Soft Palate and Larynx, and a Case of General Paralysis with Paresis of Left Half of Larynx.

Shown by Dr. Jobson Horne.

Dr. Permewan asked what was meant by "general paralysis" in these cases. Did it mean "general loss of power"?

Sir Felix Semon would not have used the word "paralysis." A point of great interest in Dr. Horne's case was the nystagmus-like movements of the left vocal cord; abduction was separated into three distinct movements. He thought this a very interesting phenomenon, of which he was unable to give any elucidation; it might be a lesion below the fourth ventricle.

Dr. Jobson Horne said by general paralysis was meant general loss of power.

A Specimen of Larynx blocked by a Mass of Papillomatous Growth from a Boy aged Eleven.

Shown by Dr. Permewan. Six years ago, while the patient was under the care of Mr. Murray at the Liverpool Infirmary for Children, Dr. Permewan had seen him and removed some growths with the intra-laryngeal forceps. The dyspnœa still continuing, Mr. Murray performed thyrotomy, removed the

growths, and cauterised the base of them thoroughly. This was followed by much relief, but three years later the symptoms had recurred, and the operation was repeated, again with relief. In April of this year he was admitted into the Northern Hospital with evident signs of growths, but with no apparent urgency of symptoms; he was, however, found dead one morning, evidently from asphyxia. On post-mortem examination the larynx was found almost completely blocked by a large mass of papilloma as shown.

Dr. Permewan thought the point to be emphasised here was the fact that two complete thorough operations had failed to cure the case; he doubted whether thyrotomy was any more radical in its effects than the repeated removal by intra-laryngeal methods, difficult though that might be in young children.

The PRESIDENT suggested that a discussion might at some time be devoted to the treatment of these cases.

Dr. POWELL asked if tracheotomy was performed on this case.

Dr. PERMEWAN said that tracheotomy was done (before he had seen the patient) six years ago for urgent symptoms. The case showed too clearly the great tendency of these papillomatous growths to recur after complete removal. He thought it was better not to perform indiscriminate thyrotomy.

SPECIMEN OF LARYNX FROM A CASE OF PERICHONDRITIS.

Shown by Dr. PERMEWAN. The patient was admitted into the Liverpool Southern Hospital under Dr. Cameron in September, 1898, having been ill six weeks. There was then much cough and dyspnœa, which necessitated tracheotomy. The epiglottis and ary-epiglottic folds were much swollen, and the larynx externally measured $2\frac{3}{4}$ inches across. There were enlarged and painful glands on both sides of the neck, particularly the right side. The diagnosis lay between malignant disease and perichondritis of the thyroid cartilage; the lungs were healthy, but there was chronic bronchial catarrh. There were no tubercle bacilli in the sputum.

After some time the glands began to soften and break down; an abscess formed on the right side, and was opened, and bare cartilage found at the bottom of it. This was repeated two or

three times, and a small bit of cartilage came away. The laryngeal symptoms became less marked and more favourable, but six weeks before death he began to complain of pain in the lumbo-sacral region of spine. This was rapidly followed by angular curvature, followed by paraplegia, paralysis of the rectum, and bleeding, from which he died.

Larynx shows necrosis of thyroid cartilage, but no growth. No examination was made of the spine.

Case of Parathyroid Tumour causing Symptoms of Malignant Disease of the Larynx; Operation and Recovery.

Shown by Mr. de Santi. Patient, male æt. 58, sent to me by Mr. Eliot, who stated that he had been persistently hoarse for ten months, had a brassy cough and some stridor. Dr. Mitchell Bruce could find no chest affection to account for it. There was no pain or dysphagia, no expectoration, and no loss of flesh. Patient denied syphilis.

There was found very impaired mobility of right vocal cord and marked limitation in abduction. The right cord was uniformly red and somewhat swollen; there was no ulceration or neoplasm visible. No glands to be felt in the neck; old scarring of right face and cheek suggestive of old syphilis. Voice very hoarse and feeble. I considered it most probable that the case was one of early malignant disease of the larynx, with an alternative of syphilis or mediastinal tumour pressing on right recurrent laryngeal nerve. I ordered rest of voice, no smoking, and iodide of potassium.

In September, 1895, the patient's voice was almost a whisper. He had gone downhill rapidly, having lost much in weight. The right carotid artery pulsated visibly, and seemed pushed forward by a smallish, indefinite, probably glandular swelling deep in the neck, and about the level of second or third ring of trachea.

In December, 1895, the swelling in the neck was smaller, the voice better, the right vocal cord a little more moveable, and there was a gain in weight.

During 1896 the patient was in very fair health, had gained

weight; the voice, though hoarse, was stronger, and the swelling in neck moveable, softer, and more defined; the right vocal cord was *in statu quo*.

In February, 1899, patient had an attack of flatulence and dyspepsia; this was shortly followed by difficulty in swallowing solids, and later liquids. He lost flesh rapidly, half a stone between February 6th and March 29th. At the same time a very marked increase in the size of the cervical swelling was noted. There was regurgitation of food, and sensation of blockage at level of cricoid cartilage.

Examination of larynx showed right vocal cord more fixed, but otherwise the same. I passed a No. 18 œsophageal bougie, and met some considerable obstruction about level of upper part of sternum; no blood or pus on withdrawal.

The lump in the neck felt to be the size of a Tangerine orange. It seemed elastic, and not stony hard. I took a grave view of the case, and advised exploratory incision in the neck, as I considered from the whole course of the events that the main trouble was extra-laryngeal.

An incision was made over the anterior border of the right sterno-mastoid down to the level of the sternum and a large tumour exposed, situate in the lower carotid triangle, extending down to and under the upper part of the sternum. By careful dissection this tumour was gradually defined; I found it distinctly encapsuled, the carotid artery and jugular vein were pushed far over to the outer side: the whole tumour was very vascular. I eventually clearly isolated it, the chief difficulty being with the right recurrent nerve, which was attached to the tumour and flattened, and with the inferior thyroid artery; the right innominate and part of the left innominate vein were exposed, as the tumour was partly substernal. The œsophagus was seen to be distinctly compressed by the tumour; the latter had no connection with the thyroid gland, but there was some fibrous infiltration of the œsophagus opposite the seat of pressure.

A cross cut and partial division of the sterno-mastoid had to be made to thoroughly get at the tumour. The right dome of the pleura, the right phrenic nerve, and the right subclavian artery were seen at the time of operation.

Recovery was uneventful, and swallowing powers improved almost at once.

Microscopic sections show the tumour to be of the nature of parathyroid tissue and essentially innocent. The growth itself is completely encapsuled, and there is a large cyst in the centre.

The case seems to be of great interest. At first everything pointed to early malignant disease of the right vocal cord—the age of the patient, the uniform redness and impaired mobility of the cord, the hoarseness, and later the presence of a lump like a gland externally; on the other hand, time proved the trouble not to be intrinsic carcinoma. Later on, *i. e.* in February, 1899, everything again pointed to malignant disease, though more of the neck than the larynx.

Though the microscopic appearances are those of innocent tumour, I am still inclined to think that the tumour was commencing to become malignant, for the clinical course of sudden and rapid increase in activity in a man of sixty-two, of a tumour anywhere which may have remained dormant even for years, is always very suspicious, and I consider clinical evidence more important in such cases than microscopic evidence.

Case of Complete Paralysis of one Vocal Cord and Impaired Abduction of the other.

Shown by Dr. StClair Thomson. This patient, a boy æt. 17, was said to have been hoarse since his voice changed at the age of fourteen, and it was therefore to be presumed that the laryngeal condition had existed for three years. The condition is sufficiently described by the title of the case. There is nothing in the boy's neck, chest, or nervous system to explain the cause of the paralysis. The exhibitor suggested influenza as a possible cause, and wished to know if others had seen cases at this early age.

Dr. Permewan had had three cases of paralysis of the right vocal cord, of which he was not able to discover the cause; possibly it was due to disease of the top of the pleura. He did not agree with the other part of the title, viz. "impaired abduction of the other cord;" from his own view, it moved quite freely. Dr. StClair Thomson's suggestion of influenza ought to be taken into account. He had a

patient who suffered from influenza and had recurrent paralysis, which remained for some weeks. The patient then became convalescent and got well again.

Sir FELIX SEMON said he had seen several cases of laryngeal paralysis after influenza, amongst them those of two medical men who both got well in a short time. With regard to Dr. StClair Thomson's question as to the age of these cases, he had seen loss of abductor power in patients of one and a half to five years of age.

The PRESIDENT remembered seeing a case with Sir Felix Semon, which almost completely recovered; he had also reported to the Society a case of double abductor paralysis in a child of six.

Dr. STCLAIR THOMSON said he had shown a case undoubtedly due to influenza, which had cleared up between the announcement and the patient's appearance at the meeting, but in that case the patient had had the paralysis only six months, whereas in the case under notice the disease was of three years' standing.

CASE OF LARYNGEAL ULCERATION WITH CALCIFICATION OF THE FASCIA OF THE NECK.

Shown for Mr. CHARTERS SYMONDS by Mr. STEWARD. The patient, a woman æt. 32, complained of loss of voice and difficulty in breathing, and gave the following history.

When a child she had an abscess on the right side of the neck, and at about the same time she became deaf.

About ten years ago swelling and stiffness of the neck began, and this has gradually increased since that time.

The present attack of hoarseness commenced three months ago. The patient is very deaf, the skin is pallid, the bridge of the nose is broad and flattened. The eyes and teeth are normal. Just behind the angle of the jaw on the right side is a large scar. The whole of the structures in the front of the neck are hard and matted. There is great thickening around the hyoid bone and thyroid and cricoid cartilages, and these structures appear to be united into a dense hard mass.

There are several enlarged glands in the submaxillary region, and lower down in the neck are several very hard nodules, one particularly hard being situated in the right sterno-mastoid muscle. The soft palate and pharynx are much scarred, and are adherent to one another.

The upper opening of the larynx is red and swollen, and there is ulceration on the right ventricular band.

Sir FELIX SEMON said that he had a strong suspicion that this case was specific. The configuration of the patient's face and the large distance between the eyes pointed to congenital syphilis. With regard to the pharynx, the adhesions are very characteristic of either tertiary or inherited syphilis.

Dr. WILLIAM HILL said that Mr. Symonds was doubtful as to the correctness of the term "calcification." To him it seemed to be an extensive line of scars rather than calcification.

Mr. STEWARD said that the whole thing might be syphilitic. There was considerable swelling on the right side of the larynx, loss of voice, and troublesome dyspnœa, which was steadily getting worse in spite of calomel baths and doses of iodide of potassium for three weeks.

CASE OF SLOUGHING ULCERATION OF THE PHARYNX.

Shown by Mr. STEWARD for Mr. CHARTERS SYMONDS. Male æt. 31, has always been healthy till nine months ago; has no history of syphilis.

At the end of October, 1898, patient had a thick discharge from the nose, with headache and pains in the back. Shortly after this a hard round lump appeared below the left ear, and a similar lump soon appeared on the right side. These were followed by other lumps, which coalesced to form large swellings. Later the tonsils were enlarged, and a large ulcer with yellow surface appeared on the left one, and soon afterwards the right tonsil became similarly affected. The left tonsil healed, but the swellings in the neck steadily increased.

When first seen on December 11th, 1898, there was a large ulcer involving the lower part of the right tonsil, and extending on to the base of the tongue. The ulcer was covered with yellow slough, and the edge was hard, raised, and indurated. There were also large masses of swollen glands on each side of the neck; some of these were soft and fluctuating, others quite hard.

Patient was ordered iodide of potassium in increasing doses, and for a time improved.

On March 9th the ulcerations had considerably increased, as had also the swellings in the neck. Small hard glands were found in the left axilla and right groin. Calomel vapour-baths were ordered in addition to the potassium iodide, and on March

14th the ulcers were curetted, and then cauterised with nitric acid.

After this considerable improvement took place and the throat nearly healed, but early in May a relapse occurred, and spread of ulceration took place.

On the 9th several softening glands were opened and curetted, and one was removed; the throat was also again curetted.

The softened glands contained a semi-fluid material of yellowish-brown colour. Microscopically the excised gland showed caseating foci and a small-celled infiltration, but no definite evidence of tubercle.

Mr. Cresswell Baber said that in his opinion the case was syphilitic.

Sir Felix Semon thought there was little doubt it was a case of lympho-sarcoma, and advised the administration of arsenic. He had seen three or four such cases in which tumours had formed and disappeared almost entirely; suddenly they would appear again and assume a serious form. He always treated them by increasingly big doses of arsenic.

Mr. Steward said the man had been treated with large doses of iodide and mercury, but had not had arsenic. It might be of interest to mention that the man had several glands in the right axilla and in the left groin. As regards the examination of the stuff from the opening in the neck and gland, the view of lympho-sarcoma was supported. Under the microscope was seen a mass of small round cells, with fair-sized nuclei, and there were caseous foci in the gland itself. No tubercle bacilli were found.

Dr. William Hill thought if the suggested arsenic treatment was of no avail it would be well to try electrolysis.

Tumour of the Nasal Cavity.

Patient and specimen shown by Mr. Cresswell Baber. A female æt. 66 came as out-patient on March 17th last, complaining of right nasal obstruction since the previous summer. She had also had a sore throat and pain in the right ear. No deafness. A large polypus was snared from the right nostril. On April 7th a polypus was felt in the right choana with the finger, and snared from the front. April 14th.—Right side still much obstructed, also much muco-purulent discharge. Posterior rhinoscopy, with the aid of the palate-hook, showed a red

growth in the right choana; two more pieces of reddish, friable growth snared from the front. May 1st.—On palpation, a small mammillated moveable growth was felt in the right posterior naris. May 2nd.—The growth could be just discerned from the front, and was moveable, but whether it grew from the inferior turbinated body, or from the outer wall of the nasal cavity, could not be ascertained—it was not attached to the septum. Transillumination on April 21st and May 2nd showed both infra-orbital regions light. No enlarged glands.

The growth removed on April 14th was reported on by the Clinical Research Association as "columnar-celled carcinoma arising from the nasal mucous membrane." I decided to take steps to lay the disease freely bare, so that its extent could be more clearly seen, and, if necessary, a radical operation performed. With this object, on May 6th I removed, under general anæsthesia, the growth in the posterior naris with the spoke-shave, and subsequently the inferior turbinated body with the same instrument. The outer wall of the nasal cavity was then freely curetted with a large sharp spoon. Afterwards, on inserting the little finger into the nasal cavity, I could feel that there was an aperture into the antrum, probably the result of the curetting. The growth was soft and irregular. The patient recovered from this well, and has been kept carefully under observation.

Her present condition—more than three weeks after the operation—is as follows:—There is some dirty-looking, fœtid, muco-purulent discharge coming from the right nasal cavity. In consequence of the removal of the inferior turbinated body the nasal cavity can be easily inspected. The only sign of the growth is what looks like small, rather vascular roots of mucous polypi, between the lower margin of the middle turbinated body and the outer wall. No growth seen by posterior rhinoscopy, though there is a red spot on the margin of the right choana at its upper outer part, where the last growth may have sprung from. Still plunging pain in the right ear. Both antra light up on transillumination, but the right seems a shade darker than the left. Possibly some of the discharge may have got into the antrum.

Mr. Baber asked the opinion of members as to the malignancy

of the growth, and the advisability of further operative measures.

Dr. PEGLER thought that the growth was not malignant; one corner of the slide showed doubtful-looking cells, but not characteristic of carcinoma. He suggested the specimen should be referred to the Morbid Growths Committee.

Dr. WILLIAM HILL asked whether it was ulcerated on the surface, and if there was any hæmorrhage before operation. It was not possible to make a diagnosis, as the sections did not go to the root of the tumour.

Mr. BABER said Mr. Butlin had seen them, and thought the case was one of carcinoma.

Dr. WAGGETT said it would be a valuable section to have in the cabinet for reference in subsequent years.

Mr. BABER said he would do no further operation unless there was a recurrence.

The PRESIDENT moved that the specimen be referred to the Morbid Growths Committee. This was adopted.

SPECIMEN OF EPITHELIOMA OF ŒSOPHAGUS CAUSING BILATERAL PARALYSIS OF VOCAL CORDS.

Shown by Dr. CLIFFORD BEALE. L. H—, æt. 33, female domestic servant, admitted January 13th, 1899, for cough and muco-purulent expectoration of long standing, with some dysphagia and occasional dyspnœa. The patient was a good deal emaciated, and complained of recent acute tenderness of the left side of the thyroid. Some swelling and tenderness was present. On examining the larynx the vocal cords were seen to be normal in appearance, but lay during normal and forced respiration in the cadaveric position. On phonation they were brought together, and a fair volume of sound was produced. While under observation in hospital many attacks of adductor spasm occurred, and the voice gradually got feebler until it was lost altogether. The sensation within the larynx was unimpaired. Tracheotomy became necessary and gave immediate relief. Dysphagia increased especially for solid food, and it was noted that fluids and sometimes solids were occasionally regurgitated through the tracheotomy tube; and hence, after a short period of rectal feeding, gastrostomy was performed, and the patient was fed directly into the stomach for the five weeks pre-

ceding her death. The constant welling up of muco-pus from the œsophagus, and the occasional regurgitation of the food in the stomach, led by slow degrees to a septic broncho-pneumonia, which was the immediate cause of death on April 12th, 1899.

The specimen showed infiltration of the mucous membrane and submucous tissue of the œsophagus by a cancerous growth. The growth began below the level of the larynx, and extended for about two and a half inches downwards, embracing the whole lumen of the tube. At the anterior part a perforation communicating with the trachea was visible. The œsophagus above and below the growth was healthy though somewhat engorged. The thyroid body was enlarged and thickened in both lobes, being exceedingly tough and fibrous on section. The trunk of the vagus was seen to be compressed, together with the vessels, on one side, while the recurrent laryngeal nerve could be traced into the body of the thickened thyroid gland on the other side. No other cancerous growth was discovered in any part. The growth in the œsophagus was a typical epithelioma.

Case of Unusual Pharyngeal Tumour.

Shown by Sir Felix Semon. The patient, a female, was shown at the March, 1898, meeting of the Society, and was now again brought forward to show that the condition remained absolutely *in statu quo.*

Dr. William Hill asked Sir Felix Semon to explain why he took such pride in keeping this tumour.

Sir Felix Semon had the greatest pleasure in answering that question; he did not feel justified in doing anything because he did not know what the growth was or how far it went. That it was intimately connected with the vagus he suspected because the least pressure caused coughing and retching; meanwhile it caused the patient no inconvenience whatever.

A Case of Stricture of the Larynx following Tracheotomy for Diphtheria successfully treated by Dilatation.

Shown by Dr. Lambert Lack. The patient, a child æt. 6, had

tracheotomy performed for diphtheria one year ago. Three months later, it being impossible to remove the tube, an exploratory thyrotomy was performed by Mr. Stanley Boyd, and an ulcer of the larnyx with much granulation tissue, almost completely obstructing the lumen, was found just below the vocal cords. The granulation tissue was removed and the wound allowed to heal. Attempts were then made to dilate the stricture of the larynx by intubating with O'Dwyer's tubes; but after a month of intermittent treatment this method was abandoned, its tediousness and painfulness seriously affecting the child's health. It was then resolved to dilate the stricture from below. A metal plug with a shield attached to fit over the tracheotomy tube was made. Under chloroform the tracheotomy wound was enlarged and the stricture forcibly dilated with curved forceps; the plug and the tracheotomy tube were then inserted. The plug was worn continuously for five months without causing any inconvenience; it was then removed, and the tracheotomy tube was corked up. The child being able to breathe freely through the mouth both day and night, after a month the tube was dispensed with. The wound soon healed, and the patient now—a month later—seems cured.

The PRESIDENT congratulated Dr. Lack on his success in this case. Many attempts had been made and much time had been spent in trying to dilate laryngeal strictures, but generally in vain.

Dr. LACK, in replying to a question by Dr. Permewan, said that the dilatation was done through the tracheotomy wound with ordinary dilators and a plug inserted to keep the parts dilated, and worn for about five months continuously. He had treated the case with intubation tubes, but directly they were left out the trouble recurred.

CASE OF NODE IN NASAL PROCESS OF THE RIGHT INFERIOR MAXILLA AND ULCERATIVE RHINITIS IN A TUBERCULAR GIRL.

Shown by Mr. ATWOOD THORNE. The patient, a girl æt. 7, came to St. Mary's Hospital complaining that for the last two months the nose had been gradually growing broader, and the nostrils becoming increasingly blocked. The trouble was attributed to a fall on the nose.

On examination there was found a mass as large as a hazel-nut attached to the nasal process of the right superior maxilla, and there was some swelling in a similar position on the left side. The nostrils were almost completely blocked by pale granular masses, and there was a thin watery discharge.

With the exception of a very small opacity of the left cornea (said to be due to an accident) there was nothing to suggest congenital syphilis, while the patient had been in St. Mary's for the treatment of a tubercular ulcer of the foot, and had had an operation at Golden Square for enlarged cervical glands.

The PRESIDENT asked if the nasal secretion had been examined for tubercle bacilli.

Dr. HILL suggested the case was a mixture of syphilis and tubercle.

CASE OF TUMOUR OF PALATE IN WOMAN ÆT. 34.

Shown by Dr. BOND. The swelling was first noticed twelve years ago shortly after the extraction of three teeth. It slowly increased in size, but lately has grown more rapidly. There is now an elastic, painless, non-tender swelling covering the hard palate, and extending into the alveolus on the right, and also into the soft palate. It is rather more dusky than the normal mucous membrane; in the centre is a paler area. There are no enlarged glands in the neck. The floor of the nose is normal.

The growth was thought by several members to be an adenoma. Dr. Bond proposed to report further on the case after operation.

Mr. DE SANTI took the swelling of the palate to be an adenoma, and considered it would be quite an easy matter to dissect it out.

Dr. WATSON WILLIAMS said that many years ago one of the first cases he saw in a young girl about fourteen was very similar to this. The tumour had existed for some years, and was increasing in size very greatly. It contained numerous small cysts. He had opened the growth and introduced weak chromic acid, with the result that the growth was inflamed for some days and soon after disappeared entirely, and it had not recurred a few years later.

Dr. BOND said he proposed attempting to remove the growth in a few days.

Female æt. 26, with Large Sarcomatous Tumour of the Naso-pharynx.

Shown by Dr. StClair Thomson. Though not by any means rare in early life, this case was shown as an example of malignant disease in a young adult. The patient had traces of having been operated upon for tuberculous glands in the neck, and it was therefore a little difficult to say whether the glands, which were now evident on each side of the neck, were also tuberculous, or whether they were secondary to the malignant growth. They were sufficiently hard. The growth pushed forward the soft and hard palates without invading them. It completely obstructed the choanæ, and had seriously interfered with swallowing and breathing. The author invited discussion as to whether an attempt should be made to remove the growth, and as to whether the patient should have tracheotomy or gastrostomy or both.

Mr. de Santi looked upon this swelling as probably of a malignant nature; its rapid growth and general appearance were consistent with such a diagnosis. The glands, though originally the patient had had tubercular cervical glands removed, were probably sarcomatous. Though the case might be one of mixed infection, tracheotomy should be done soon, and then an attempt to explore the palatal growth might be made. It would be interesting to know the microscopic appearances.

Dr. Bond thought that tracheotomy ought to be done; then it would be possible to get away some of the mass from the mouth: a large part might be snared off. In any case after tracheotomy, it should be thoroughly examined with the finger. He thought something might be done to relieve the case for a time.

Dr. Tilley asked if the glands were secondary to the particular growth in the palate or independent.

Dr. StClair Thomson was encouraged to follow the advice given. The woman had had tubercular glands in the past, and he thought they were not secondary to this growth.

A Case of Laryngeal Disease for Diagnosis.

Shown by Mr. E. W. Roughton. A man æt. 42, suffering from hoarseness, cough, and dyspnœa of three months' duration.

There was a swelling involving and fixing the left cord and arytænoid. No evidence of tuberculosis and no history of syphilis. He asked for a diagnosis.

Mr. DE SANTI was of opinion that this was a case of epithelioma. There was marked infiltration of the parts and very impaired mobility. Moreover the redness was quite unilateral, and fulness could be seen below the cord. An early laryngo-fissure was urgently needed.

Dr. WILLIAM HILL said he was inclined to think it was malignant. There were no glands on the outside; it was the sort of case well suited for an exploratory thyrotomy.

Sir FELIX SEMON suggested removing a piece first.

Dr. STCLAIR THOMSON said the cord was quite fixed, and the growth extended below the cord. He thought it a good case for laryngo-fissure.

The general opinion of members was that the case was very suitable for exploratory thyrotomy.

CASE OF MALFORMATION OF PALATO-PHARYNGEI MUSCLES.

Shown by Dr. FITZGERALD POWELL. A man æt. 22 presented himself for treatment at the hospital, suffering from suppuration of the middle ear, with hypertrophic rhinitis. This condition followed scarlet fever fourteen years previously.

On looking into his pharynx it was seen that the palato-pharyngei muscles forming the posterior pillars of the fauces on both sides, instead of passing down in the normal position, were drawn backwards and united together, leaving a small opening below the uvula into the post-nasal space.

The united muscles spread out over the posterior wall of the pharynx and became attached to it for some distance, when they parted and fell away in crescentic folds to their attachment to the posterior border of the thyroid cartilage.

The appearance on examination conveyed the impression that this condition was caused by extensive ulceration, and the history of severe scarlet fever deepened this impression, though on further and more prolonged inspection doubts arose as to whether this malformation was not due to congenital mal-development, the condition was so very symmetrical.

Mr. BABER thought it was the result of an ulceration, secondary to scarlatina rather than congenital. In the first year of this Society he

had shown a similar case. He was not sure whether it was from scarlet fever.

The PRESIDENT had seen almost the same thing. He thought a deep ulceration, if in the centre, would cause that symmetry.

A CASE OF EPITHELIOMA OF THE PHARYNX.

Shown by Mr. ATWOOD THORNE for Dr. DUNDAS GRANT. The patient, a clerk æt. 58, came to the hospital on May 25th complaining that for two months he had had increasing pain on swallowing. He had also been losing flesh somewhat for about the same period.

On examination there is seen a craggy mass on the right side of the pharynx, extending to the base of the tongue on the same side. With the finger the mass is found to be of almost cartilaginous hardness. There is marked involvement of the glands on the right side of the neck.

The case was shown especially for the consideration of the advisability of operation.

A CASE OF PACHYDERMOID LARYNGITIS TREATED WITH SALICYLIC ACID.

Shown by Dr. DUNDAS GRANT (per Mr. ATWOOD THORNE). The patient, a man æt. 56, "chucker-out" at a music hall, came to the hospital at the beginning of April complaining of a "husky voice."

The cords were partially concealed by very swollen ventricular bands; they were obviously less tense than normal, and on their edges there was what looked like a layer of desquamating epithelium. The rest of the cords was red and succulent, and in the interarytænoid space the mucous membrane was swollen and sodden-looking. The nasal mucous membrane was in general hypertrophied, and there was a considerable excess of mucous secretion.

The patient was advised to give up all alcoholic drinks (in which he usually indulged somewhat freely), and twice a week, in gradually increasing strength, an alcoholic solution of sali-

cylic acid has been applied to the thickening in the larynx. At the same time he has been ordered an alkaline lotion to wash out his nose. He has now quite regained his voice, and though the swelling has not altogether disappeared, the whitish thickening on the edges of the cords is hardly perceptible.

Case of Bilateral Abductor Paralysis, &c.

Shown by Mr. Richard Lake. The patient is a man, and has suffered from cough and dyspnœa for three months; now both cords seem fixed in the cadaveric position: there is a breaking-down gumma of the right tonsil. There is slight ptosis of the left eye, the left pupil is large and inactive, there is paralysis of all the recti muscles and of the inferior oblique. Under iodide the conditions have improved.

A case of pachydermia laryngis in a tubercular patient was also shown by Mr. Lake.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY

OF

LONDON.

VOL. VII.

1899—1900.

WITH

LISTS OF OFFICERS, LIST OF MEMBERS, ETC.

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1900.

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OF THE

Laryngological Society of London

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THE ANNUAL GENERAL MEETING,

JANUARY 5TH, 1900.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

52ND ORDINARY MEETING, *November 3rd*, 1899.

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

WILLIAM HILL, M.D., }
LAMBERT LACK, M.D., } Secretaries.

Present—21 members and 3 visitors.

The minutes of the preceding meeting were read and confirmed.

The President referred to the loss laryngology had sustained by the death of Prof. Störk, of Vienna, one of the earliest and most distinguished laryngologists and an honorary member of this Society.

The following cases and specimens were shown:

MICROSCOPICAL SECTION OF A GROWTH (LYMPHANGIOMA?) REMOVED FROM THE RIGHT VENTRICULAR BAND OF A MAN AGED FORTY.

Shown by Dr. FURNISS POTTER. The specimen was brought before the notice of the Society because there was some doubt as to its nature, and also because, as far as the exhibitor knew, a growth on the ventricular band was not of common occurrence.

Mr. WAGGETT said he had been asked by Dr. Furniss Potter to suggest that this case might be referred to the Morbid Growths Committee, as Dr. Potter had some doubt as to whether it was lymphangioma.

The suggestion was supported by the PRESIDENT and adopted.

CASE OF ENLARGEMENT OF THE NOSE.

Shown by Dr. WILLIAM HILL. A boy æt. 8, the subject of congenital syphilis, first came under observation as an out-patient a year ago with necrosis of the pre-maxilla and ulceration of the septum. Subsequently a large sequestrum was removed under an anæsthetic. About a month ago signs of symmetrical periostitis of the nasal bones and of the nasal processes of the maxillary and frontal bones appeared. The enlargement and deformity of the nose had steadily increased; the swelling, which was very painful to touch, had now extended halfway up the forehead; the usual depressions at the inner angles of the orbit had disappeared, and the cheeks were becoming puffy. There appeared to be no active destruction now going on in the septum, but there was present a condition of crusty rhinitis. The boy had been taking grey powder, but the condition was gradually getting worse, and the exhibitor asked whether any one present could suggest any local or constitutional treatment likely to arrest the morbid process; otherwise much destruction and deformity seemed to be inevitable.

A CASE OF LATERAL ENLARGEMENT OF THE NOSE.

Shown by Dr. HILL. The patient, a girl æt. 11, had been under observation as a sufferer from atrophic rhinitis for more than a year. Owing, presumably, to retarded growth of the septum, the shape of the nose, with its now depressed bridge, was quite different from what it was formerly, and the patient had been gradually altering in appearance for two years. Within the last two or three months, however, a more rapid change had taken place. This consisted of a lateral widening of the nose; the nasal bones, instead of forming a bridge, have become

markedly flattened out, and the nasal processes of the superior maxillæ were now widely separated and formed prominent ridges, rising above the level of the depressed and flattened nasal bones. The question asked was, could anything be done either to correct the present deformity or to arrest its progress ?

Female aged Twenty-four with Enlargement of Nose.

Shown by Dr. StClair Thomson. This patient applies for relief for frontal and occipital headache and nasal obstruction. She states that her nose was always rather broad, but that lately it has increased. The bridge of the nose appears expanded on either side, the ridge of the nose is ill defined, and (apparently from distension of the skin) appears thin, and the capillary circulation in it is marked, while the alæ seem thickened.

She has cacosmia, but states that she cannot smell on the right side. Both nostrils are patent; there is no pus on either side, and no marked pathological change in the nose, except that the middle turbinal is enlarged and pushed inwards against the septum. A view has not been obtained of the post-nasal space.

Male aged Fifteen with Enlargement of Nose.

Shown by Dr. StClair Thomson. In this case the nose is not only enlarged externally, but it is red and decidedly tender. The tenderness is slight over the lower wall of the frontal sinus, hardly perceptible over the centre of both maxillary sinuses, but is increased over the nasal process of the superior maxilla, while it becomes very marked over the nasal bones and on pressure at the inner canthus of the eye on the region of the ethmoidal labyrinth.

The patient states that for twelve months the discharge from his nose has smelt badly both to himself and others.

Pus has been seen on the posterior wall of the cavum and on the floor of the right choana, as well as a slight amount in the left middle meatus.

Nasal Case for Diagnosis.

Shown by Mr. Atwood Thorne. The patient is a boy æt. 12. Six weeks ago it was noticed that his nose was broader than usual, and since that time it has been getting gradually worse.

He has also had increasing difficulty in breathing through his nose.

There is a history of a blow three months ago, when his nose bled a good deal for an hour or two and then ceased.

He came to St. Mary's Hospital on November 3rd, and was seen to have a broad nose with a depressed bridge. He could not breathe at all through either nostril. On examination both nostrils were found to be filled with hard, blood-stained masses. On clearing these away the septum was found to be thickened and ragged immediately within the columella, and beyond was a large perforation of the cartilaginous septum.

There is nothing in the boy to suggest tuberculosis.

There is nothing in the teeth or eyes to suggest hereditary syphilis, but he is the youngest child, and the mother had a miscarriage three and a half years after his birth.

Dr. William Hill said: I think Dr. StClair Thomson's two cases are instances of perichondritis and periostitis of a more or less acute character, and we can dismiss, at any rate as a prime factor, the question of ethmoiditis, though secondarily the ethmoid region may be involved. I have had cases resembling them before in which I had thought I had excluded syphilis, but on more than one occasion they eventually turned out to be syphilitic; others were apparently of an erysipelatous nature.

In the female I cannot help thinking that there is perichondritis of the septum present owing to the thickness of septum, and if so that might explain the condition of the rest of the nose, because when you get perichondritis of the septum the inflammation often does spread to the adjacent structures; I cannot, however, throw any light on the ætiology of the case.

Dr. Scanes Spicer said in the boy's case the bony and cartilaginous framework of the nose appeared quite normal and not hypertrophied, whereas the hyperplastic condition was confined to the soft tissues of the tip, dorsum, and alæ, and appeared to be only of the skin and subcutaneous cellular tissue. The explanation of this seemed to him not clear in all cases. Doubtless sometimes this enlargement resulted from œdema of an acute inflammation which did not completely subside. At others it was secondary to the congestion consequent on systemic circulatory disorder. Reflex congestion from

intra-nasal irritation might explain other cases; and sometimes, as in this case, a stagnation of lymph-flow was suggested, although one could not determine the fact of blockage of lymph vessels.

Dr. F. DE HAVILLAND HALL: The first case reminds me of the case of a lady who consulted me some years ago, though in my case there was more swelling, redness, and tenderness. In order to get a satisfactory examination I applied cocaine to the interior of the nostril. There was no change in the nose, and I sent her back to her medical adviser in the country. To my dismay I heard three weeks later that, a few days after I had seen her, acute mischief set up in her nose with the formation of an abscess and destruction of the bony framework, so that the bridge of the nose fell in. At the time there was very little more to be noticed than in the case we are discussing; it had been going on for some weeks, and seemed a chronic or subacute case, and I had no idea that such rapid mischief was in progress. I have been unable to satisfy myself of the final result, as the lady would never come near me again.

Sir FELIX SEMON: I have had the opportunity of seeing a good many similar cases, and in the majority I have satisfied myself that the origin of the enlargement was traumatic. It appears that often enough after a fall in early infancy, or after a blow during school-time, or a fall in the hunting-field, etc., an inflammation is set up, not only of the soft parts, but also of the perichondrium or periosteum, the acute symptoms of which (pain, obstruction, epistaxis) quickly subside. But later on it progresses very slowly and insidiously. So much is that the case that patients often, when first asked about a history of traumatism, distinctly deny such; but on a subsequent occasion return with the statement that, on further thinking about the matter, they remember having had months or even years ago an injury to the nose. The best treatment I have always found in such cases consists in applications of ice-water externally, and iodide of potassium internally.

Dr. DUNDAS GRANT: I share the diffidence which seems to usually possess the members of this Society with regard to these cases; personally I have a good deal to learn about them. With regard to the youth whose case was brought before us by Dr. StClair Thomson, I agree with Dr. Scanes Spicer that the condition is more that of vascular congestion from pressure, owing, I think, to the size of the medial turbinated bones; and I am of the opinion that a very considerable diminution will take place if the turbinated bones are removed. Very often early swelling is due to some skin disease affecting the lining of the vestibule, and I think that repeated small follicular abscesses will leave this enlargement.

With regard to the case of Dr. Hill, it is a very serious one indeed: the child seems to have been inoculated with some virulent form of suppurative disease, which has resulted in a chronic atrophic condition and cirrhotic contraction of the parts; afterwards this has resulted in the falling down of the soft tissues which bring with them the nasal bones, which do not seem to have acquired their attachment to the nasal processes of the superior maxilla, as they would do at a later

period of life. I do not think it is necessary to assume a syphilitic condition in that case.

Dr. FITZGERALD POWELL: To help clear up this matter I wish to ask Dr. StClair Thomson to tell us whether any cultures have been made from the nasal secretions, especially in the case of the boy. I think we must look further afield in the majority of such cases for the cause, and if sought for it will be found in certain blood dyscrasias such as tubercle, syphilis or perhaps septic infection. In traumatism no doubt we may have the exciting cause, the disease remaining latent until the blow or injury has been received. We know in septic, tubercular, and other forms of osteitis, a blow or other injury is often the starting-point of the disease, which not infrequently runs a rapid course. In these nose cases tubercle or syphilis will, I think, generally be found at the base of the trouble, and not septic infection.

Dr. STCLAIR THOMSON in replying said: I am very glad to have raised a discussion, and I hope that members having similar cases will bring them before the Society. Firstly, I would say that no cultures have been made from either of my patients. While no doubt traumatism is a cause in a large number of cases, I hardly think it will explain all cases. Among my private patients such cases have occurred in middle-aged ladies, who do not seem likely to be exposed to traumatism; one was over fifty years of age, who was quite sure she had had no injury. Her nose was tender, shiny, and red, and for this reason she had a dislike to going into society. I had another case in consultation in which the condition was in an advanced stage; the bone and skin were distended to such an extent as to cause superficial ulceration. It was seen by a general surgeon in consultation; he could give no opinion, and regarded the case as very obscure. The post-nasal space was perfectly clear. Under potassium iodide (up to 30 grs. three times a day for six weeks), given by a Manchester surgeon on the suspicion of syphilis, no improvement took place.

A CASE OF LARYNGEAL GROWTH (ANTERIOR COMMISSURE) IN A MAN WITH ALTERED VOICE FOR OVER THIRTY-FIVE YEARS.

Shown by Dr. HECTOR MACKENZIE. The patient is a man æt. 48. His voice has never been natural since the age of ten or twelve, when it suddenly altered and became weak and hoarse. Since then the voice has remained high-pitched, weak, and more or less hoarse, but sometimes worse, sometimes better. He has noticed no difference recently.

He has suffered from a cough off and on since he was a boy. For the last six or seven years he easily gets out of breath on exertion. It was on account of the cough that the patient sought

advice. He was found to have a slight degree of emphysema, together with some bronchial catarrh.

On examination of the larynx there was to be seen a flat, smooth, reddish growth projecting from the epiglottis immediately above the anterior commissure, and extending above the anterior fourth of the right vocal cord. The remainder of the larynx appeared healthy.

During the three months that the patient has been under observation the growth has not altered in size or appearance. From the appearance, shape, size, and situation of the growth it is probably a fibroma.

I have brought the case forward especially with regard to the question of treatment.

The growth as far as we can observe produces no symptoms, unless we are to suppose that it is the cause of the alteration of voice, in which case we must assume that the growth has been in existence for thirty-five years. Is this not one of those cases where the growth is best left alone, the patient being seen from time to time and surgical interference being employed only if required by increased size of the growth or by interference with the breathing.

I very much doubt whether it would be of any advantage to the patient to have a perfectly normal voice, seeing that he has reached the age of forty-eight with his present vocal peculiarities, even if it were possible to secure this by operation. What the man hopes from operation is to be cured of his shortness of breath, with which the growth has no causal relation.

The PRESIDENT: If I were the patient I would prefer to go to the grave with my voice in the present condition.

Dr. DUNDAS GRANT: Is it not worth while to have that growth removed? I think an attempt ought to be made. It is not always an easy place to get at with forceps, but the "seat of election" for operation by means of a snare. I have seen a case just like it where it could not be removed intra-laryngeally, and the result of removal by means of thyrotomy was to restore the voice, though it is generally supposed that thyrotomy is attended with great risk of loss of voice.

Dr. SCANES SPICER: This particular growth seems an easy one to remove by snaring, since it appears free from and above the vocal cords; with no attachment below the anterior commissure, and with a constricted pedicle, removal would probably entirely cure the unpleasant hoarseness.

Mr. WAGGETT advised Dr. Mackenzie to remove it, or some one else would.

Dr. HERBERT TILLEY thought that the growth might quite well be removed by intra-laryngeal forceps; he had recently thus treated a case at Golden Square Throat Hospital, and had found no difficulty with it. He felt bound to differ from Dr. Mackenzie's view of the treatment. The fact that the patient had had a bad voice for thirty years seemed to the speaker a powerful argument that it was time to endeavour to give the patient a good voice.

Dr. HECTOR MACKENZIE: I am very glad to have had the opinion of the members of the Society about this case. I had an opportunity this afternoon of seeing the man's elder brother, who confirmed what the patient had told me, that the change in the voice came on quite suddenly; he said he could remember the very place where his brother lost his voice, namely, a certain field in Oldham. This is rather difficult to explain if the cause of the alteration of voice is the presence of the tumour. Mr. Waggett says if one person does not remove the growth some one else will do it. I believe the man himself wants it done, because he thinks he will be cured of his shortness of breath. Unless I felt it was the best thing for the man I should neither do it nor advise it to be done. I quite agree with you, Mr. President, that as the man has gone about all these years—nearly forty years—with very little inconvenience resulting from the tumour, it is better to allow things to take their ordinary course.

[The PRESIDENT subsequently had an opportunity of re-examining Dr. Hector Mackenzie's patient, and agreed with those members who advocated the removal of the growth.]

A CASE OF EPITHELIOMA OF THE LEFT ARY-EPIGLOTTIC FOLD IN A MAN AGED SIXTY-FIVE.

Shown by Mr. WYATT WINGRAVE. The only symptom was painful deglutition of seven months' duration. Portions were removed by snare and Grant's forceps, and proved to be squamous epithelioma.

During the last two months he had lost weight, and the growth showed signs of extension.

Mr. BUTLIN: I could not quite convinc emyself how far the growth extended anteriorly and posteriorly, but it seems to me from most points of view a good case for operation in that situation, though such operations are very rarely successful. The best way to do it is to open through the thyroid cartilage, turn back the two halves of the larynx to obtain a better exposure, and then deal with the growth. I have per-

formed infra-hyoid laryngotomy for a growth not quite so large as this one under discussion; it was not a great success, there was very little room to get at it. I have removed very few growths from this situation, but such as I have done I have exposed from the front.

Male with Unusual Indrawing of the Alæ Nasi.

Shown by Mr. Richard Lake. This case was shown simply as a curiosity.

Dr. Scanes Spicer: The stenosis of nose from alar collapse is so extreme in this case, that he would probably derive comfort from wearing tubes to keep nostrils open.

Mr. Lake: The patient wears Schmidt's dilators, and derives great benefit from their use.

Dr. Scanes Spicer: He wants nothing more than small pieces of ordinary drainage-tube, which fulfil every indication and do not irritate.

Mr. Waggett: Mr. Stewart asked me to draw your attention to the fact that he had a similar case which was shown to the Society, which perhaps will be remembered, and that he made use of an apparatus with a not very favourable result.

Dr. StClair Thomson: The man is a neurotic subject; by manipulating the speculum, though I gave him a good deal of space and could see right through into the nose, he was still breathless. He has cardiac disease, and I have noticed that people with heart trouble, whose nasal respiration is deficient, are very neurotic.

A Case of New Growth in the Vocal Cord, probably Cystic in Nature.

Shown by Dr. Dundas Grant. Man æt. 26, omnibus conductor, was brought under my notice by Dr. Mackintosh on account of the peculiar condition of his left vocal cord, of which he has made a very faithful portrait. The cord is shaped very much as if a small lemon-seed had been let into the middle of its vibrating part. The mucous membrane over the swelling is perfectly normal in colour and lustre, and the mobility of the cord is unimpaired; a few blood-vessels ramifying on the surface are just visible. There has been no pain, and the only symptom has been a pronounced degree of hoarseness each winter for four years, coming on gradually, lasting for the winter, and

then gradually diminishing, but not wholly going, as summer comes on. The growth appeared to me to be in the substance of the cord rather than on its surface, and its presence, no doubt, gave rise to a chronic laryngitis under unfavourable climatic conditions, this retrogressing under favourable ones. Its rounded contour suggests that it is a cyst.

I propose making an incision, or at least a puncture, in the first instance, subsequently applying an electric or chemical cautery.

Dr. DUNDAS GRANT: This growth has increased in size since I first saw it, and has become more prominent. It has been suggested by Dr. Tilley that it would be better to remove it with my own forceps than make an incision as I proposed. Having again examined the case, I shall act on the suggestion.

Dr. HERBERT TILLEY advised removal by means of intra-laryngeal forceps; the growth was freely moveable, and the treatment suggested would be much easier than the endeavour to puncture it and apply chromic acid to its interior.

Dr. STCLAIR THOMSON: Are cystic growths common? I thought I had a similar growth once, but when removed and put under the microscope it turned out to be a case of œdematous fibroma.

Dr. SCANES SPICER: It also struck me as being a fibroma.

Mr. WAGGETT had operated on a case very similar in appearance to that now shown. Microscopic examination proved it to be a cyst lined with columno-squamous epithelium.

Dr. DUNDAS GRANT in replying said: I hope to bring this growth (be it œdematous fibroma or cystic) before the Society on another occasion. My reason for thinking it cystic was that it was deeply buried in the substance of the cord, whereas fibromatous growths are usually outgrowths from the surface of the cord.

A CASE OF FIBRO-PAPILLOMA OF THE VOCAL CORD CAUSING HOARSENESS; RESTORATION OF VOICE AFTER INCOMPLETE REMOVAL OF THE GROWTH.

Shown by Dr. DUNDAS GRANT. A teacher æt. 19 came under my care last September on account of extreme hoarseness of about two months' duration, which had come on after an attack of bronchitis and influenza. The laryngoscope revealed a pink nodule of the size of a large pin's head on the edge of the left vocal cord at the junction of the anterior and middle thirds, and a much smaller one immediately opposite it on the right cord.

By means of my laryngeal cutting-forceps I succeeded in at once effecting a somewhat incomplete removal of the growth, which Mr. Wingrave considered to be a fibro-papilloma. The voice, however, was so well restored that I have not deemed it justifiable or requisite to carry out any further surgical treatment.

Case of Sarcoma of the Post-nasal Space.

Shown by Mr. Waggett. A young woman æt. 30, who six months previously had begun to notice nasal obstruction, and also the formation of a lump in the neck. Some pain was experienced at the back of the neck, and otorrhœa on the left side had recently developed without pain.

Examination showed infiltration of the left lateral and posterior walls of the naso-pharynx with a firm growth of pinkish white colour, ulcerated in parts. A large secondary growth fixed to the deep structures was present beneath the upper quarter of the left sterno-mastoid muscle. The primary growth had descended almost to the level of the palate. The nasal fossæ were not involved.

Dr. Bond: This is a very grave case, and it is evident that an operation will either sooner or later be required to relieve the girl. I think that an early attempt should be made, that the palate should be split, and the growth thoroughly examined before deciding what should be done further. It is possible the whole mass in the naso-pharynx might be snared and scraped away and the site cauterised; one cannot tell before exploration, but the patient should have the benefit of the doubt, and an attempt be made to either cure or relieve her. I should recommend a preliminary laryngotomy, and then a few days later, if the last operation was a success, an attempt should be made to remove the glands. It is within the bounds of possibility that the girl can be cured; she ought to have her chance. My own argument is that something in any case must be done.

Dr. Scanes Spicer: I have had such a case under treatment during the last two years, and which has up to now been a great success. The patient was a gentleman aged sixty-five, with almost complete nasal obstruction on left side with septal exostosis and deflection, hypertrophied inferior and middle turbinated bodies, and left nasal cavity blocked with growths. These were thoroughly removed in December, 1897, and the nose rectified. The growths were myxomatous and fibromatous, and presented no evidence of malignancy. The nose was quite clear for some months, but there

was an undue amount of mucous secretion and post-nasal irritation leading to hawking. Towards the end of 1898 the passage seemed to be narrowing again at the back, though no growth whatever was to be seen in the nose or naso-pharynx. In February, 1899, owing to increased stuffiness the patient again sought advice and complained of a lump and tenderness externally, but deep behind ramus of lower jaw. I then suggested that Mr. Butlin should be asked to see the case, as it looked as if it was a case of malignant disease in an early stage, and that an external operation would be required. The patient was examined under an anæsthetic, and a portion of swollen lump in naso-pharynx removed for examination, and found by Mr. Butlin to be sarcomatous. The patient thereupon agreed to extirpation of the growth internally and externally at two operations. Mr. Butlin operated on the internal mass after dividing soft and partly the hard palate. The patient was weak, and made but a tardy recovery from the first operation, and it was decided to defer the second, at all events for some time until he was stronger. The cervical gland mass did not appear to increase in size or to spread. Arsenic was tried, but was not tolerated. The patient went to the Riviera for some weeks, and later in the summer to Switzerland. In the Engadine he consulted Dr. Bernhard, of Samaden, who thought it necessary there and then (September, 1899) to excise the enlarged masses in the neck; pain was a prominent symptom, and the possibility of there being deep suppuration in a gland or glands had been held throughout, though it was considered probable that the neck growth was also sarcomatous. Dr. Bernhard's expert declared the tumour removed from the neck to be glands affected with chronic lymphadenitis with suppurative foci, and to be free from malignancy or tubercle. The patient left the Engadine within three weeks of the operation, and now, save a slight fistulous track over clavicle, is quite well. The practical lessons to be derived from this case appear to be that it is almost impossible to form an exact and complete opinion of such a case as this from the results of a histological examination of portions removed; that post-nasal sarcomata should be removed as early and as thoroughly as possible; and that secondary enlargements in the cervical glands outside are not necessarily malignant.

Dr. DE HAVILLAND HALL: I remember one case in which a growth was mistaken for adenoids, and an operation performed, but which later was found to be a case of sarcoma.

Mr. ATWOOD THORNE: I have seen a case in hospital practice which was taken to be adenoids, and was operated on as such. The mass recurred, was found to be sarcomatous, and did not admit of removal.

Mr. WAGGETT: I only have to say that these cases appear to be much more common than the scanty literature would lead one to suppose. I have seen four cases during the present year, in two of which an erroneous diagnosis was at first made. I shall attempt to carry out the suggestions made by Dr. Spicer and Dr. Bond.

Case of Laryngeal Perichondritis in a Man of Twenty-six, the Subject of Pulmonary Tuberculosis.

Shown by Dr. Scanes Spicer. The exhibitor called attention to the confinement of the disease to the right half of the larynx, to the considerable induration over the right half of the thyroid and cricoid cartilages, to the displacement and tilting of the larynx over to the left, and to the marked œdematous infiltration of the right side of larynx on laryngoscopy.

Extra-laryngeal (?) Malignant Growth.

Shown by Mr. Waggett for Mr. W. R. H. Stewart. A woman of 56, the subject of chronic throat symptoms, for eighteen months had suffered pain in the throat and left ear.

Careful examination with the mirrors early in July had revealed no disease, the patient's note-book bearing the remark that the movements of the cords were normal. Paresis of the left vocal cord was noted in September, and early in October œdema of the left arytænoid region developed, partly hiding the paretic cord. A plaque, white in colour and resembling in appearance the surface of a furred tongue, was now seen on the posterior pharyngeal wall on the left side and close to the arytænoid.

Digital examination revealed the presence of a hard nodular infiltration of the left linguo-epiglottic fold.

The case was regarded as malignant and inoperable, though no glandular enlargement was detected. Consequently no microscopic investigation had been made.

The President: This case is one of three,—either tubercular, syphilitic, or malignant. Sir Felix Semon seemed in favour of syphilitic, and he put malignant last, though I should put it first.

Dr. Dundas Grant: I should consider it a case of epithelioma of the larynx and pharynx.

Mr. Waggett said that iodide of potassium had been used in this case.

Dr. Hill: The diagnosis could readily be cleared up by snipping a

bit off for examination. This, assuming the case to be operable, ought to be done at once. with a view to prompt surgical measures.

Dr. LAMBERT LACK: I should advise that the growth be not touched in any way. The diagnosis seemed quite certain, and the tumour was quite inoperable.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

53RD ORDINARY MEETING, *December 1st*, 1899.

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

WILLIAM HILL, M.D., }
LAMBERT LACK, M.D., } Secretaries.

Present—33 members and 6 visitors.

The minutes of the preceding meeting were read and confirmed.

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

F. O'Kenealy, Capt. R.A.M.C., India.

George Constable Hayes, F.R.C.S., 22, Park Place, Leeds.

Frederick Hibbert Westmacott, F.R.C.S., 5, St. John Square, Manchester.

The following cases and specimens were shown:

A DIAGNOSTIC MISTAKE.

By Sir FELIX SEMON. On October 18th, 1898, I was consulted by Mr. A. W—, æt. 39, on account of soreness of the throat on the right side, about the level of the larynx, limited

to one definite spot. He also stated that his voice had become gruff, and that swallowing, particularly of his saliva, was somewhat inconvenient. He had not brought up any blood and stated that he had not lost flesh.

On examination the pharynx was healthy, but the right vocal cord was fixed in about the cadaveric position, and the mucous membrane over the right arytænoid cartilage and the adjoining portion of the plate of the cricoid was considerably tumefied. There was no definite evidence of new growth and no ulceration. On phonation the left cord crossed the median line.

Externally there was general fulness of the glands below the anterior belly of the sterno-mastoid muscle, and this region was more tender on pressure than the corresponding part on the left side. There was a somewhat indefinite history of a chancre many years ago, apparently not followed by any secondary symptoms, although the patient had never been properly treated for it.

I gave him iodide of potassium in 10-grain doses for a fortnight, after which time I wished to see him again.

On the occasion of his second visit no improvement was noticed; on the contrary, the laryngeal tumefaction had increased, and the glands on the right side of the neck were distinctly larger and harder than they had been before. The patient also complained about increased pain in swallowing, sometimes shooting into the right ear. The iodide of potassium was increased to 20 grains three times daily, and the patient was told to come again in a fortnight's time.

When he saw me for the third time, on November 18th, matters were again worse than before. Still no ulceration was visible in the larynx, but the tumefaction had increased, and he was now very hoarse. The pain in swallowing had also become worse, and there was more swelling of the glands in the anterior triangle than before.

It seemed practically certain that one had to do with infiltrating malignant disease of the larynx. The removal of a fragment for microscopic examination was impossible owing to there being no distinct projection, but only general tumefaction.

As the question of operative interference became urgent, I sent the patient to Mr. Butlin for an independent opinion. Mr.

Butlin shared my conviction that the disease was malignant, as also, I understand, did Dr. StClair Thomson, whose independent opinion the patient sought.

Although, on account of the extensive glandular swelling in the neck, I did not think the case a very suitable one for radical operation, still I felt it my duty to lay the alternatives of letting matters go on or attempting a radical cure before the patient, who decided in favour of operation.

I had a consultation with Mr. Watson Cheyne, who also did not consider the case a favourable one; but felt sure that if any radical operation were attempted at all, it ought to be complete laryngectomy. The patient consented to this.

On November 26th, in the presence of Dr. Lambert Lack and of myself, Mr. Watson Cheyne commenced the operation. In making the initial incision for tracheotomy, he came at once across an enlarged and apparently infected gland, in the middle line, quite distant from the region in which one would have previously anticipated that infection might have taken place. Other enlarged glands were detected immediately afterwards, which seemed to come through the crico-thyroid membrane. Tracheotomy having been performed, and a cut joining the tracheotomy incision having been made parallel to the border of the lower jaw, a number of small glands, apparently infected, became visible immediately, almost along the entire line of the incision.

Under these circumstances I urged that it was hardly worth while going on with the more serious operation originally contemplated, and Mr. Cheyne agreed with this view. The operation was therefore abandoned, but the tracheotomy tube left in position. So far as one could judge with the naked eye, the glands appeared epitheliomatous; unfortunately no microscopic examination was made.

The patient quickly recovered from the tracheotomy, and returned home a fortnight after the operation.

On October 24th of the present year, Mr. W—, whom both Mr. Cheyne and I had supposed to have long since succumbed to his illness, suddenly called on Mr. Cheyne, looking very well, and saying that he had been gaining flesh and strength. He told him that the glands in the neck had continued to

enlarge after the operation, but had gone down a month or two afterwards. He had been taking "Clay's Mixture" (a preparation of Chian turpentine). His voice was still somewhat hoarse but strong. He was still wearing his tube, but wanted to have it removed if possible, this being the reason he had gone to see Mr. Cheyne. There was no difficulty in breathing without the tube, and the difficulty in swallowing had entirely disappeared. Nothing in the shape of glands was to be felt in the neck.

Mr. Cheyne wished me to see the patient with him, and a consultation took place on October 27th of this year.

The patient looked better than I had ever seen him before, and stated that he had gained 13 lbs. in weight since last year. His voice was good and strong; he wore the tube with de Santi's speaking apparatus. No glands could be felt externally, the right vocal cord was still fixed as before, but the tumefaction on the right side of the larynx had quite disappeared.

I put this case on record because it seems to me to teach the important lesson that, even under circumstances such as I have described, and which practically seemed to leave no doubt as to the nature of the disease, a number of experienced observers may be mistaken, unless indeed it be assumed that the disease had after all been epithelioma, and that it had been cured by Chian turpentine.

What the real nature of the disease was can even now, I think, hardly be stated with absolute certainty. What seems most probable, however, is that, after all, there had been a syphilitic perichondritis of the larynx, in the course of which an extensive but purely inflammatory swelling of the cervical glands occurred, and that whilst the laryngeal affection for some unknown reason had not yielded to the iodide, later on it had spontaneously subsided, followed by reduction of the glands to their normal size. Other causes, such as a so-called "idiopathic" or tubercular perichondritis, do not seem to come into question here.

There can of course be no objection to the patient's tube being now removed if, after preliminary corking, it is found that his laryngeal respiration suffices.

The PRESIDENT expressed the opinion, which he was sure was

unanimous, that Sir Felix Semon had done a very kind thing in bringing this case before the Society; an example which they might all follow with advantage, for they certainly learnt more from mistakes than from anything else. As regards the cause of the great improvement, the man himself was firmly convinced that it was due to his mixture. Chian turpentine had a reputation at one time, and there might after all be something in it. It reminded him of a similar diagnostic mistake in a different part of the body. He had a clergyman with chronic jaundice in the Hostel of St. Luke. His colleague, Mr. Wm. Rose, and he proposed to the patient that he should be examined surgically, to see if the obstruction could be removed. Mr. Rose accordingly opened the abdomen, and found a hard mass which he regarded as malignant disease of the liver. He (the President) was present at the operation and agreed with him. The patient was sewn up, and left the hostel in two or three weeks. Six months later he wrote to say he was completely well and had remained so since the operation. There is another example in which an incision is followed not immediately by improvement, but improvement some time later; he referred to tubercular peritonitis. He would therefore suggest that possibly the incision in the neck had something to do with the improvement.

Mr. Butlin said: I saw this patient in consultation with Sir Felix Semon, and came to the conclusion that the disease was probably malignant, not so much on account of the appearance of the larynx as because of the enlarged gland at the angle of the jaw. It is a very unfortunate circumstance that the glands which were taken out were mislaid, so that no microscopic examination of them was made; for we very much need more knowledge of the real nature of these diseases which disappear spontaneously, and which yet have many of the characters of malignant disease. It is, of course, almost certain, but it is not actually proved, that the disease in this case was not malignant, and that the diagnosis was erroneous. As to the mere error in mistaking an innocent affection for malignant disease, I have seen that mistake made so frequently by the best surgeons that I have long ceased to think seriously of it. And in many of the cases the disease has been so situated that it could be easily handled and closely examined. What wonder, then, if errors of diagnosis are made now and again in regard to tumours of the larynx which cannot be reached with the fingers, and which are only seen in the distance in a looking-glass. The wonder is, not that mistakes of diagnosis are occasionally made, but that the diagnosis is so frequently correct. I suppose no disease is so frequently mistaken for malignant disease as syphilis; and I have often said that iodide of potassium has cured more reputed cancers than all the quack medicine in the world.

Dr. StClair Thomson said it might interest the members if he read his notes of this case, as the patient consulted him a little over a year ago, and as he did not mention that he had been under the care of any colleague the notes had the value of being uninfluenced by any suggestion. He found on the 19th November, 1898, that the patient was slightly hoarse, had slight dysphagia, and no cough but some irritation in the throat. There was an enlarged hard gland below the

right maxillary angle. The laryngeal mirror revealed a tumour of the right arytænoid, irregular, not ulcerating, concealing the greater part of the glottis, but the right cord on phonation was evidently fixed. The left cord moved easily. There was no loss of weight; no history of lues. The heart and lung sounds were normal. The patient was advised to take iodide and mercury for a week, when the question of operation would have to be considered. The patient then withdrew from Dr. Thomson's study, and the patient's brother proceeded to show such an intimate acquaintance with thyrotomy, iodide of potassium, extirpation of the larynx, etc., that he was charged with having seen other medical men about his brother. He confessed that the patient had been under Sir Felix Semon's care for the past five weeks, and that he had also seen Mr. Butlin. He was thereupon advised to return to their care, and be guided by their advice.

Dr. StClair Thomson had not seen the patient again until he was shown at the meeting. In connection with this curious case, Dr. StClair Thomson said he would venture to refer to another, as it was not probable that he would be able to bring it before the Society. It was that of a poor professional man, æt. 48, who was sent to him for loss of flesh, and dysphagia of three or four weeks. The left arytænoid region was occupied by an irregular, dull red growth, with white necrotic-looking patches on it, something like the snow drifts in the hollows of high mountains. The speaker believed that Sir Felix Semon had referred to unusual snow-white appearance of tumours as pointing strongly to malignancy. Gleitsmann had also referred to the very white appearance in a laryngeal growth of unusual character. In Dr. Thomson's case there was much pain and discomfort from the constant tendency to swallow mucus. The cord on the same side was partially hidden, but was seen to move, while the right cord was normal. A gland was felt to be slightly enlarged on the affected side. There was no specific history. Under these circumstances a very gloomy prognosis was given, and indeed the patient's attendant in the provincial town where he lived was written to to be prepared for tracheotomy. Happening to be in the same town a month later Dr. Thomson had asked to see the patient, and found his voice clear, his swallowing easy, and the growth entirely disappeared with the exception of a slight thickening of the left aryepiglottic fold. The cords were clear and moved freely. This improvement had taken place without the administration of any antispecific, or any particular line of treatment.

Mr. Spencer asked, respecting the two enlarged glands seen on the crico-thyroid membrane, one on each side of the middle line, were these glands frequently seen? He had seen the two glands enlarged in an undoubtedly syphilitic patient, who had first been treated by iodide of potassium and mercury, but who had afterwards to be submitted to thyrotomy in order to clear out the interior of the larynx. These glands might have been considered malignant to the naked eye had not the diagnosis of syphilis been certain.

Sir Felix Semon, in replying, said, with regard to the remarks of the President, that he also had seen cases of tubercular peritonitis get infinitely better, although not entirely cured, after opening the

abdomen. He hardly thought, however, that such an explanation would apply to the present case, the less so, as only a very small number of enlarged glands had been exposed to the air in the course of the operation. He certainly was not a believer in the efficiency of Chian turpentine in cancer. With regard to Dr. StClair Thomson's observation, he begged to disclaim all responsibility for the description of certain forms of larynygeal cancer as similar to a "snowdrift." What he had said in reality was: that if one met with a growth of particularly snow-white colour, which at first sight looked like a papilloma, but the eminences of which were not nearly so bulbous and rounded as in papilloma, but *sharply pointed* like grasses, that such an appearance was extremely suggestive of malignant disease. With regard to Dr. Spencer's remark, he thought glands existed near the crico-thyroid membrane on both sides of the trachea.

Case of (?) Myxofibroma of the Post-nasal Space.

Shown by Dr. FitzGerald Powell. The patient, a boy æt. 17, states that he always had good health until four years ago, when he began to sleep badly at night, and as soon as he went off to sleep he was awakened by a feeling of suffocation. He had also at this time attacks of free bleeding from the nose and mouth, which occurred about twice a week. This got gradually worse. Two years ago he went to St. Bartholomew's Hospital and was an "in-patient" for six weeks. He states he had a swelling in his throat which was lanced, but not otherwise dealt with. For over two years he has been unable to breathe through his nose. The growth grew pretty quickly about two years ago, but the patient does not think it has grown of late. Since the nose has been completely blocked he has not had any bleeding, but has suffered from great drowsiness, and has had incontinence of urine for two years.

On examination the naso-pharynx is seen to be full of a somewhat soft reddish-white growth, resting on the soft palate and pushing it forward, but not extending below the free edge of the palate. It is lobulated, moveable, and is free posteriorly and at each side.

On pushing the finger along the front of the growth it appears as if its point of origin can be felt. It seems to be

firmly attached to and to be continuous with the posterior end of the septum, which appears to be pushed to the left.

The right choana is roomy and filled with a prolongation of the growth, which can be seen from the front.

Dr. HERBERT TILLEY thought the growth was of a sarcomatous nature. It was soft, very vascular, with an extensive attachment, points which he had been enabled to determine satisfactorily by examining the growth with the finger in the post-nasal space. He advised removal, and in view of the difficulties which might be encountered at the time, especially free hæmorrhage, a preliminary laryngotomy or tracheotomy would be advisable. The soft palate should then be divided, and the growth fully exposed to view, so that there could be no difficulty in dealing efficiently with its attachments, and the whole treatment would be rendered easier.

Mr. SPENCER did not think this case malignant, but some of these growths tended to burrow extensively outward into the neighbouring sinuses and fossæ. In a recent case he had found such a growth extending outwards behind the upper jaw into the temporo-malar region and cheek. It had been successfully removed from the face by cutting away the outer wall of the nose and antrum without disturbing the orbital plate or the alveolar border and hard palate. He did not see the necessity of tracheotomy if the parts were well exposed, a sponge drawn upwards into the naso-pharynx, and the patient well propped up.

Dr. SCANES SPICER said, as far as one could see from a cursory examination, this was not likely to be a malignant tumour. He had seen many similar cases, which were like modified polypi. A more careful examination was necessary, and, in his opinion, the growth should be removed by means of a snare. He called attention to the large space between the soft palate and the spine, which would render possible almost any manipulation without dividing the palate in this case. He agreed with the name the exhibitor had given to the case—myxofibroma.

Mr. BUTLIN said:—The tumour in this case, from its large size and red surface, appears to me to be probably a fibroma, and may probably be removed with safety. I have had a considerable experience in the removal of these post-nasal tumours, and have long since come to the conclusion that by far the safest and most certain method is to divide the soft palate and the soft parts of the hard palate in the middle line, and cut away the bone of the hard palate until the tumour is thoroughly exposed. I am very much opposed to temporary resection of the upper jaw and other methods practised through the nose. Nor do I find it necessary to perform tracheotomy. The patient should be laid on his side, with the head forwards and low, the mouth well opened with a gag, and the light reflected from a head lamp or mirror. When the surface of the tumour has been thoroughly exposed, and its attachments have been ascertained, it can be freely cut out with scissors, chisel, and bone forceps. The

hæmorrhage is often very severe in such cases, but it can be arrested by plugging with gauze if it does not cease spontaneously. The removal of the tumour in this manner is not likely to be followed by recurrence of the disease.

Mr. SYMONDS said he thought that in a great many of these cases it was unnecessary to perform so large an operation as that proposed. He thought in the great majority of young people these fibromata could easily be removed from the mouth, while the smaller ones could be extracted through the nose He had on several occasions dissected them from their adhesions by the finger introduced from the naso-pharynx, and sometimes from the nose at the same time. While the hæmorrhage was for the moment smart, he had never encountered any difficulty in arresting it immediately by a plug in the naso-pharynx, this plug being removed before the patient left the table. He thought the hæmorrhage in this case did not indicate any special vascularity. He had noted that there was not uncommonly an adhesion between the tumour and the pharyngeal wall, which bled freely on being torn. In a recent instance this hæmorrhage led a surgeon of distinction to abandon a case which was successfully dealt with in the manner described. He would, therefore, reserve the larger operation for those cases where the tumour grew into the neighbouring fossæ. He would call attention also, on the point of recurrence, to the fact that the mass removed on the second occasion might be a growth from a considerable mass left behind, and yet be of a simple nature. In one such instance he had at a second operation removed a process from the sphenoidal sinus.

Dr. BOND recommended that the growth be attacked through the mouth, which would not be difficult. The soft palate should be split, and thick pieces of silk should be passed through the sides of the palate and used as retractors, so as to afford a good view of the whole thing before chiselling away part of the hard palate, if that should be necessary. He was a strong believer in laryngotomy in operations on fibroids and sarcomata in the naso-pharynx, and recommended that a small sponge, fixed on the middle of a piece of tape, should be pulled down into the top of the larynx. Thus ample room was afforded the operator in the mouth and pharynx: he was not incommoded by sponges or chloroforming impedimenta; the chloroformist could do his work at ease, and any severe hæmorrhage could be readily treated. The laryngotomy wound was a trivial one, and healed in two or three days.

Dr. STCLAIR THOMSON referred to a paper by Doyen, who had operated on a considerable number of these cases, and who had come to the conclusion that they should be attacked from the mouth. Doyen's great point was that the operator should push through quickly with the removal, regardless of the abundant hæmorrhage, for the latter ceased rapidly as soon as the growth was completely detached. For the operation itself specially adapted raspatories were advised. Dr. Thomson also suggested the adoption of the Trendelenburg position for operations of this character.

Dr. FITZGERALD POWELL, in replying, said he was glad his case had given rise to such an interesting discussion, and he thanked the

members for the remarks they had made and for the information he had derived from them. In connection with the treatment to be adopted, he thought the first point to be settled was as to the character of the growth; was it a pure fibroma, a sarcoma, or, as he believed, a myxofibroma? If the latter, its presence should not be attended with such serious consequences, and it was not so prone to invade the antrum, orbit, and other parts as the pure fibroma or sarcoma. It was softer and grew more rapidly than the fibroma, but not so rapidly as the sarcoma. So far as he could make out it was not attached to the "basi-occipital" bone. His own feeling with regard to the operation was that it would most likely be successful, and his intention was to do a preliminary laryngotomy, then split the palate and examine the tumour and its attachment thoroughly. and if necessary, lift the periosteum from the hard palate and chisel away as much of it as was required to expose the origin and facilitate its removal. He hoped to show them the growth at a later meeting.

Case of Recurrent Papillomata of Larynx.

Dr. Bronner (Bradford) showed sketches of a case of recurrent papillomata of the larynx before and after the local use of formalin. A man of 49 had been treated for papillomata for several years, and a large number of the growths had been removed by forceps every two or three months. Various local remedies had been tried. A formalin spray was used for three months, and the growths had to a great extent disappeared, and there had been no recurrence during the last nine months. The spray was now used only one day in the week.

The papillomata were large, finely divided, of cauliflower appearance, and sprung from the vocal cords, ventricular bands, and interarytænoid fold. They frequently gave rise to severe attacks of dyspnœa. After the use of formalin the papillomata became much smaller and round; the finely pointed excrescences had disappeared altogether. The ventricular bands were nearly normal, but the vocal cords were still irregular and thickened.

In reply to Dr. Dundas Grant,

Dr. Bronner said among other applications he had used salicylic acid, but it had not the slightest effect

Dr. Bond asked the strength of the sprays used.

Dr. Bronner replied that he began with sprays of the strength of 1 in 2000, but gradually increased this till he employed a solution 1 in 250 or even stronger. He would like to know if any other members of the Society had had any experience of formalin.

Case of Acute Ulcer of the Faucial Tonsil.

Shown by Mr. Wyatt Wingrave. Married female, æt. 32, was seen on Tuesday, 14th inst., when she complained of sore throat and painful swallowing of three days' duration. On examination a single ulcer about the size of a shilling was seen on the right faucial tonsil. The outline was sharply defined, edges red, while the base was of a greyish-white colour, and the slough was readily removed by throat cusps, exposing a rough mammillated surface. The surrounding tissues were apparently normal. There was but very slight constitutional disturbance, temperature being 100·2°. There was no history of syphilis, but she had lost her father and one sister from consumption. Two days later the ulcer was unchanged in appearance, and her only trouble was constipation of the bowels. On the 21st inst. the ulcer had quite gone, leaving a ragged depression in the tonsil.

Scrapings were examined and showed mono- and multinucleated lymphocytes, free epithelial squames, streptococci, staphylococci, and numerous slender rods which stained faintly with methyl blue. There were no tubercle, nor Klebs-Loeffler bacilli. The history, clinical signs, and the microscope having enabled one to exclude syphilis, diphtheria, and tubercle, it was diagnosed as acute ulcerative tonsillitis, since it conformed in all respects with the classical description of Moure.

Mr. Lake exhibited a case two years ago, and described a special braded form of bacillus as predominating. In this instance the slender pale staining rods were the most numerous.

Case of Paresis of Soft Palate.

Shown by Mr. Wyatt Wingrave. A married man, æt. 34, had complained of pain and a sense of constriction in his throat for four weeks, and of a change in his voice of one week's duration.

He stated that he had syphilis fourteen years ago, and had

enjoyed fair health till a month ago, when he became short of breath, had attacks of giddiness and headache occurring frequently. He noticed that he was gradually losing control over his bladder, and his knees gave way. Later still food returned through his nostrils and his voice became nasal. Deglutition was painful.

On examination the soft palate was markedly paretic, and he evidently swallowed with difficulty and could not pronounce his gutturals. The vocal cords were normal in colour and texture, but abduction seemed sluggish. Although the eyeballs were somewhat prominent, paresis of the ocular muscles was not observed, nor of the facial or lingual. Sensation and reflexes were normal.

He was at once ordered five-grain doses of potassium iodide, and in the course of three weeks has shown marked improvement, although the palate is still paretic and his voice still somewhat nasal in quality. Deglutition is painless and normal.

The PRESIDENT said the patient had had some difficulty in swallowing, together with a very sore throat, and as diphtheria seemed to be excluded by the absence of the knee-jerks, he would suggest that it was a local neuritis due to the inflammatory condition of the patient's larynx.

GROWTH OR GRANULOMA OF THE EPIGLOTTIS FOR DIAGNOSIS.

Shown by Mr. WAGGETT. The case of a robust man of 60, complaining merely of slight hoarseness of four months' duration, sent to the hospital for removal of a papilloma of the uvula. Laryngoscopic examination showed an epiglottis much curled, deflected to the right and concealing the vestibule of the larynx. A mammillated excrescence was to be seen projecting from the posterior surface of the epiglottis near its right border. This excrescence had been white in colour at first, but had on a later examination appeared purple. The posterior part of the right arytænoid region could be seen red, swollen, and immobile during phonation; no glands in the neck. No evidence of pulmonary tuberculosis. One brother died of phthisis. A history of gonorrhœa. After fourteen days' exhibition of potassium iodide

the patient expressed himself as better, but the laryngoscopic image was unaltered.

Digital examination was not feasible.

Case of Œsophageal Pouch.

Shown by Mr. Butlin. I show here the fifth pouch which I have removed from the œsophagus. Like all the others, it was situated at the junction of the pharynx and œsophagus, and projected on the left side behind the œsophagus. The symptoms had been noticed for about eighteen years in a female 59 years old, and were the typical symptoms of pressure-pouch: return of particles of undigested food a day or more after they had been swallowed; escape of gas and food on pressure; the absence of wasting; and the impossibility of passing a bougie further than about nine inches from the teeth. There was no actual bulging in the neck. The operation presented peculiar difficulties on account of the large size of the pouch and consequent deviation of the course of the œsophagus. On this account it was exceedingly difficult to pass an instrument into the stomach, even when the pouch was exposed in the neck, separated from its attachments and drawn upwards. This was, however, accomplished before the pouch was cut out.

The patient is now convalescent. The result of the five operations has been four recoveries and one death. I think, if I had had the experience of this case before I removed the pouch in the fatal case (the third in order), that I should not have lost the patient. I probably should not have proceeded to take the pouch out after exposing it, as I could not, even then, pass any instrument into the stomach. I look on that as a necessary preliminary to the safe removal of an œsophageal pouch.

The President congratulated Mr. Butlin on the great success of his treatment in these rare cases of œsophageal pouch.

Mr. Butlin asked if any one knew of any case having been done in this country; he himself had not heard of any.

Case of Double Abductor Paralysis under Treatment by Intra-muscular Injections.

Shown by Dr. Pegler. H. H—, 44, married, and in very good general health, came to the Metropolitan Throat Hospital in June, 1899, complaining of loss of voice and some difficulty in breathing on inspiration, especially when hurrying. The voice was strident and disagreeable, but not aphonic. He admitted having had chancres at the age of 22, when he was put through a mercurial course. On examination the vocal cords were seen in the cadaveric position, or if anything rather nearer the middle line, and they remained so on deep inspiration, the right cord abducting rather more than the left. On phonation they adducted slightly. A small conical projection was visible in the interarytænoid space. The biniodide was administered freely by the mouth; in about ten days the small growth disappeared, and the patient felt much benefit both as regards breathing and voice. About a month ago, following the example of my colleague, Mr. Lake, I began and have continued using intra-muscular injections of perchloride, 1 in 120. The cords now move if anything a little better, and the patient insists that there is a still further improvement in his voice. He prefers the injections in every way. About 20 mins. of the solution are injected into the buttock twice a week.

The President said that Sir Felix Semon had seen this case of laryngeal abductor paralysis, and thought one might be called upon to do tracheotomy for it; it was one of those cases which were always under a cloud.

A Case of Tubercle of the Larynx.

Shown by Mr. Charters Symonds. The patient, a woman æt. 48, came to the throat department at Guy's Hospital in October last, complaining of loss of voice. The left ventricular band and cord were occupied by a deep red firm infiltration, extending the whole length. In the centre was a depressed irregular grey surface with raised edges. There was slight mobility of the

cord and arytænoid, the appearances closely resembling those of malignant disease, more especially as the arytænoid was quite normal, and there was a total absence of the gelatinous infiltration commonly seen. At this stage the diagnosis of malignant disease presented some difficulty. To remove any doubt, a portion from the centre of the ulcer was removed, and proved microscopically to be tubercular granuloma. Subsequent to this a history of hæmoptysis some years previously was obtained. No disease was found in the lungs.

At the present time the appearances resemble closely those above described, except that the gap in the centre is larger, on account of the operation, and the cord is slightly more moveable. The patient is pale and thin, and exhibits signs of pulmonary trouble.

The object of showing this case is to mark the resemblance of this form of tubercle to that of epithelioma. Recognising that tubercular tumours may remain with little alteration for considerable periods in the larynx, and thus closely resemble malignant disease, I brought this patient to illustrate that point. I may add that in a recent case the solid tubercular growth was sufficient to occlude the larynx. In this case there was no ulceration, no expectoration, none of the gelatinous swelling; in fact all the appearances closely resembled carcinoma.

Dr. Clifford Beale asked whether there had been any obstruction of the larynx before the piece was removed? He thought that in cases of submucous tubercular infiltration without breach of surface, the swellings might remain for long periods without change or even with diminution. He had shown such cases at previous meetings, and in one instance under observation for five years the patient had died, and the larynx showed that there had been no real obstruction and no breach of surface. After removal of a part of the swelling a raw surface must remain, as in the present case, and if the patient happened to be bringing up tubercle bacilli in the sputum there was danger of reinoculation.

Rhinolith.

Shown by Mr. Charters Symonds. The specimen shows a calcareous laminated wall enclosing a cavity. When recent, this cavity was occupied by some soft grumous material, which

may have been an old decolourised blood-clot or some inspissated mucus. It was removed from a boy æt. 11. He had had a cold for a couple of months, and it was noticed in the later stages that the discharge was confined to the right side and had become sanguineous. The rhinolith was removed by a probe. There was no history whatever of the introduction of a foreign body, nor was there any evidence of old disease in his nose. He was the son of well-to-do parents, and therefore had not been neglected.

The object of exhibiting the specimen is, first, to show its peculiarities, and, secondly, to note the short duration of the symptoms caused by a foreign body which must have existed for some years. That this must be the common history in such cases is well known. In another instance, where a friable calcareous mass was removed, the symptoms were also of short duration, but here there was a history of the introduction of some rose leaves into the nose six years previously.

Case of Tertiary Specific Ulceration of the Ala Nasi.

Shown by Dr. Dundas Grant. The patient, a married woman æt. 36, came under my care on the 23rd of the present month on account of an ulcer on the right ala of the nose of about two months' duration. The ulcer was about the size of a sixpence, and in the centre there was a small portion of tissue which appeared to be true skin but infiltrated. The ulceration furrow around this was deep, and the edges considerably thickened and infiltrated.

It had first appeared six months previously to my seeing her as a white speck followed by spreading ulceration, but had healed up under the action of medicine, presumably iodide of potassium. In the fauces there were cicatricial changes such as would result from tertiary ulceration involving the loss of the uvula.

Six years ago the patient suffered from a sore throat which lasted some weeks, and was accompanied by a rash and by loss of hair; and four years later she had severe ulceration of

the throat. She has two children, the youngest of which is thirteen years old.

Presumably this specific affection dates about six years back.

Case of Tuberculous Ulceration of the Pharynx and of the Lower Lip.

Shown by Dr. Dundas Grant. J. R—, aged 42, who looked much older, came under my care on the 23rd of the present month complaining of sore throat and cough, which had gradually developed during the last three months. The voice was husky, deglutition was painful, and the cough was accompanied by the expulsion of a yellowish coloured sputum tinged with blood. On inspection there was seen on the left half of the palate, uvula, tonsil, and anterior pillar an extensive ulcer, which on the flat surfaces was very shallow, but owing to its dipping into the irregularity of the part appeared in some places to be excavated. It was pale and the floor was covered with dusky greyish granulations from which exuded a slight moisture. The edges were not everted, and there was no induration on palpation. There was a fiery red areola. There were unmistakable signs of tuberculosis in both lungs, especially the right, and the diagnosis was made of tubercular ulceration. A scraping, however, was not found to contain tubercle bacilli, but the examination will have to be repeated. The glands are scarcely perceptibly involved. On the lower lip there is a deeper ulcer with soft slightly œdematous edges, the base being covered by a yellowish scab, the condition being probably a secondary focus of tuberculous inoculation.

Case of Swelling about the Bridge of the Nose.

Shown by Mr. Waggett for Mr. Stewart. A boy of 18, exhibiting indolent swelling about the bridge of the nose and œdema of the skin in both orbital regions, a condition very similar to that of the cases shown at the November meeting. The swelling commenced two years ago and had been under

observation now for eight months with permanent improvement. There was a history of a kick on the nose three years ago, and several blows had been received since.

Iodide of potassium had effected no change, and the same was to be said of the continuous application of the icebag for ten days.

Ulceration of Alæ Nasi.

Shown by Mr. Charles A. Parker. The patient was a female æt. 22, who had suffered from ulceration of the nose for two years. It affected both alæ, but extended more on the right side than on the left, and there was considerable loss of tissue.

The diagnosis rested between syphilis and lupus, and the opinion of the Society was invited as to which of these two troubles was the cause of the ulceration. The patient had been on potassium iodide for three weeks, but had not taken it with any great regularity.

The President: It struck me as lupus or chronic tubercle.
Dr. Dundas Grant: I should say lupus decidedly.
Dr. Lambert Lack: I should say syphilis.
Mr. Parker thought it rested between syphilis and lupus, and treatment alone would settle the question.

Case for Diagnosis. A Boy æt. 10 suffering from Aphonia.

Shown by Mr. Roughton.

Dr. Pegler thought the boy could scarcely be considered aphonic, as he had succeeded in making him speak in a fairly audible though feeble voice. With reference to treatment, he thought the fault lay perhaps as much with the respiratory muscles as with those of the larynx. He therefore recommended a course of exercises in breathing, as the boy exhibited deficient chest expansion, and his vital capacity was probably much below par. The speaker was directing his attention to this point in similar cases at the present moment, and in an extremely obstinate case of functional aphonia now under his care he found the breathing much at fault, the vital capacity being 80 in place of 150. The hope was that by remedying this defect the loss

of co-ordination between the muscles of respiration and phonation would be restored, and there seemed some promise of its fulfilment. In the boy's case the same plan was worthy of a trial, as in any case the exercises could but be beneficial.

The PRESIDENT concurred as to the advantage to be derived from exercises such as those mentioned by Dr. Pegler. He started regular systematic exercises of the chest in a patient, whom, however, he had not seen since. Sir Felix Semon had suggested it was much more of a spastic condition than an ordinary aphonia. He (the speaker) did not think the air current was sufficiently large to put the vocal cords into proper action.

CASE OF DOUBLE UVULA.

Shown by Mr. DE SANTI.

Mr. SPENCER doubted whether the case should be termed one of "double uvula." The bands appeared to be congenital, stretching across between the posterior pillars of the fauces, and presumably were remains, at the junction between the stomodæum and the foregut, of the primitive septum.

The PRESIDENT thought it looked as if some ulceration had been present, though there was no history of scarlet fever; it did not look like a congenital production.

CASE OF TUBERCULAR LARYNGITIS IN A MAN ÆT. 31.

Shown by Dr. FITZGERALD POWELL. When first seen on November 16th he complained of loss of voice and some difficulty in breathing.

The patient enjoyed good health until five years ago, when he caught a severe cold and lost his voice; he has regained it somewhat, but it has been husky ever since. Two months ago the voice got worse. Twelve months ago he had an attack of dyspnœa, but otherwise has not felt the breathing to be laboured, though at night he is seen to have considerable stridor.

On examination the general appearance of the larynx is rather red; the glottis is little more than a chink. On the right side the arytænoid is fixed, and the cord is obscured by the false cord, which is drawn over it and is ulcerated. On the left the vocal cord is broad and thickened, and is covered with

granulations. In the posterior commissure, rather to the left, there is a pedunculated growth, which flaps to and fro on inspiration and expiration.

His family history is good, and I can find no history of syphilis.

Signs of cavity and consolidation are found in the lungs, though no bacilli were found in his sputum on examination.

On November 29th, when he was last seen, he was much better, and the breathing during sleep quite free from stridor.

The right cord can now be seen beneath the ventricular band, the left cord is smoother, and there appears to be much more breathing space.

Mr. SPICER thought this was a very complicated case, possibly a "mixed" case of tubercle and syphilis.

Dr. FITZGERALD POWELL apologised for not being able to give the Hon. Secretary notice of this interesting case at an earlier date, to enable him to put it in the list of cases shown. He regretted not being able to have had the opinion of the members, though he believed some of them had seen the case, and thought with him that it was a case of syphilitic ulceration with later tubercular infection.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

EIGHTH ANNUAL GENERAL MEETING, *January 5th*, 1900.

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

WILLIAM HILL, M.D., } Secretaries.
LAMBERT LACK, M.D., }

Present—14 members.

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

Drs. FitzGerald Powell and Jobson Horne were appointed Scrutineers of the ballot for the election of Officers and Council for the ensuing year. They reported the result of the ballot as follows:

President.—F. de Havilland Hall, M.D.
Vice-Presidents.—A. A. Bowlby, F.R.C.S.; W. H. Stewart, F.R.C.S.Ed.; E. Law, M.D.
Treasurer.—E. Clifford Beale, M.B.
Librarian.—J. Dundas Grant, M.D.
Secretaries.—H. Lambert Lack, M.D.; E. Waggett, M.B.
Council.—Walter G. Spencer, M.S.; F. W. Milligan, M.D.; Herbert Tilley, F R.C.S.; Barclay Baron, M.B.; William Hill, M.D.

The Report of the Council was then read and adopted.

The Council, in making their Annual Report, have pleasure in calling attention to the continued prosperity of the Society.

The installation of additional lamps has enabled more cases to be exhibited than had previously been possible; and the average attendance at each meeting—thirty-six—has also surpassed any previous record.

An endeavour has been made to render the printed reports of the proceedings a more accurate record of the discussions by the employment of a shorthand writer; and further improvements in this direction are contemplated in the ensuing Session.

The Ordinary Meeting, held on May 5th, 1899, was devoted to a discussion on "Asthma in Relation to Diseases of the Upper Air-passages," introduced by Dr. Percy Kidd and Dr. MacBride. This meeting was attended by 42 members and 9 visitors, many of whom took part in the discussion.

Seven new members have been elected, and three resignations of membership have been received since the last Annual Report; and by the lamented death of Professor Stoerk, of Vienna, the Society has lost one of its best known honorary members.

The satisfactory financial position of the Society will be dealt with separately by the Treasurer.

The Treasurer's Report was then presented and adopted.

The actual receipts for the year 1899 amount to £132 6*s*. This includes seven subscriptions for 1898 and two for 1900.

Six subscriptions for 1899 and five for 1898 and 1899 are still outstanding, and one entrance fee remains unpaid.

The actual expenditure for the year amounts to £127 4*s*. 8*d*., leaving a balance of £5 1*s*. 4*d*., which, added to last year's balance, leaves a total credit balance of £215 16*s*. 3*d*.

BALANCE-SHEET, 1899.

Income.	£	*s*.	*d*.	Expenditure.	£	*s*.	*d*.
Balance from 1898	210	14	11	Rent, Electric Light, etc. .	31	10	0
108 Subscriptions	113	8	0	New Electric Lamps . . .	11	10	0
7 „ (1898) . .	7	7	0	Adlard's Bill—August, 1898, to December, 1899 . . .	66	15	9
2 „ (1900) . .	2	2	0	Reporting	10	10	0
9 Entrance Fees	9	9	0	Rogers—Spirit Lamps, etc. .	1	4	9
				Clarke—Indexing	1	5	0
				Mathew (porter)	1	8	0
				Hon. Secretary's Expenses .	1	3	6
				„ „ (Dr. Lack)	0	9	11
				Hon. Treasurer's Expenses (stamps, petty cash payments)	1	3	2
				Bank Charges	0	4	7
					127	4	8
				Balance in hand	215	16	3
Total . .	£343	0	11	Total . .	£343	0	11

Audited and found correct, { H. BETHAM ROBINSON. G. SCHORSTEIN.

In presenting the Librarian's Report Dr. DUNDAS GRANT said:

During the past year the members of the Society have made rather more use of the Library than previously. I have had a complete "slip" catalogue of the Library prepared by an experienced person, and I trust that this piece of work, which I have great pleasure in presenting to the Society, will be found useful by the members. As the Catalogue thus prepared is one which permits of indefinite enlargement, I trust that members will do their utmost, by giving or procuring donations to the Library, to increase the bulk of the work. I append a list of works which have been added since my last report, and have revised the list of exchanges up to date. The list of microscopical preparations in the possession of the Society is also added. Dr. Pegler has kindly gone through them so as to report upon their condition, which I am therefore able to inform you is perfectly satisfactory. He has further made out a list of those specimens which have been exhibited to the Society or brought before the Morbid Growths Committee, but which do not find a place in our collection. I have still a number of copies of Professor Massei's resumed note upon '500 Cases of Laryngeal Neoplasms' for distribution to any members of the Society who may desire to have them.

A number of pamphlets and monographs and various reprints have been received, and I should be glad to have the benefit of the assistance of a small sub-committee to consider the question of preserving, binding, or in some cases destroying this accumulating material. I could imagine no better group for the purpose than my predecessors in the post of Librarian.

I find that the exchanges with the following have lapsed, and I shall at once negotiate for their resumption:—'Annals of Laryngology, Rhinology, and Otology' (America). Dr. Natier's 'Revue Internationale de Laryngologie' (which has merged into a journal called 'La Parole'). Transactions of the French and of the Parisian Laryngological Societies.

Volumes of the 'Proceedings' at present in the Librarian's charge: Of the bound volumes I have—

11 copies of Vol. I.
3 copies of Vols. I and II bound together.

While of unbound volumes I have—

4 copies of Vol. I (one copy with January missing).
19 copies of Vol. II (one copy with January missing).
19 copies of Vol. III (one copy with January missing).
19 copies of Vol. IV (one copy with January missing).
14 copies of Vol. V.
11 copies of Vol. VI.

In addition I have the following surplus copies of 'Proceedings:'

List of Members, 1894, 2 copies.
Supplemental List of Members, 1894, 3 copies.
List of Members, 1896, 1 copy.
List of Members, 1897, 1 copy.
List of Members, 1898, 4 copies.

'Proceedings.'—November, 1897, 1 copy; December, 1897, 2 copies; January, February, March, April, June, 1898, 1 copy; May, 1898, 2 copies; November, 1898, 3 copies; December, 1898, 9 copies; January, 1899, 17 copies; February, 1999, 9 copies; March, 1899, 6 copies; May, 1895, 1 copy; October, 1895, 4 copies; November, 1895, 1 copy; December, 1895, 1 copy.

Title-pages, 1894–5 and 1896–7, 1 copy of each.

1 Index.

List of Various Works received during 1899, presented by their Authors.

Grosheintz. On the Relation of Hypsistaphylia to Leptoprosopia.
Moure. Case of Acute Osteitis Consecutive to Influenza.
Moure. Some Facial Paralyses of Otitic Origin.
Goguenheim. Traumatic Abscess of the Nasal Septum.
Olivier. The Whispered Voice.
Collet. On Anosmia.
Bonnier. On Tests for Hearing.
Natier. Neurasthenia in Relation to Certain Affections of the Nose and Throat.
Proceedings of the Brighton Medico-Chirurgical Society for 1898–9.
Rousselot. History of the Practical Application of Experimental Phonetics.
Olivier. Etiology and Treatment of certain Vocal Affections, with Remarks on the Treatment of Nervous Aphonia and Dysphonia.
Natier. Recurring Spontaneous Epistaxis.
Report of the Annual Meeting of the Dutch Society for Diseases of the Throat, Nose, and Ear.

The following books have been presented by Sir Felix Semon:

Hajek. The Pathology and Treatment of Inflammatory Affections of the Accessory Cavities of the Nose (German).
Pieniazka. Laryngoscopy (Hungarian).
Semon. The Nervous Affections of the Larynx and Trachea (German).

Also the following shorter monographs and reprints:

Felix, Sir Semon.

Clinical Lecture on the Diagnostic Significance of Laryngeal Abductor Paralysis.
Remarks on a Case of Congenital Web between the Vocal Cords associated with Coloboma of the Left Upper Eyelid.
The Mutual Relationship and Relative Value of Experimental Research and Clinical Experience in Laryngology, Rhinology, and Otology.
Caillots sanguins simulant des néoplasms du larynx.
Die Thyreotomie bei bösartigen Kehlkopfneubildungen.
Zur Frage der Radikaloperation bei bösartigen Kehlkopfneubildungen mit besonderer Berücksichtigung der Thyreotomie.
Herr Grossman und die Frage der Posticuslähmung.
Die Stellung der Laryngologie bei den Internationalen Medicinischen Congressen und die Frage ihrer Vereinigung mit der Otologie bei diesen und ähnlichen Gelegenheiten.
Einige Bemerkungen zu der neuen Sendziakischen Statistik über die operative Behandlung des Larynxkrebses.

Kelly, A. Brown, Esq., B.Sc., M.B.

Large Pulsating Vessels in the Pharynx.

Hopmann, Dr.

Zur Operation der harten Schädelgrundpolypen (Basisfibrome bezw. Fibrosarkome) nebst Bemerkungen über Nasenpolypen.

Gleitsmann, J. W., M.D.

A Case of Unusual Laryngeal Growth.

Frankenberger, Dr. O.

Un case de double rétrécissement du Pharynx.

Grazzi, Prof. V.

Nouveau traitement des inflammations chroniques catarrhales du pharynx en rapport particulièrement avec les maladies de l'oreille.

Frankfurt, Dr. George Avellis.

Ueber die bei kleinen kindern ein kieferhölenempyem vortäuschende tuberculose des Oberkiefers.

The periodicals so far as the volumes have been completed have been bound.

Catalogue of Microscopical Specimens.

Nose.

1. Section of the normal mucous membrane of the inferior turbinal.
2. Another section of ditto.
3. Section through the normal inferior turbinated body.
4. Regeneration of the mucous membrane of the inferior turbinal after turbinectomy (Dr. Hill's case).
5. Posterior moriform hypertrophy of the mucous membrane of the inferior turbinal.
6. Papilliform hypertrophy of the anterior end of the inferior turbinal.
7. Simple anterior hypertrophy of the inferior turbinal.
8. Tuberculous growth of the inferior turbinal (Dr. Hill's case).
9. Polypoid hypertrophy of the middle turbinal.
10. Section of the middle turbinal from a case of rhinitis sicca.
11. Polypoid hypertrophy of the septum nasi.
12. Giant-cell sarcoma (Mr. Hadley).
13. Fibro-angioma of the septum (Dr. Scanes Spicer).
14. „ „ „ „
15. Polypus of the nose.
16. Cystic polypus of the nose.
17. Sarcoma of the vestibule.

Accessory Sinuses.

18. Polypoid vegetations of the antrum (Mr. Charters Symonds).
19. „ „ of the frontal sinus (Dr. Tilley).

Mouth and Tongue.

20. Fibroma of the tongue (Dr. Morley Agar).
21. „ „ „ „

Naso-pharynx.

22. Adenoid vegetation.

Fauces and Pharynx.

23. Papilloma of the uvula.
24. Tuberculous uvula.
25. Chronic tonsillitis.

Neck.

26. Tuberculous glands of the neck with giant-cells.

Larynx.

27. Tubercle of the larynx with giant-cells.
28. Normal section of the inter-arytænoid space.
29. " " " " "
30. Lupus of the epiglottis (Professor Massei).

The Report was adopted, and a vote of thanks was given to the Librarian for the excellent catalogue which he had prepared.

The meeting then adjourned.

The Ordinary Meeting of the Society was then held, A. BRONNER, M.D., Vice-President, in the Chair.

Present—the two Secretaries, 30 members and 4 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were unanimously elected members of the Society:

F. O'Kenealy, Capt. R.A.M.C., India.

G. Constable Hayes, F.R.C.S., 22, Park Place, Leeds.

F. H. Westmacott, F.R.C.S., 5, St. John Street, Manchester.

Dr. WATSON WILLIAMS showed a series of stereoscopic lantern slides of anatomical and pathological preparations of the larynx, pharynx, nose, and its accessory cavities. He pointed out and demonstrated the remarkably realistic effects obtained by this method, and its value in showing to a large number of spectators or pupils various anatomical and pathological specimens.

A special vote of thanks was accorded to Dr. Williams for his excellent demonstration.

Dr. JOBSON HORNE gave a lantern demonstration of preparations illustrating the following pathological conditions of the larynx.

1. *Œdema of the Glottis.*—The epiglottis, ary-epiglottic folds, and arytænoid regions presented a considerable amount of œdema; this had been well preserved by means of the formalin method. The mucous membrane itself was free from ulceration and erosion. There was prolapse of the mucous membrane lining the left ventricle of Morgagni. On the outer surface, in the region over the left ala of the thyroid cartilage, a cavity surrounded by inflammatory thickening contained pus and fragments of necrosed cartilage. The left ala of the thyroid cartilage was involved in the necrosis, and this had no doubt led to the detachment and prolapse of the mucous membrane lining the ventricle.

The cricoid cartilage and the hyoid bone were not affected. At the post-mortem, brawny swelling was noted behind the angles of the jaw, and also much inflammatory thickening of the structures about the pharynx and larynx. The posterior pharyngeal wall was raised from the vertebral bodies by inflammatory products, but there was no suppuration. A scar in the spleen was suggestive of an old gumma.

The patient, a man æt. 28, five months before his death contracted a "cold," which was followed four months later by a sore throat. Inspiratory dyspnœa set in and steadily increased in the course of five days, when the man sought relief. Tracheotomy was speedily performed, but the patient succumbed very shortly afterwards from heart failure. When in India some years previously he had had enteric fever.

2. *Cyst of the Epiglottis.*—The original size, shape, and tenseness of the cyst were well preserved by means of the formalin method. It was mainly situated on the lingual surface, but occupied the free edge of the right half of the epiglottis.

The larynx was removed from a man æt. 34, who died from a mediastinal new growth with secondary growths in the neck. The left recurrent laryngeal nerve was implicated, and the left vocal cord had atrophied.

3. *Laryngeal Tuberculosis.*—This preparation was from the larynx of a child æt. 12 *months,* who had died from pulmonary tuberculosis. A microscopic section had been cut horizontally through the entire larynx, passing through the arytænoids, inter-arytænoid folds, and the ventricular bands just above the

level of the cords. The section showed a well-developed tuberculous excrescence projecting from the right side of the inter-arytænoid region into the glottis; this growth contained giant-cells and tubercle bacilli, which were also met with in the outer and posterior wall of the left ventricle. The specimen is important having regard to the age of the child.

4. *Pachydermia Laryngis Verrucosa.*—The interior of the larynx had been exposed by an incision through the inter-arytænoid region. The specimen was very typical of the warty condition seen about the vocal processes in the earlier stage of the disease.

5. Another specimen illustrating the same disease, for which Dr. Jobson Horne was indebted to Dr. Herbert Tilley; the inter-arytænoid space had been brought fully into view by an incision through the thyroid cartilage.

In this case the pachydermia was more advanced and diffuse, the entire mucous membrane being more or less affected. The inter-arytænoid space was occupied by a symmetrical pair of warty excrescences, one on either side of the middle line, and projecting forwards into the glottis.

Case of Tabes with almost Complete Laryngoplegia.

Shown by Sir Felix Semon. A. S—, a carman æt. 40 years, was admitted under the care of Dr. Hughlings Jackson into the National Hospital on December 11th, 1899. He had syphilis five years ago with secondary symptoms, and was treated only a few weeks. His present symptoms began fourteen months before admission with loss of control over the bladder. This was followed by numbness and shooting pains in the legs, trunk, and hands, ataxia and gastric crises. For nine months his voice had been altering and he had had shortness of breath, but apparently no laryngeal crises.

Summary of Symptoms.—Extreme general emaciation. Arteries thickened and tortuous. Double ptosis. Reflex irido-plegia. Slight weakness of the right half of face. Extreme inco-ordination; marked hypotonia; can only walk when supported. Entire loss of sense of passive movement in lower

extremities. Analgesia (partial) over face, over arms and upper part of chest, and over lower extremities. Severe shooting pains and gastric crises. Complete incontinence of sphincters; no anal reflex. All deep reflexes absent; plantar reflexes show a typical tabetic response. No difficulty in swallowing, no return of fluids through the nose.

Voice.—Speaks in a loud hoarse whisper. When talking he quickly runs short of breath, and between his utterances a sort of subdued inspiratory stridor is sometimes audible. He cannot cough in the usual way, but on attempting it a long noisy expiration results.

Palate.—On attempted phonation the palate itself remains perfectly motionless, but the posterior arches make some rapid and feeble inward movements. The tactile sensibility is perfectly normal, but the reflex excitability is much diminished, though not completely abolished.

Larynx.—During quiet respiration both vocal cords stand perfectly motionless in about the minimum width of the cadaveric position (about 3 mm.) apart, but their posterior ends are a little nearer one another than is usual under such circumstances, and their free borders are not excavated but perfectly straight. Neither on attempted deep inspiration nor on phonation is the slightest movement of the cords visible.

On touching the epiglottis with a probe, no reflex movement whatever is noticeable. On touching the inter-arytænoid fold regular closure of the glottis takes place immediately, without cough being produced.

On touching the right ventricular band reflex closure ensues. The same more strongly and combined with feeble cough ensues when the left ventricular band is touched.

Remarks.—The case is shown on account of its extreme rarity. It is the third case I have ever seen of complete or nearly complete bilateral recurrent paralysis, and the first I have ever seen in tabes. There is only, so far as I know, one case of complete bilateral recurrent paralysis in tabes on record. This has been described by Gerhardt.* Another very remarkable

* "Bewegungsstörungen der Stimmbänder," Nothnagel, 'Spec. Pathologie und Therapie,' Bd. xiii, 1896.

circumstance is the comparative loudness of the patient's voice. As a rule in bilateral recurrent paralysis the voice is entirely extinct, and the whisper absolutely toneless. Finally, the manner in which a few fibres of the accessory and vagus have escaped (as shown by the fibrillary contraction of the palatinal muscles, by the possibility of closing the glottis on peripheral stimulation, by the maintained possibility of producing tension of the vocal cords through the crico-thyroids, and by the diminished yet not quite abolished reflex irritation of the palate and larynx) is very remarkable.

I have to thank Dr. Hughlings Jackson for kindly permitting me to show the case, and Dr. H. L. Collier for the notes of the general condition of the patient.

Mr. W. G. Spencer said that this was another instance of focal lesions in tabes, which agreed, in his opinion, with the results of experiments concerning the vagus group of nerves. The case pointed to a bilateral lesion of the nuclei corresponding to the pneumogastric roots, as shown by the sensory paralysis, the impairment of the respiratory muscles, and the impossibility of coughing. Dr. Tilley and others had shown cases where the lower bulbar roots of the vagus were involved, in which, as distinct from the present case, there was noted paralysis of the abductors of the soft palate without loss of sensation in the larynx or disturbance of respiration, etc. There were also cases in which the spinal accessory nuclei were involved, and the trapezius and the sternomastoid muscles were paralysed; in other cases the hypoglossal nucleus being also involved, there had been paralysis of one side of the tongue.

Sir Felix Semon said that he did not wish to say anything at present as to the general question of the innervation of the larynx. This patient had not isolated abductor or adductor paralysis, but practically complete recurrent paralysis. If the patient attempted to cough, a large quantity of air escaped through the glottis, and this was the cause which prevented him coughing in the ordinary fashion. He was not aware that Dr. Tilley had ever shown a case of adductor paralysis in tabes, and doubted whether he had done so; cases of *ab*ductor paralysis in that affection of course were not rare. His reason for showing this case was that it was, so far as he knew, the second on record in the whole of the literature on the subject in which there was a *complete* laryngoplegia in a case of tabes dorsalis. As to the escape (?) of some fibres of the palate, he had pointed out in his paper this remarkable fact, both in the motor and sensory spheres, in the palate and larynx. The laryngoscopic image was not exactly as it would have been if the patient was suffering from complete paralysis of the superior laryngeal nerve, *i. e.* the cords were not excavated but

perfectly straight, which showed that the crico-thyroid muscles must have escaped, a fact which was further corroborated by the comparative loudness of the patient's voice.

Case of Injury of the Larynx in a Female.

Shown by Mr. Lawrence. The patient was a woman æt. 46, who in 1891 had her throat cut; the air-tube and œsophagus had both been divided. The case did well, and recovery took place in a few weeks. Since then her voice has been husky, and sometimes reduced to a whisper. The larynx shows the vocal cords normal, but they do not quite meet posteriorly during efforts at approximation.

Just now the patient has a cold and some slight laryngitis, which rather masks the curious feature of her case.

Case of Pharyngo-œsophageal Carcinoma.

Shown by Mr. Spencer. The patient is a man about 60. He complains of wasting, owing to difficulty in swallowing during the last three months. He has a mass of carcinoma at the junction of the pharynx and œsophagus and involving the back of the larynx, causing swelling of the arytænoids and ventricular bands, and there is also some infiltration of the glands in the neck.

Five other such cases have been seen during the past year. Two had very extensive infiltration of the glands in the neck, with some hoarseness and dysphagia. The primary growth was situated in the hyoid fossa, and quite small, not more than 1 to 2 cm. in diameter.

No attempts at removal have been made, as there seemed no prospect of affording relief, especially as the larynx itself would have to be removed. Neither would gastrostomy have improved the patient's condition.

All the cases have tended rapidly to a fatal issue.

Sir Felix Semon made some observations of a general character with regard to this case. Mr. Spencer had shown a case of early cancer of the *pharynx* in which the primary focus was very small, and

yet there were big masses of glands in the neck. He asked, Why did not the same happen in "intrinsic" cancer of the *larynx?* The school of Sappey was totally opposed to Luschka's statements on this question, according to which the laryngeal lymphatics were of a more isolated character than those of the pharynx, which freely anastomosed with neighbouring lymphatics. Luschka's views had at any rate the merit of intelligibly explaining the undeniable clinical differences between intra-laryngeal and pharyngeal cancer with regard to infiltration of the neighbouring lymphatics, which, if Sappey's statements were correct, was absolutely unintelligible. The speaker thought that this was a most important question, which deserved re-investigation.

Case of Primary Atrophic Rhinitis commencing in Infancy.

Shown by Mr. Spencer. A child, æt. 5, was first brought for treatment on account of ozæna and crusts. She has been for some time under Mr. Spencer, and has been treated by a saline douche without any marked improvement. The appearances in the nose are typical. There is an entire absence of any evidence that the rhinitis was secondary.

The child had nothing wrong with the nose during the earlier months of infancy, and she has had no other illness.

Dr. Bronner had seen several cases of ozæna which had begun at an early age—twelve, indeed, between two and three years of age. They should make a distinction between atrophic rhinitis and ozæna, which were distinct and separate diseases. In the north of England atrophic rhinitis was extremely common, especially amongst the mill girls. Ozæna attacked its victim early, whilst atrophic rhinitis began between the ages of fourteen and eighteen. The cases of ozæna he had seen in babies had been independent of syphilis; possibly, perhaps probably, they were connected with purulent discharge at birth caused by contagion. As regards the smell, the children of the working classes often smelt so badly that it would be difficult to detect the smell of ozæna.

Dr. Herbert Tilley said he could find no evidence of congenital syphilis in this case. He had seen similar cases, and did not consider them very rare. It was interesting to find that no history of a purulent discharge preceded the present condition of scab formation, and therefore the case was opposed to Bosworth's view that atrophic rhinitis was a late stage of purulent rhinitis in childhood. The speaker thought the great majority of the latter cases were due to adenoids. Again, such cases as Mr. Spencer's showed how improbable

it was that "ozæna" arose from accessory sinus suppuration, as stated by Grünwald and others.

Dr. JOBSON HORNE suggested that bacterioscopic examinations made at intervals might possibly throw some light on the ætiology of the condition.

Dr. LAMBERT LACK said he had seen a family in which several members among the children suffered from ozæna, which commenced at an early age. He thought he could bring forward a dozen cases in which the discharge had commenced at as early an age as in the case under discussion. In the majority of these cases there was a history of purulent rhinitis at quite a young age, though it might not always be due to any special cause, such as gonorrhœa, syphilis, etc. He believed that, as a rule, atrophic rhinitis was the result of long-continued purulent rhinitis; and that if one reckoned the discharge as an early symptom of atrophic rhinitis, the majority of cases could be dated back to an early period of life.

Mr. WAGGETT referred to a family case of atrophic rhinitis. The disease was well developed in the mother. Six years ago her daughter, six years of age, came to the hospital with muco-purulent catarrh. In spite of nose-washes, etc., she had gradually developed atrophic rhinitis, which was well established at the present date. Her younger sister had during the last two years exhibited the same sequence of changes. There was still another little sister, who was following the same course. Here was a case of family ozæna quite unconnected with syphilis, and making itself evident between the ages of four and six.

Mr. SPENCER, in reply, said the points in the case were that there was no evidence of congenital disease; the formation of crusts and the ozæna had been first noticed at ten months. Atrophic rhinitis was very generally secondary, but in the present instance all inquiry as regards a secondary origin failed. He thought the related histories of affected families important in relation to a possible bacterial origin. Hitherto the bacteriology of the nose had not advanced far.

CASE OF PAPILLOMATOUS CONDITION OF TONGUE.

Shown by Dr. BALL. A healthy-looking girl, æt. 20, with good family history, has had discomfort in her tongue for about two years, and for the same period has noticed a "growth" on her tongue which has gradually increased in extent. The discomfort and soreness get worse for some weeks at a time, and then diminish, but never quite leave her. For the last few months she has felt some soreness of the throat on the right side. There is no history or suspicion of syphilis. Immediately to the right of the middle line of the dorsum of the tongue there

is a marked outgrowth over an area about half an inch broad, extending from near the tip to the origin of the circumvallate papillæ. It is made up of separate nodular masses varying in size from a grain of rice to a small pea. The surface is redder than the rest of the tongue, and the papillæ are enlarged. Under the tip of the tongue to the right of the frænum are some small warty growths. The right anterior pillar of the fauces is congested, and presents a few small glistening elevations.

Mr. Butlin said he had carefully examined the tongue, and believed that the disease should be described as a local macroglossia—an affection of the lymphatic system of the tongue. He had seen many similar cases, and this one resembled the first in which he had removed the disease. The patient was just such another red-faced country girl, and the tumour occupied the middle line of the tongue in two longitudinal crests. He thought they were papillary growths, and cut them out with scissors. The hæmorrhage was very abundant, and continued to recur in so serious a manner that pressure had to be employed for part of two days before the bleeding was arrested. Ever since, Mr. Butlin had made a practice of cutting such growths out between two deep incisions which passed far into the substance of the tongue. The edges of the incisions are brought together with silk sutures, and there is no fear of recurrent or secondary hæmorrhage.

Specimen of a Bony Cyst of Middle Turbinate Bone.

Shown by Dr. Herbert Tilley. The specimen was a large bony cyst removed from the left middle turbinate of a young woman æt. 29, who complained of nasal obstruction, aching over the root of the nose, and a constant discharge of clear fluid from the left nostril.

The cyst would contain a horse-bean, and was interesting from a pathological point of view. It contains a muco-purulent secretion and a few œdematous granulations. It was removed by dividing the attachment of the middle turbinate to the outer wall of the nose with scissors, and then snaring the semi-detached portion.

The patient was quite relieved of her symptoms.

Dr. Watson Williams remarked that an ethmoidal cell sometimes existed normally in the middle turbinate body, and this, like the other

ethmoidal cells, might become the seat of inflammatory disease. He thought it probable that in this specimen, as in many of the cases of cysts of the middle turbinate, some such "primary accessory sinusitis" arose, resulting in the blocking up of the ostium, and consequent distension with retention of secretion and formation of the cyst.

Dr. JOBSON HORNE inquired whether the cyst communicated with the interior of the middle turbinal body. He had met with what might be a somewhat similar condition, and in which he was inclined to regard the cyst as a modified anterior ethmoidal cell.

Dr. BENNETT said these cysts were not rare, and in one or two cases, owing to pressure and pain, he had had to remove such at a comparatively early stage; there were no contents, but the space was lined with a perfectly smooth membrane. In one case he had to operate on account of the neuralgic pains. He did not understand how such cystic dilatations originate. He had seen larger cysts than those shown.

In reply, Dr. TILLEY said that he had searched carefully for communication with the other ethmoid cells, but had found none. There was no evidence of accessory sinus suppuration. The exhibitor could offer no satisfactory solution as to the origin of such growths; they might possibly be a dilatation of the normal cells existing in the middle turbinate, which became enlarged as part of a chronic inflammatory process; or, as MacDonald has suggested, they may arise from incurvation of the free margin of the bone enclosing a cavity lined with normal nasal mucous membrane as the result of an osteophytic periostitis.

CASE OF MALE ÆT. 17 YEARS AFTER REMOVAL OF FIBRO-MYXOMA OF THE POST-NASAL REGION.

Shown by Dr. FITZGERALD POWELL. The case was shown at the last meeting of the Society.

On December 2nd he was placed under an anæsthetic, and examination disclosed the extensive character of the tumour.

A preliminary laryngotomy was performed, and the upper aperture of the larynx plugged with sponges.

The soft palate was then split and the divided portions held apart by long silk threads passed through them. It was not necessary to remove any of the hard palate, as the posterior edge had been considerably eroded by the pressure of the growth. In this way the tumour was fully exposed, and was found to be attached to the body of the sphenoid. It filled the whole of the naso-pharyngeal cavity, and sent prolongations into the right spheno-maxillary fossa and right nostril, pushing the septum

against the external wall of the left nostril, and completely occluding it.

The bony walls of the naso-pharynx were considerably eroded by the growth. It was removed by the aid of "Lack's" snare and cold wire, and strong scissors curved on the flat, with which the toughest parts were dissected away.

The bleeding was severe, but was controlled by hot sponges and pressure.

The edges of the wound in the palate were brought together by silk sutures, and a sponge left in the post-nasal space for twenty-four hours and then removed.

The laryngotomy tube was allowed to remain in for three days.

The boy is now doing well, and returns home to-morrow. The wound in the palate has healed, but some of the stitches broke out, and there is still a small opening near its junction with the hard palate. This, though interfering somewhat with his speech, has the advantage of enabling us to observe the condition of the parts, and to treat the atrophic state of the naso-pharynx.

An operation at a future time may be attempted to close the wound and straighten the septum, or a suitable obturator may be worn.

The wound in the neck is quite healed, and gave no trouble.

The incontinence of urine and drowsiness from which the patient suffered has completely disappeared.

The tumour is a pure fibroma, dense and tough.

Mr. Butlin said the tumour was the largest he had ever seen taken from the naso-pharynx, and he thought it must have opened its way into one, if not both, of the antral cavities by absorption of the bone. It appeared more likely to be a fibroma than a sarcoma, and the operation bid fair to be a complete success. But he was afraid the hole in the palate was not likely to close.

Mr. Spencer had on the previous occasion expressed the opinion that the tumour belonged to the upper jaw, and should be operated upon through a facial wound. He thought that the case should be carefully watched, and if there were signs of renewed growth, this measure should be undertaken early. In a similar case the growth extended out into the spheno-maxillary fossa behind the antrum towards the temporo-malar and cheek region.

Dr. FitzGerald Powell in reply thanked Mr. Butlin and Mr. Spencer for the kind way in which they had alluded to his case.

He did not think that the growth had invaded the antrum, and he was quite certain it had not reached it from the nose, but it was possible that it had done so from behind, through the spheno-maxillary fossa. However, on the removal of the tumour, from its appearance and general contour he felt quite satisfied that he had got it all away. The prolongations of the growth, one into the nose and another which filled the spheno-maxillary fossa, were quite intact, and the growth itself was so tough and firm that it would have been impossible to break away any part of it without being able to recognise it.

There were two interesting points in connection with such tumours. The first was the difficulty in determining the extent and attachments of the tumour, and indeed the impossibility of doing so until the palate had been split and the growth exposed. The second was with regard to the diagnosis at an early stage.

This patient two years ago had been an in-patient at a London general hospital for six weeks, and was said to be suffering from a nævus of the throat (this was the history given by the boy's father), and he thought it was quite possible for such an error to be made at an early stage when frequent and serious bleedings were occurring.

Case of Intractable Aphonia with Occasional Apsithyria.

Shown by Dr. Pegler. A girl æt. 22, a school teacher, had long been liable to temporary loss of voice on catching cold.

In February, 1899, she suddenly lost it altogether and, except for a slight recovery in response to a local galvanic application by the family doctor, had since been not only unable to speak, but often could not even whisper, and in the months of July and August following had either carried a conversation book about with her, or had communicated with her friends on her fingers. She came as an out-patient to the Metropolitan Throat Hospital in November. On examining the larynx a stammering action of the vocal cords was all that could be seen on attempted phonation, but the stimulus induced by probing the larynx in any situation was sufficient to create adduction and production of tone. The laryngeal electrode was applied to the vocal cords systematically about three times a week for a month, resulting in considerable improvement. The glottic chink was then elliptical, the internal thyro-arytænoid being mainly affected. More latterly much of the improvement fell off, the arytænoid muscle became also paretic, causing the

triangular glottis, and the girl had on more than one occasion become apsithyric again, so that there was distinct retrogression, and the usual treatment having so far failed, fresh suggestions were invited from the Society. The family history was noteworthy. Paternal grandfather epileptic; mother liable during her pregnancies to violent fits of hysteria. Two brothers, out of a family of six living, were epileptics. Patient herself had shown no other manifestations of hysteria.

Dr. HERBERT TILLEY gave details of a case of an inveterate nature in which very strong intra-laryngeal faradic shocks produced no result whatever, not even temporary improvement, neither had any other sudden painful shock been of avail, and he asked Sir Felix Semon if he knew of any successful means of treating such cases. In the case referred to by the speaker, the latter advised isolation, Weir Mitchell treatment, and then when the system was in a healthy condition the application of the strong faradic current.

Dr. BENNETT suggested that breathing exercises should be tried. He had recently, after two or three years of trouble with a patient who had been to several hospitals, tried these exercises systematically; the voice after a short time completely returned. No other treatment, such as faradisation, etc., had done any good. The patient had now been several months without return of the aphonia. He should say that in the case under discussion the upper chest breathing was very bad; in fact, her whole method of breathing was irrational.

Dr. BRONNER recommended the trial of the faradic current with the metal brush. It was extremely painful, but most useful. He had treated a servant some months ago who had been aphonic for several months, and in fact was about to be dismissed; he tried the above treatment, and she was cured almost immediately.

Sir FELIX SEMON looked upon cases such as had been mentioned in the discussion, in which, apart from the aphonia, there was functional paralysis of the whole apparatus of articulation, including the movement of the lips, as examples of Charcot's "hysterical mutism;" they represented, as it were, the superlative of hysterical aphonia. In reply to Dr. Pegler's question, he stated that in his experience the vast majority of cases of hysterical aphonia could be cured in one sitting by intra-laryngeal applications of electricity, one electrode being applied to the inter-arytænoid fold, and he wished to repeat this statement emphatically, in spite of the fact that this experience of his had been recently queried in a text-book. But it was necessary to exercise very considerable energy in many of these cases. With increasing experience, he had become more and more convinced that, added to the physical inability, there was in many of these cases considerable mental perversion. When after restoration of the voice by electricity, as manifested by the involuntary cry which usually was the first sign of the restored function of the adductors, the patients

were directed to use their voice, as in counting from one to ten, or as in replying to questions, many of them did not make the least effort, and showed themselves as wilfully obstinate as possible. He always insisted, in view of this mental perversion, and of the danger of one's therapeutic efforts being afterwards misrepresented to the patient's friends, that a friend—or, if possible, the patient's general medical attendant—should be present when intra-laryngeal faradisation was applied. He instanced one case, occurring in Dr. Playfair's practice, of the very worst form of general hysteria, in which intra-laryngeal faradisation, sufficiently strong and sufficiently long-continued, had succeeded in restoring the voice in the first sitting, but only after very severe applications, and emphasised the necessity of persevering with one's efforts until this result had been obtained. Failure in the first sitting almost always meant the patient's non-reappearance for the second. Whilst thus extolling the effects of intra-laryngeal faradisation, he wished to state that a few of his cases had remained rebellious to it, and to every other form of treatment recommended, such as hypnotism, articulation exercises, use of internal remedies, change of air and residence, attempting to make the patient speak loudly when awaking from chloroform narcosis, etc. In one such case the voice had been restored by the unexpected application of a cold water douche; in others, this remedy too had failed. He particularly remembered the case of a major in the army, a strong, powerful man, and the very last whom one would expect to become a victim to hysterical aphonia. This patient assiduously tried everything that was suggested, because loss of his voice of course meant professional ruin to him; however, everything failed. Fortunately, however, in this case, as in all other rebellious cases known to him personally in which medical art had failed, the voice one day without any external cause returned as suddenly as it had disappeared. With reference to Dr. Tilley's question, whether local treatment was likely to be more successful after a previous course of Weir Mitchell's treatment, he could not answer it, having had no experience with regard to this special point. Finally, with regard to a question of Dr. Pegler's, asking which laryngeal muscles were chiefly affected by hysteria, Sir Felix said that ordinarily, in his opinion, the whole group of adductors were concerned. In cases in which the inter-arytænoid muscle only was affected, with the well-known laryngoscopic image of a small triangular opening in the hindermost part of the glottis, the prognosis in his experience was not nearly so good; but then he thought that in a good many of these cases the paralysis was not merely functional, but that the small inter-arytænoid muscle had actually undergone trophic changes, and some of these cases in his experience had permanently resisted every form of treatment, and had remained uncured.

In reply, Dr. PEGLER said that the patient being always accompanied by friends, the latter had been often able to judge of the comparative facility with which the voice could be coaxed back by a probe or electrode in the larynx. The faulty breathing was most apparent; the chest muscles also seemed to stammer in a certain sense, and she

could only count six figures before requiring to take a fresh breath. The spirometric reading was 50 per cent. below par, and the patient was under special treatment and in expert hands for that defect. Every precaution had been taken to allow the muscles of respiration free play by wearing suitable clothing in place of the old-fashioned tight corsets.

Case of Naso-pharyngeal Growth (? Sarcoma).

Shown by Dr. Pegler. A man æt. 27, complaining of complete inability to breathe through his nose for four years, and occasional profuse attacks of nose-bleeding on making the attempt. This case had some interest through having first come under observation at the Metropolitan Throat Hospital about two and a half years ago, when the following note was made:—"On digital exploration of the naso-pharynx a soft polypoid mass is felt, much like adenoids, dependent from roof and posterior wall, chiefly to the left of mesial line. Being easily detached, two fleshy masses were expelled, one from each nostril, and the breathing became quite free. Sections of the material consisted of small-celled apparently lymphoid tissue." The patient did not return to the hospital till January, 1900, and the nasal obstruction was then absolute. Inspection from the front showed a dark, softish, vascular and brittle growth in the right nasal chamber, which space it was expanding posteriorly. In the left naris the septal mucous membrane was turgid, and freely bled on the least touch. In the naso-pharynx a large lobulated mass could be felt depending from the roof. The free edge of the septum was difficult to reach owing to its absorption. A piece of the mass was snared off, and sections shown under the microscope displayed mixed cells,—small, round, and spindle, with no structural disposition. Lymphoid follicles and gland-cells were absent.

Dr. Herbert Tilley said he had made a digital examination, and found a soft vascular growth occupying the post-nasal space and spreading forwards into the nose; the posterior portion of the vomer had also been destroyed, and he thought it high time to proceed with the radical operation, after first splitting the soft palate and performing a preliminary tracheotomy. This course had also been suggested by Mr. Butlin.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

FIFTY-FIFTH ORDINARY MEETING, held *February 3rd*, 1900.

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

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

Present—28 members and 4 visitors.

The minutes of the preceding meeting were read and confirmed.

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

Dennis Vinrace, M.R.C.S., L.R.C.P., 24, Alexander Square, South Kensington.

Felix Klemperer, M.D., Strassburg im Elsass.

A report from the Morbid Growths Committee was read by the Secretary. The Committee reported that sections made from tissue handed to them by Dr. Cresswell Baber from his case of nasal tumour (see 'Proceedings' for June, 1899, page 109) showed no evidence of malignant disease. They also reported that the tumour of the ventricular band shown by Dr. Furniss Potter (see 'Proceedings' for November, 1899, page 1) was a fibro-angioma.

The following cases and specimens were shown:

A Case of Complete Fixation of The Left Vocal Cord.

Shown by Mr. Wyatt Wingrave. A girl æt. 19, born and until lately resident in India, complained of weakness in her singing voice and huskiness in her speaking voice, of gradual onset, about four months ago. There was also some dyspnœa on exertion and singing. She had always been somewhat pale.

When first seen, about a fortnight ago, the left vocal cord was fixed in the cadaveric position, its texture and colour with the rest of the larynx being normal.

There was no definite evidence of organic interference with the recurrent laryngeal, neither was there any history or collateral sign of local inflammation or hysteria.

She was ordered complete rest from singing and nerve tonics.

The President said that evidently the condition had altered lately, as the cord was now fairly moveable. Such cases of paresis were generally the result of some neuritis; and he thought this case probably had a similar origin.

Mr. Wyatt Wingrave said it was very gratifying to find that the cord was now moving. The case was interesting because only one cord was involved, and that one the left.

An Unusual Form of Ulceration of the Throat in a Patient the Subject of Syphilis.

Shown by Mr. Wyatt Wingrave. A male, æt. 25, was first seen on January 16th last, when he complained of pain in the throat and inability to make his teeth meet of four months' duration and gradual onset.

A deep, ragged ulcer with fleshy projections was seen in the right post-molar fornix, from which a firm œdema extended to the whole of the soft palate and uvula; in appearance it was translucent, with milky patches. Movement of the mandible was painful, and the incisors did not meet by a quarter of an inch. Deglutition was difficult but painless. The submandibular and supra-clavicular lymphatic glands were thickened. The patient was very anæmic, and complained of great weakness and loss of flesh.

There was a history of syphilis five years ago, also of renal colic twelve months ago. His wisdom teeth were present.

He was at once ordered potass. iodid. and bichloride of mercury.

The œdema is considerably reduced. He is free from pain, and can now masticate without much difficulty.

The appearance and physical character were at first somewhat suggestive of malignancy (sarcoma), but so far the result of treatment points to syphilis.

The PRESIDENT said this case reminded him of a similar one under his care at Westminster Hospital, which also had a history of syphilis — a man with gumma in the throat. He improved under large doses of iodide of potassium, and was discharged as cured. About a year later he came again with the same complaint, and again improved on the same treatment and was discharged. A few months later he was admitted a third time, and on this occasion iodide of potassium had little or no effect upon him, and eventually he died of malignant disease. At the commencement he thought his diagnosis of syphilis had been confirmed by the good results obtained from treatment by potass. iodid.

CASE OF NASAL POLYPI WITH SUPPURATION AND (?) ABSENCE OF MAXILLARY SINUSES.

Shown by Dr. LAMBERT LACK. The patient, a man æt. 28, came under my care complaining of nasal obstruction and purulent discharge, with a disagreeable odour in the nose. The polypi having been removed, the pus appeared to flow from under the anterior ends of the middle turbinates. After wiping the discharge away and bending the patient's head forward it reappeared in large quantity. On transillumination the cheek on both sides appeared quite dark, and the patient had no subjective sensation of light. The diagnosis of antral suppuration was now considered almost certain, and the patient was advised to have both antra punctured from the alveolar margins. This was accordingly attempted under gas, but although the antrum drill was forced in for its full length no cavity was reached. I next attempted puncture from the inferior meatus of the nose, and used considerable force in two different spots, but with no better result. It seems, therefore,

that the antra must be very small, if not entirely absent. The case is a somewhat embarrassing one, as the patient is naturally disappointed. I have brought him forward as a very rare—in my experience an unique—case, and I should be glad to know if any members have had similar experiences.

Mr. SPENCER suggested, in the absence of any evidence of a collection of pus in the frontal sinus, that the best method of treatment would be to remove the inferior turbinal on the left side. It must be one of those convoluted turbinals which form a gutter in which pus collects. He had seen such a case. With regard to the osseous condition of the nose, he had seen a man in which this condition was much more marked than in the case under discussion. On tackling the nose, he started with the idea of doing what he advised here, inferior turbinectomy under an anæsthetic, but there was so much bony thickening of the outer wall of the nose that he had to bore his way right back to the naso-pharynx until he could pass his finger through the nose. A good deal of hæmorrhage resulted, and plugging had to be resorted to. This young man, who had had a swelling for several years, was now in a most satisfactory condition.

Dr. PEGLER could see no justification for any interference with the inferior turbinal body. He inquired if the cavity of the antrum had been explored by means of Krause's opening. He had no doubt that Dr. Lack would remove the diseased portion of the middle turbinal from which some polypus buds could be seen sprouting, after which the source of the pus might perhaps be more easily traced.

Dr. HERBERT TILLEY thought it probable that there was a small antrum on one or both sides, and reminded those present of Ziem's paper on antral suppuration read before the British Medical Association when last held in London. He then pointed out that the antrum may be represented by a mere dehiscence in the bone. The speaker questioned the probability of an antrum so small as that producing so much suppuration as in Dr. Lack's case; possibly ethmoidal disease was present also. He (Dr. Tilley) had just experienced a similar difficulty in finding an antrum situated high up in the maxillary bone, the perforator entering one and three quarter inches before striking the pus. He should advise in Dr. Lack's case removal of the anterior half of the middle turbinate, and exploration of the antrum from the middle meatal region, if necessary making a large opening into it in this position. He had recently operated upon a young man in whom the naso-antral wall in the inferior meatus was so thick that the heads of two strong burrs had been broken off in the attempt to enter the antrum in this position, consequently the operation undertaken for exploration of the antral cavity developed into one for removing foreign bodies from the nose.

Dr. SCANES SPICER, understanding that there had been polypi and suppuration on both sides, thought the probable explanation of this case was that a traumatism had deflected the septum and initiated

inflammatory changes in the middle turbinals. The left nose was now almost functionless, from the approximation of the septum and inferior turbinal combined with alar collapse, and the right nose had to do a double share of work, a state of affairs which tended to maintain congestion, suppuration, and recurrence of polypus in the middle turbinals. From the cursory examination then alone possible and the history given, he thought the ethmoidal disease sufficient to account for the symptoms and course of the case, without assuming that the antra (which were doubtless small) were suppurating.

Dr. LAMBERT LACK, in reply, said that he agreed that it was a case of ethmoidal disease. He had brought the case forward because of the remarkable way in which it had simulated antral suppuration, and because of the failure of the attempts to perforate the antrum. The fact that the cheek was opaque on transillumination was explained by the osseous condition. He could not insert a trocar in any direction. He thought there was probably suppuration in the ethmoidal cells, and he intended to remove part of the middle turbinate and open some of these cells, and he would also at the same time endeavour to open the antrum from the middle meatus as Dr. Tilley suggested.

CASE OF PACHYDERMIA LARYNGIS.

Shown by Dr. JOBSON HORNE. The patient, a married woman æt. 23, had been troubled with hoarseness and dryness of the throat for nearly two years. Aphonia had developed gradually two years previously, during her first pregnancy, and she had reached the sixth month of another pregnancy.

Both ventricular bands were considerably thickened, with little or no œdema. The left band presented a longitudinal grooving on its inner aspect, and into this there passed during phonation a wedge-shaped excrescence of the right band. The free edge of the epiglottis was a little rounded. The cords themselves, though partially obscured to view, moved freely and appeared natural, and so did the arytænoid and inter-arytænoid regions.

The examination of the thorax yielded no signs of tuberculosis, nor was there any family or personal history suggesting tuberculosis; but the sputum had not been obtainable for examination.

There was also to be noted some chronic pharyngitis and atrophic rhinitis.

Dr. Jobson Horne was inclined to regard the case as one of

pachydermia laryngis, but what had given rise to the condition was not at present very clear.

Dr. DUNDAS GRANT thought from the appearance of the larynx that it was a tubercular pachydermia, and that it was not primary but secondary to tubercular disease. Perhaps Dr. Horne would bring the case before the Society on a future occasion.

Dr. SCANES SPICER also thought this case was one of a chronic tubercular laryngitis, the mass of growth being on one side only, extending the anterior two thirds of the cord, and there being no protuberance corresponding cupping over the opposed vocal processes.

CASE OF LARYNGEAL AFFECTION IN A TUBERCULAR PATIENT FOR DIAGNOSIS.

Shown by Dr. CATHCART. The patient, a male æt. 26, unmarried, came under my care at the London Throat Hospital last week. He complained of chronic hoarseness, which began at the end of September, 1899. The family history is good, except that two brothers have died of consumption. For some months prior to July, 1899, patient had been losing weight and spitting blood. He had no night sweats, and only a slight cough. At that time tubercle bacilli were found in the sputum.

During August he went for a holiday, and gained weight slightly, and also ceased to spit blood. In the beginning of September the sputum was again examined, but no tubercle bacilli were found. At the end of September he began to get hoarse, and has been getting gradually worse. His general condition at present is better than it has been for some time. He is not losing weight or spitting blood, and has a very good appetite. When his larynx was examined last week it was found to be very irritable, red, and inflamed; the cords were red and thickened. There was no swelling at the posterior part or over the arytænoid cartilages, but there was a slight uniform swelling below the anterior commissure. I shall be glad to have the opinion of the members on the case.

Dr. CLIFFORD BEALE would be rather inclined to describe the condition as one of simple irritation due to a local cause, which in this case was obviously subglottic. He did not think that the appearance

was characteristic of tubercle. It was a matter of common observation that mucus might collect and remain for a long time in the anterior commissure of the cords, and he had watched cases for several weeks in which such collections of mucus were always present. Dried and decomposing mucus was apt to give rise to irritation if undisturbed by coughing, and he thought that the subglottic swelling in this case had probably arisen in this way. Infection of such irritated areas by tubercular mucus from below was always likely to happen, and hence he should always advise early treatment by removal of such mucus with a mild astringent.

The PRESIDENT said the condition of the larynx reminded him of that seen after tracheotomy, where the irritation of the tube had caused growth of granulation tissue below the vocal cord; he would agree with the views of the previous speaker.

Dr. J. DUNDAS GRANT said the appearance reminded him of cases he had dissected of laryngeal and pulmonary tuberculosis, in which there were shallow oval ulcers on the mucous membrane of the trachea. The fact that the patient had evidence of tubercular disease made it only natural to suppose that the appearance in the trachea was due to tubercular disease.

Dr. CATHCART said that the opinion of the majority of the members was that the ulceration was tuberculous. Several had suggested that it was perhaps syphilitic, but on questioning the man no trace of a syphilitic history could be found. The sputum had been examined that day, but there were no tubercle bacilli present. He intended to treat the case as one of a tuberculous nature.

CASE OF BULBAR PARALYSIS.

Shown by Mr. WAGGETT. A man æt. 61, of temperate habit, and denying syphilis, presented the condition of progressive muscular atrophy, involving the region of the bulbar innervation as well as other parts.

Symptoms commenced in the spring of 1899 with difficulty in swallowing, lisping speech, and wasting and paresis of the hand muscles. Later cramps had been experienced in the legs and inability to walk securely.

At the present time there was paresis of the lips; atrophy, tremor, and paresis of the tongue. Paresis of the palate more marked on the left side, and causing escape of air through the nose during speech. The most marked symptom was great and increasing difficulty in swallowing. This symptom had slightly decreased since galvanism had been employed. On one occasion

temporary diplopia and a fluttering in the ear had suggested a recent spread upwards of the nuclear degeneration.

With regard to the larynx, when first seen a fortnight ago there was fixation of the left cord in the middle line, with abductor paresis of the right cord. At the present time there was marked abductor paresis on both sides.

The question of tracheotomy was raised, and experienced opinion was sought as to the real value of galvanism in the treatment of the pharyngeal paresis.

The PRESIDENT said he had experienced great difficulty in diagnosing a case of commencing bulbar paralysis where there was no impairment of the movement of the tongue. The patient was brought to him on account of the attacks of severe dyspnœa. On examining the vocal cords he found some paresis of the abductors, with a certain amount of adductor spasm.

Dr. DUNDAS GRANT said that the general features of the case confirmed Mr. Waggett's opinion that it was part of a general muscular atrophy, or anterior poliomyelitis, the first interossei and trapezius muscles having almost completely gone.

Sir FELIX SEMON, in reply to Mr. Waggett's question, said that in the early stages of bulbar paralysis methodical use of the constant current sometimes greatly improved the patient's swallowing. He had had several cases which had so improved.

The PRESIDENT added that his case had improved under the use of galvanism.

CASE OF THYROTOMY FOR TERTIARY SYPHILITIC LARYNGITIS.

Shown by Mr. SPENCER. A man æt. 30, on whom he had performed thyrotomy three months before. A quantity of very tough fibrous tissue was removed, along with a portion of the right vocal cord.

The man had been under observation for a year, and the laryngeal stenosis had gradually increased in spite of full doses of iodide and mercury, until he had dangerous dyspnœa at night.

The choice of treatment then lay between thyrotomy and tracheotomy. The former had been selected because the larynx was already filled with such masses that no voice could have been anticipated after tracheotomy. Moreover, in a former almost identical case, in which he had done tracheo-

tomy, the patient when drunk got his tube out, could not replace it, and was asphyxiated very quickly.

At present the patient could breathe well at night, and had gone back to work. He had at present only a loud hoarse whisper.

There had been some recurrence, but the patient had returned, and was again taking iodide in forty-grain doses.

The PRESIDENT said from their experience it was difficult to say what was the best thing to be done. This case looked as if it were contracting again and tracheotomy would be required. He had had a distressing case in which tracheotomy was done; the growth continued into the trachea, and tracheal stenosis resulted in spite of potass. iodid. The patient went to several London surgeons, but there was nothing to be done. He then went to Paris, and died on the operating table. The President asked all members to bring such cases before the Society, that they might solve the question as to the best mode of treatment by the consideration of a series of cases.

CASE OF ULCERATION OF THE PHARYNX FOR DIAGNOSIS.

Shown by Dr. STCLAIR THOMSON. The patient, a man æt. 64, has complained of sore throat for three months. There is no history of syphilis. When first seen the left tonsil was covered by a "wash leather" slough, which also extended slightly on to the soft palate and anterior pillar of the fauces. On examination with the mirror the same condition was observed passing down nearly as far as the pyriform fossa. Some days later the slough separated and showed an ulcer with raised edges and somewhat hard on digital examination. There is no glandular enlargement.

Sir FELIX SEMON said there could be little doubt as to the malignant nature of the ulcer.

Dr. TILLEY said the hardness of the growth confirmed the view just mentioned.

CLEFT SOFT PALATE AND WELL-MARKED POST-NASAL ADENOIDS.

A case of a boy æt. 13, with cleft soft palate and well-marked post-nasal adenoids, was also shown by Dr. StClair Thomson.

At a SPECIAL MEETING held February 3rd, at 4.30 p.m., for the purpose of discussing the question, it was proposed by Dr. Scanes Spicer, seconded by Sir Felix Semon, and carried unanimously: "That it was desirable that at all International Congresses there should be full and separate sections for Laryngology and Otology."

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

FIFTY-SIXTH ORDINARY MEETING, *March 3rd*, 1900.

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

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

Present—26 members and visitors.

The minutes of the preceding meeting were read and confirmed.

The following gentlemen were unanimously elected members of the Society:

Felix Klemperer, M.D., 42, Dorrotheen Strasse, Berlin.
Dennis Vinrace, M.R.C.S., L.R.C.P., 24, Alexander Square, South Kensington.

The following cases and specimens were shown:

CASE OF SINUSES IN THE VAULT OF THE NASO-PHARYNX.

Shown by Mr. CHARLES HEATH. The patient, an unmarried woman æt. 31, had suffered for some years with discomfort in the nose, throat, and mouth, with dyspepsia and frequent

dyspeptic ulcers on tongue and gums. The nose showed considerable atrophy of the mucous membrane of the middle and inferior turbinals anteriorly and posteriorly; the pharynx being also much atrophied, the cavity large, and post-rhinoscopy easy. The Eustachian eminences were seen to be enormous, filling the fossæ of Rosenmüller and reaching nearly to the pharyngeal roof. Just behind the upper edges of the choanæ, on each side, there appeared a transverse elliptical opening, which was about half an inch long and one fifth inch across at the widest part on the left side, and slightly less in each dimension on the right; a probe extends apparently about a quarter of an inch. The openings could be easily felt, and the finger inserted a little into the larger one; but the floor of the cavity could not be felt, as the edges of the opening would yield but little.

Dr. William Hill had seen a similar condition several times, although not so marked as in this case. These were not "sinuses" in the ordinary rhinological acceptation of the term, but merely the two fossæ of Rosenmüller rendered much deeper than normal by the development of steep banks of adenoid tissue. These banks were formed internally by the hypertrophied lateral borders of Luschka's tonsil, and the transverse bands so prominently seen were the remains of the transverse alar laminæ of the same tonsil passing across to a large Eustachian cushion.

Mr. Baber had arrived at the same conclusion as Dr. Hill, that the depressions were the upper part of Rosenmüller's fossæ unusually well marked. On examination with the finger, he had not been able to feel any bony growth or sinus.

Dr. Dundas Grant thought these sinuses were formed by the remains of adenoid tissue which had acquired adhesions.

Sir Felix Semon did not share the opinions of the previous speakers. In the first place, he did not think there was any adenoid tissue present at all in the neighbourhood of the clefts. Secondly, these fissures traversed a direction parallel to the fossa, instead of longitudinally or vertically, and were infinitely deeper than those he had seen in the most developed cases of fissures in the adenoid tissue. To him it seemed as if there were two deep indentations into the bone itself. He put forward as a hypothesis, that there might be some form of arrested development.

Mr. Spencer did not see with the light available the amount of adenoid tissue that would be necessary to explain Dr. Hill's theory. He should suggest that there were sinuses growing into the bone, and possibly some excessive development of the sphenoidal sinus. He asked Mr. Heath to have a very careful drawing made of the naso-pharynx, as it was an unusual condition, and he suggested that when made the illustration should appear in the 'Proceedings.' Except that

these "sinuses" were bilateral, they might be connected with the development of the infundibulum of the pituitary body.

Dr. Scanes Spicer said the boundary walls of the unusual cavities in the naso-pharynx were quite soft on digital examination. He thought the normal central adenoid tissue of Luschka's tonsil was displaced laterally in this case. This was especially well seen on the left side, where the adenoid tissue of the posterior wall was united to that forming the Eustachian cushion by a fleshy bridge. He could not concur with Mr. Spencer's view as to the depressions being the openings of the sphenoidal sinuses, for the latter were half an inch further forward, more in the nose, and closer to the septum.

Dr. StClair Thomson shared Dr. Hill's view, *i. e.* that there were no sinuses except by optical illusion. There was quite distinctly an Eustachian tonsil on the top of the cushion, not merely a thickening, and this came into contact with the roof of the cavum, forming a deep recess which gave the impression of a sulcus. He thought that a careful examination under chloroform would reveal no adhesions. Such conditions as these were not at all rare, but fairly common; he had paid a great deal of attention to them, with the object of seeing whether there would be any improvement in ear cases by breaking down the cushions and adhesions, if existing, even when there were no adenoid growths.

Mr. Richard Lake said, as far as the description of the case was given, his opinion coincided with that of Dr. Dundas Grant. These "sinuses" were more outside than usual, but were caused by the pharyngeal tonsil.

Mr. Heath was much gratified by the amount of interest taken in his case. His opinion had always been, and was still, in harmony with that of Sir Felix Semon, that there was some unusual development in this case. Some of the members seemed to have rather mistaken the locality of the sinuses on account of the enormous size of the Eustachian prominences and their upward projection, and thought them further downwards and backwards than they really were; as a matter of fact, they were close under the back part of the roof of the choanæ. The locality was one in which adenoid tissue is rarely abundant, although it often runs towards the septum; the sinus was so close to the choanæ that it could not be of adenoid origin, and in this case there was advanced atrophy of the mucous membrane and no sign of adenoid tissue.

Case of a Female æt. 23, with Obstruction of One Nostril from Antral Affection of Uncertain Character.

Shown by Dr. StClair Thomson. The patient said that she had not had any nasal obstruction until after acute faceache, some four months ago. For this she had had a number of teeth removed with considerable relief, and she only came to the hospital for the nasal obstruction. The left nostril was entirely

occluded with what appeared to be a normal hypertrophy of the inferior turbinal. It did not in the least diminish under cocaine. The left posterior choana was normal. There was no discharge. Transillumination showed the antra to be the same on both sides. The left antrum was drilled from the alveolar border, but no pus escaped, and no fluid could be syringed through into the nose. With the probe the inside of the cavity appeared to have a soft thickened lining. There was still some tenderness above the canine fossa, and he suspected that the trouble might prove to be entirely periostitis.

Mr. DE SANTI said it was impossible to say very much about the diagnosis until the turbinal had been treated; he thought there was suppuration, and that the antrum was probably involved.

Dr. DUNDAS GRANT said it looked more as if there were a cyst in the antrum. There was a certain amount of distension; no pus or fluid had been washed out on puncturing. A cyst seemed the only growth that would distend the antrum, and at the same time give no dulness on transillumination.

Mr. SPENCER thought there was hyperostosis of the maxillary bone; similar cases had been shown to the Society. He should relieve the nasal obstruction by removing the inferior turbinate body. He had seen more marked cases, which were due to thickening of a large area of the side of the nose, and in which there was marked symmetrical opacity upon transillumination.

Dr. STCLAIR THOMSON said it was his intention to remove the anterior end of the inferior turbinal body; and he had simply exhibited the case in order that members might see its present condition.

CASE OF A GROWTH IN THE LARYNX IN A MALE ÆT. 25.

Shown by Dr. FITZGERALD POWELL. In October, 1899, the patient first noticed a slight hoarseness, which gradually increased until January 16th, 1900, when he came under my notice.

He attributes his loss of voice to the excessive use of alcohol, and also to the strain of public speaking.

Nine years ago he had pneumonia, and since then says he has been subject to colds which fly to his chest. On one occasion he strained his voice so much by speaking that he brought up some sputum streaked with blood. There is no history of

syphilis. There is no evidence of disease in his lungs, and he is increasing in weight.

On examination the whole of the larynx, especially the ventricular bands and true vocal cords, are seen to be red and swollen, and there is some paresis in adduction.

At the anterior portion of the right cord a growth is observed apparently growing by a broad base from the substance of the cord, and partly free anteriorly and posteriorly. The inflammatory condition has recently improved, but the growth has increased somewhat in size.

Sir FELIX SEMON stated that he did not think it was possible to say at present for certain what the growth was from mere laryngoscopic examination. It much reminded him of one of his own cases, in which he was for a long time doubtful as to the nature of the disease. In that case at first a small reddish growth was observed on the free margin, and under the middle of the left vocal cord. It passed very gradually over into the cord itself. In the course of the next twelve months it gradually spread, infiltrated the left cord more and more, and finally an almost uniform semi-transparent thickening of the whole vocal cord occurred, and the movements became somewhat sluggish. Owing to the uniformity of the swelling, it was impossible to remove a piece for microscopic examination. Seeing the patient's age (fifty-five), the unusual appearance of the growth, and the sluggish movements of the cord, there was a strong suspicion of malignancy, and this opinion having been confirmed by Mr. Butlin, thyrotomy was performed, and the whole of the cord was removed. On microscopic examination, however, by Mr. Shattock, it remained doubtful as to whether the growth was of the nature of fibro-sarcoma, or of what he called "continuous" fibroma (*Fibroma molluscum*). The case had been fully described in the speaker's paper on "Malignant Disease of the Larynx," in the 'Lancet,' 1894. It was Case 12 of his tables, and a full report of Mr. Shattock's microscopic examination was given in it. The gradual blending of the growth with the cord in Dr. Powell's case and its semi-transparent appearance much reminded him of that case. Of course the comparative youth of the patient seemed to militate against the idea of malignancy, but as he had himself seen undoubted malignant disease of the larynx in a patient æt. 27, the present patient's youth was no absolute proof to the contrary. If the case were his own, he certainly should at once remove by intra-laryngeal operation a good-sized piece of the growth near the anterior commissure, where it most projected, and should make his further proceedings depend upon the result of microscopic examination of the fragment removed.

Pseudo-membranous Adhesion in the Anterior Commissure and Symmetrical Thickening below the Anterior Part of the Vocal Cords (Congenital ?) in a Young Man.

Shown by Sir Felix Semon. The case is shown as representing the lowest degree of a tendency to formation of congenital webs between and below the vocal cords. The patient is a young gentleman æt. 27, who since birth had suffered from extreme weakness of voice, and who was sent to the observer by Dr. Clayton, of Hampstead, on the 13th January, 1900, on account of a red, granular, elongated, mobile growth, inserted on the free edge and on the lower surface of the left vocal cord, about the border of the anterior and the middle third. This growth practically covered the anterior part of the glottis. It was removed with forceps, and turned out to be a soft fibroma. After its removal, however, the voice remained weak, and it was then seen that the vocal cords were united somewhat extensively at the anterior commissure by an intermediate, reddish, granulating mass, whilst from the anterior commissure two symmetrical thickenings extended almost the entire length of the vocal cords and below them, simulating, as it were, a reduplication of the vocal cords themselves. After removal of a small part of the reddish mass in the anterior commissure, which was found to be much softer than in previous cases seen by the observer of congenital adhesions in the anterior commissure and between the vocal cords, the voice became perfectly normal.

The President said he understood the condition was more pronounced prior to commencing treatment.

Sir Felix Semon stated in reply to this question that the mass previous to operation was not much bigger than at the present time. The single pieces removed were so small that it was hardly worth submitting them to microscopic examination. He wished to add to his description of the case that, according to the explanation given by Roth, at the commencement of fœtal development the two halves of the larynx were glued together by epithelial masses, which gradually cleared up from behind. In normal cases the whole epithelial mass disappeared, whilst in cases of arrested development an adhesion remained, more or less developed, in the anterior part of the glottis, and thickest in the neighbourhood of, and below, the anterior commissure. His patient had incidentally mentioned to him that his

father also had always had an extremely weak voice, and being mindful of Professor Seifert's series of cases, in which the developmental arrest in question had been observed in four members of one and the same family, he had obtained permission to examine his patient's father, but there was no evidence whatever of a similar arrested development.

Case of Bulbous Middle Turbinates.

Shown by Mr. Richard Lake. This patient has the so-called adenoid facies, but there is only a trace of adenoid growth. Her nose has gradually become broader, and her parents brought her to hospital on that account.

The middle turbinates are both "bulbous," that on the left side being apparently the larger.

In view of the fact that this condition is not a pathological one, I shall be glad to have the opinion of the members as to any course of treatment other than operative, or, I should say, than of excision.

Case of Growth from the Arytænoid Region in a Male æt. 56.

Shown by Mr. R. Lake. The patient when he first came under my care six months ago complained chiefly of dysphagia and otalgia with excessive secretion of ropy mucus. There was, and there has been, no loss of voice, nor at any time any other symptom pointing to the larynx as being the seat of the disease. The patient gave a somewhat unintelligible history of the pain coming on suddenly after a meal.

The ear had been considered the seat of the trouble, and he had been using sedative drops for some six months.

The objective symptoms were as follows; the pharynx was red and swollen, and had the appearance of a gouty pharyngitis. The ear was devoid of any active lesion. The larynx was difficult to examine, but a whitish translucent growth was noticed under the tip of the left arytænoid cartilage on its anterior surface.

The patient was put under treatment to reduce the irritability

of the pharynx; this was accomplished and the removal of the growth suggested. At this the patient demurred, and disappeared for some time; he however returned, and I removed the growth, or rather the major part of it, with the forceps (shown at a previous meeting of this Society). There is still a small piece left on the outer side, which will also be removed. The subjective symptoms have almost disappeared.

The section under the microscope is one which I think will interest the members of this Society. The mucous membrane over the growth is much thinned, but does not seem to have any connection with it, and there is an absence of signs of activity in the surrounding tissues except just below the epithelium. The growth consists of large epithelioid cells, and the vessels run chiefly in the trabeculæ.

Specimen of Bony Spur from Ethmoid.

Shown by Mr. Richard Lake. This specimen is the bony end of a septal ridge; as will be seen, the whole thickening of the vomer was removed. The apex of the exostosis, as it practically is, was firmly adherent to the middle turbinate bone, and in breaking through this adhesion I drove the sharp end of the severed base through the septum. The result was a perforation of the septum, which is of no importance to the patient, who does not know of its existence.

Case of Pharyngeal Growth involving the Larynx in a Man æt. 59.

Shown by Dr. Furniss Potter. T. R—, æt. 59, came to the London Throat Hospital three weeks ago, complaining of difficulty in swallowing, which he had first noticed six months ago. He stated that three years previously he had had part of the lower jaw removed at the Radcliffe Infirmary, Oxford. On examination the left ascending ramus of the lower jaw had obviously been removed. There was a hard sloughy swelling in the left faucial and tonsillar region, including the left half of

the palate, which extended down the side of the pharynx involving and almost completely obscuring the larynx. There was a hard swelling immediately below and in front of the mastoid process, and also what felt like a gland just above the great cornu of the hyoid on the left side. The patient had always been a healthy man, but had lost flesh lately; no history of syphilis.

He had been taking potassium iodide for three weeks, and asserted that he could swallow more easily and "had more room in his throat." The glandular enlargement had subsided to a certain extent.

Although Dr. Potter had little doubt in his own mind as to the diagnosis—malignant disease,—he had ventured to show the case, thinking it would be of interest, though perhaps more from a general surgical than a purely laryngological point of view.

The PRESIDENT said, with regard to the treatment of such cases, he remembered a doubtful one, which was treated with fifteen-grain doses of iodide of potassium without any benefit; on increasing the dose to twenty grains the improvement was most marked.

Dr. FURNISS POTTER, in reply to the President, said that the iodide had been given in ten-grain doses, increased to fifteen during the last week; a larger dose had not yet been given. In reference to the present condition, the patient had more room in his throat, and the glandular enlargement had subsided to a certain extent.

CASE OF ADVANCED ATROPHIC RHINITIS IN A YOUNG GIRL.

Shown by Mr. L. A. LAWRENCE. E. P—, a girl æt. 14, was shown for the purpose of adding one more to the number of young people having advanced atrophic rhinitis. In this case the patient to her knowledge had suffered for three years.

The usual crusts were present along the whole of the upper respiratory tract. In addition, the uvula was markedly bilobed.

Dr. STCLAIR THOMSON mentioned that, at the last meeting of the Society, Mr. Spencer had said that the bacteriology of the subject had not been sufficiently investigated. Curiously enough, that very afternoon Dr. Thomson had been reading a long and interesting paper on the subject, narrating the experiments of an Italian investigator on

thirty-two cases.* As a full translation might not appear, he thought a brief epitome might be interesting. A Dr. de Simoni had found that in the secretion of ozæna pathogenic germs were constantly met with—the diplococcus of Fraenkel, streptococci, and pyogenic staphylococci. Non-pathogenic germs, such as the capsule bacillus and the pseudo-diphtheria bacillus, were also met with. None of these have any ætiological importance. They may be met with in nasal cavities with no trace of ozæna. Pure cultures were made and introduced into the nostrils of healthy individuals without reproducing the morbid process. Even when inoculated on to the mucous membranes of healthy individuals in association, as they are met with in the ozænatous mucosa, they are incapable of producing the disease. The same can be said of non-pathogenic germs, to which the origin of ozæna had been wrongly attributed. Dr. Thomson added that De Simoni's experiments appear to have been carried out very carefully, and therefore tended to exclude the idea of the infective character of ozæna.

Case of Suppurative Cyst of Turbinal Bone.

Shown by Dr. Henry A. Davis. The patient, a woman æt. 40, complained of a lump in the nose of three months' duration. On examination there appeared to be a large hypertrophy of the left inferior turbinal, which diminished slightly under cocaine. In spite of treatment, the swelling increased till almost complete nasal obstruction on the left side ensued. The swelling was red, dense, and painful.

The mucous membrane was incised with a bistoury, and about two drachms of thick pus escaped. On passing a probe into the cavity, bone was felt in all directions.

The patient refused further treatment, and beyond inserting a rubber tube into the cavity (which the patient herself learnt to do) and syringing with creolin lotion, nothing further was done till January, 1899, when the patient again applied for active treatment.

She was taken into the hospital, and the inferior turbinal sawn off; the cyst was too large to extract through the nostril, and it was removed piecemeal with forceps, so the specimen was not obtained.

The cavity was in the substance of the turbinate; it was filled with pus, and surrounded by a fine shell of bone.

* 'Il Policlinico,' 1899, vol. vi.

Since the operation a bead of pus is always visible external to the middle turbinate bone; and whether this originates from the antrum, ethmoid, or frontal sinus, it is difficult to ascertain. Transillumination does not show any inequality of the infra-orbital shadows, and, if anything, owing to the absence of the turbinate, the left cheek is more transparent than the right.

Dr. HERBERT TILLEY said he had twice examined this case, but found he could not agree with Dr. Davis as to his view of the topography of the parts. The speaker said that the anterior half of the middle left turbinate had undoubtedly been removed, and the remaining portion of the bone was now plainly visible and could not be mistaken for anything else. The inferior turbinate was seen below, but a considerable portion of this had been removed also. The granulation mass seen in the middle meatus he regarded as typical of suppuration of the anterior ethmoidal cells, and he should attack this with Grunwald's forceps until a healthier region was reached, and thus prevent other accessory sinuses becoming infected, if that had not already taken place.

Mr. R. LAKE had arrived at the same conclusion as Dr. Tilley, *i. e.* that it was the middle turbinal which had been removed, and not the inferior.

Dr DUNDAS GRANT said the pus might arise either from the anterior ethmoidal cells or from the frontal sinus, and he thought it would be very difficult to exclude frontal sinus disease with the evidence at their disposal. There was a slight amount of tenderness over the left frontal sinus on percussion. One very characteristic sign of frontal sinus disease was that pus ran into the nose, chiefly after the patient moved about for some little while, as when on his way to business. This was a contrast to antral suppuration, in which the nose was usually full of pus on waking in the morning. As to the anatomical condition of the middle turbinal body, he should agree with Dr. Tilley's description.

Dr. WILLIAM HILL had elicited from the patient some symptoms that would point to frontal sinus disease. She had a feeling of fulness at times, and the position of this struck him as suggestive of the implication of the fronto-ethmoidal cells. He thought the middle turbinal had been removed, and that the granular mass seen was much above the position of the bulla ethmoidalis, and probably sprang from the fronto-ethmoidal cells.

Dr. DAVIS said that when the patient first came to hospital there was a swelling on the inferior turbinal body, as in Dr. StClair Thomson's case of the girl shown that day; the middle turbinal was jammed and pressed against the septum. The cyst was located on the inferior turbinal body, and he thought that what the members now saw was the stump of the inferior turbinal. Fourteen months had elapsed since the operation. The middle turbinal had been scraped, and a polypus had been removed from it. One could see the back of the pharynx on looking through the inferior meatus.

Mr. Baber agreed with Dr. Davis. On examination he had seen a dilated nasal cavity with apparently a small inferior turbinated body lying on the outer wall, which he supposed was the remains of the amputated inferior turbinated body; the middle turbinated body was thickened by disease, and pus was seen on its outer side. Treatment would consist in removing the anterior part of the middle turbinated body as much as possible, and then investigating the antrum, when possibly pus would be found in it. That course must be followed before doing anything to the frontal sinus.

Case of Extreme Hypertrophy of Inferior Turbinals in a Boy.

Shown by Dr. Henry A. Davis. The patient, a baker boy æt. 13, has extreme hypertrophy of the turbinals on both sides. The hypertrophied tissues are soft and polypoid, and though they have been treated with cautery and snare, after a short time the hypertrophy is as large as ever. There is œdema of the root of the nose; no adenoids are present, and headache is constant. He is to have both turbinals removed anteriorly, and is brought before the Society simply as a case of interest.

Dr. Herbert Tilley thought that such extreme hypertrophy of the inferior turbinals in a small boy was uncommon, and he suggested removal of the anterior extremities, which would give very great relief, whereas a galvano-cautery operation would be inefficient and not permanent in its results, because the bone as well as mucous membrane was hypertrophied.

Dr. Scanes Spicer had seen a similar extreme condition in a girl æt. 13, at St. Mary's Hospital that day; he had removed the hypertrophied masses with a cold wire snare.

Dr. Dundas Grant considered it might be difficult to introduce the scissors satisfactorily underneath the turbinal in this case, and under these circumstances he advocated the use of Bosworth's saw, cutting from below upwards. This instrument he had used in a good many of these cases for the purpose of cutting through the lateral attachment of the anterior part of the inferior turbinated body. When this was done it was easy to cut through the detached peninsula by means of a snare. Secondary hæmorrhage was never great, and coming from a spot so far forward in the nasal cavity, it could be easily checked by means of a pledget of gauze. In this respect it contrasted strongly with the "spokeshaving" operation.

Mr. Baber said if there was no thickening at the back of the turbinated bodies, he should snare off all the hypertrophied tissue in front, and if that was not sufficient he should remove the anterior end of the inferior turbinated bodies with scissors and snare. As regards plugging, he did not think he had ever plugged the posterior nares

since he had been in practice. One ought to be able to find the position of the hæmorrhage, and be able to stop it with long strips of gauze or lint introduced from the front.

Dr. FitzGerald Powell asked if the galvano-cautery should not be given a trial in the treatment of hypertrophy of the turbinate bones before resorting to the more severe method of removal by the snares and spokeshaves.

Dr. Davis said that on post-nasal examination there was no enlargement of the turbinal body, or adenoid vegetations, but some stenosis of the posterior pharynx. He had tried the galvano-cautery, and the growths had been completely snared off, but they always recurred. He had not applied any local treatment to the patient for a month.

Case of Extensive Ulceration of the Throat for Diagnosis.

Shown by Dr. Scanes Spicer. Patient was a man æt. 19, with extensive, continuous, painless ulceration of the mucous membrane, reaching from the nasal septum over the sides and posterior wall of the naso-pharynx and pharynx down to the vocal cords, and involving the epiglottis, which was pale and seamed with antero-posterior cicatrices, and not ulcerating now. The ulcerating surface was dry and covered with a glazed pellicle. The ulceration was quite superficial, and the surface did not readily bleed. The soft palate was almost entirely gone, but there was no loss of bone in the hard palate. There was no neoplastic granulomatous raised infiltrated margin, and nothing like "apple jelly" spots; and, except in the epiglottis, there was no cicatrisation going on. The condition had lasted five years, but what treatment had been adopted could not be ascertained. There were no other evidences of syphilis, congenital or acquired, nor of ordinary tuberculosis. The age and several observations led him to consider it a case of lupus, and by exclusion of syphilis, tuberculosis, and epithelioma, he was supported in this view.

The President said that twenty-five years ago the case would have undoubtedly been called a case of inherited syphilis; but there were no signs of this either in the teeth or eyes or elsewhere, and no other syphilitic signs. His epiglottis had an appearance rather suggestive of lupus. Personally he would look on the case as of the chronic tuberculous lupoid type.

Mr. R. Lake said this case reminded him of the class of patient

formerly described as "syphilo-scrofula," a disease in children with some syphilitic and "scrofulous" taint.

Dr. StClair Thomson suggested testing of the case with the old tuberculin; it had not been used in these doubtful cases to the extent it might have been, as no harm could be done when the lungs were not affected; this was a matter for regret.

Mr. Spencer thought the ulceration of the palate certainly looked like a syphilitic lesion, and he suggested that iodide of potassium and mercury might be given for some time; there did not seem to be any marks of tuberculous taint about the patient.

Dr. Spicer thought there would be more destruction of tissue if this were syphilis, as the ulceration had been going on for five years. He could find also no other signs of syphilis, congenital or acquired.

Sir Felix Semon entirely agreed with the President; the epiglottis was so characteristic of lupus that probably no one would hesitate to make that diagnosis were it not that the pharyngeal aspect was more doubtful.

Dr. Lambert Lack thought that potassium iodide should be given if this had not already been done.

Dr. Scanes Spicer said the boy was taking iodide of potassium in 5-grain doses since his first visit a week ago. He should be pleased to show the case again to the Society in three months' time.

Case of Hoarseness and Aphonia of Long Standing in a Girl æt. 13.

Shown by Mr. de Santi. The hoarseness and whispering voice had been present from the time the child first began to talk.

The larynx appeared normal, and there seemed to be nothing the matter with the nasal or pharyngeal regions.

She had been treated with valerian and electricity, but with no benefit.

He asked for suggestions as to treatment.

The President said that the ventricular bands were thickened, and not as smooth and regular as in normal circumstances.

Dr. Dundas Grant said there was evidence of chronic purulent rhinitis; had treatment been directed towards the nose?

Mr. R. Lake understood Mr. de Santi to say "it was a rare case of a normal nose."

Mr. de Santi said treatment had not been directed to the nose. The patient had a brother, 22 years of age, in a somewhat similar condition, but there was some voice in his case. The mother was going to bring her son to see him (speaker).

Dr. LAMBERT LACK said in his opinion this was not a normal larynx, but a case of well-marked chronic laryngitis.

CASE OF OBSTRUCTED SUBDERMAL LYMPHATICS OF THE FACE, IN WHICH FRONTAL AND ANTRAL DISEASE HAD BEEN SUSPECTED.

Shown by Mr. DE SANTI. The patient, a woman of 22, suffered from a curious affection of the subdermal lymphatics of both cheeks.

The left eye was nearly closed through œdema of the upper and lower lids, and there was puffiness and œdema over both frontal sinuses. The case was really not one for the Laryngological Society, but he showed it because it had been suggested that antral or frontal sinus mischief might be the cause of the trouble.

It was, however, quite obvious this was not the case, and Mr. de Santi diagnosed the condition as "blocked lymphatics." As to its causation, the patient attributed it to mosquito bites in Holland and Paris some three months ago, and this might possibly be the cause.

The treatment adopted was inunction with Ung. Belladonnæ.

Mr. EDWARDS remarked that this was not a laryngological case. He agreed with Mr. de Santi in the diagnosis.

CASE OF ULCERATION OF THE LARYNX.

Shown by Dr. JOBSON HORNE. The patient is a man æt. 45, with symptoms of eighteen or nineteen months' duration; at first weakness and uncertainty of voice at intervals, then hoarseness. For the last six or eight months he has been steadily getting worse, with at times complete aphonia.

There is pain and oppression referred to the right side of the larynx, and a lump could be felt in this region for the past two or three months.

There is some wasting.

There is no history or evidence of tuberculosis in the lungs, and the examination of the sputum is negative.

Case of Tumour of Nasal Septum.

Shown by Dr. Herbert Tilley. The patient, a female æt. 62, had a dark red, broadly pedunculated tumour growing from the right side of the septum. Nasal obstruction and repeated nose bleedings drew her attention to this mass last September, when the growth nearly reached the external naris.

It was removed by means of a snare, and profuse hæmorrhage occurred some four hours afterwards, which was checked by plugging the nostril.

The growth has since then recurred, and is now the size of a broad bean, and is of a purple-red colour and grows from the region of the tubercle of the septum.

The President thought it was suggestive of sarcoma, owing to the large amount of bleeding and the age of the patient. He advised operative interference.

Dr. StClair Thomson said the growth had the characters of a fibro-angeioma or bleeding polypus of the septum. He had shown a similar case himself, and had watched several others which had been shown to the Society; so that he ventured to think Dr. Tilley need not be alarmed at any hæmorrhage which might take place, or at the recurrence. One of Dr. Thomson's cases had recurred twice, and had been condemned as a sarcoma requiring free excision of the septum. The growth had simply been thoroughly snared, the base curetted and cauterised, and the patient was now alive and flourishing two years afterwards. Finally he would say "Put not too much faith in pathologists, but be guided by the clinical symptoms."

In reply Dr. Tilley said that Mr. Robinson had suggested the malignant nature of the growth because the septum was bulged towards the side opposite the seat of the growth. He (the exhibitor) thought that this deviation was only part of a general deviation of the septum, and that the slow recurrence of the growth after its first removal six months ago was opposed to the view of malignancy. It seemed more of the nature of a fibro-angeioma; he purposed removing the recurrence in the course of a day or two, and microscopic sections of the tumour would be shown at the next meeting.

Case of Pachydermia Laryngis.

Shown by Mr. Charles A. Parker. This case occurred in a male æt. 45, who works in a forge. He came to the Throat Hospital a week ago on account of dyspnœa. He gave a history

of having had a bad attack of laryngitis three years previously, and frequent attacks of hoarseness since then. Three days before coming to the hospital he had apparently a most severe attack of dyspnœa.

On examination there was found to be an exceptionally large pachydermatous mass occupying rather more than the posterior third of either cord, and superimposed upon this chronic condition there was an acute laryngitis, with a plentiful formation of crusts. He was admitted into hospital on account of the dyspnœa. The laryngitis is now much better, but the pachydermatous condition remains.

The case seemed worth bringing before the Society on account of its being an unusually well marked example of pachydermia laryngis, and on account of the dyspnœa which accompanied it.

Dr. DUNDAS GRANT considered it very suspicious of tubercular disease, and if it were under his care he should give a diagnosis accordingly. There was much infiltration of the tissues round about what was otherwise a typical pair of pachydermatous growths, and the patient himself asserted he had been wasting and felt very flabby. Very often a diagnosis of pachydermia laryngis proved to be incorrect on further development.

Dr. SCANES SPICER did not see any evidence of tuberculosis in the larynx; the ventricular bands were greatly enlarged, red, and prominent; why was this? He was not aware that this remarkable enlargement, confined to the ventricular bands, was any evidence of tuberculosis. The condition of the cords was pathognomonic of what has been called pachydermia.

Mr. R. LAKE was in accord with the opinion of Dr. Grant; he would like Mr. Parker to show the case again if possible. The patient had lost flesh in six months; the masses of tissue were very red, more so than one would expect in a case of pachydermia laryngis, where they should be pale.

Mr. PARKER had not examined the larynx at the meeting, but he thought that all the surrounding thickness and redness might be accounted for by the laryngitis the man had a week ago. This swelling was subsiding.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

FIFTY-SEVENTH ORDINARY MEETING, *April 7th*, 1900.

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

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

Present—36 members and 8 visitors.

The minutes of the preceding meeting were read and confirmed.

The President referred with regret to the loss the Society had sustained in the death of Dr. McNeill Whistler, one of the original members.

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

Chichele Nourse, F.R.C.S.Edin., Abchurch House, E.C.
H. Skelding, M.B., B.C.Cantab., Bedford.

The following cases and specimens were shown:

CASE OF LARYNGEAL (?) WHISTLING.

Shown by Sir FELIX SEMON. The patient, a boy æt. 13½ years, who shows this physiological curiosity, was brought to the observer on account of a nervous cough. His father incidentally mentioned that the boy was able to produce a curious noise of a

shrill whistling character with his mouth wide open. The Society will convince itself that this is so. The whistling sounds as if it were produced in the ordinary way, but as the boy can produce it whilst a laryngoscopic examination is being made, it is obvious that the origin of the sound must be in the larynx or even lower down. When he produces the sound it is seen that the epiglottis is forcibly drawn downwards, so that it is impossible to see the cords in their entire length. Enough, however, is seen of the posterior parts of the cords, and of the arytænoid cartilages to show that the glottis is not closed in its entire length, but that the inner surfaces of the arytænoids stand at least one and a half to two millimetres apart from one another whilst the whistling is produced. No abnormal movement of the chest can be perceived when the boy is stripped and then produces the sound. It is therefore very likely that the sound is actually produced in the larynx, although it is difficult to understand how it can be with comparatively so widely open a glottis.

The PRESIDENT thanked Sir Felix Semon for bringing this case before the notice of the Society. It was certainly a rare phenomenon. He wondered if any member had ever come across a similar case; he certainly had not himself. He thought they would all agree with Sir Felix Semon that the sound was produced in the larynx; he did not think there was any need for the mark of interrogation which was applied to the word "laryngeal."

Dr. FURNISS POTTER said it would be interesting to know if the whistling would take place if the epiglottis were held up. It seemed to him that on expiration the epiglottis became doubled upon itself, and was drawn down upon the arytænoid region. He wondered if it were possible that the whistling sound might be produced by the air passing through the chink formed by this drawing down of the epiglottis?

Mr. SPENCER did not think the whistling was due to the position of the epiglottis; the whistle had still been heard under the conditions the previous speaker mentioned; besides, the epiglottis was not drawn down so far as Dr. Potter imagined.

Mr. WAGGETT asked if Sir Felix Semon had obtained a view of the bifurcation of the trachea? Was it certain the boy had not some structure resembling the syrinx of a bird? The notes produced had the characters of the birds' notes.

Dr. BOND mentioned that some twelve years ago he remembered a student at the Golden Square Hospital who could whistle with the top of his larynx. He had abnormal power over his throat muscles altogether; for instance, he could put the tongue behind the soft palate and swab out the naso-pharynx. It was easy to see the larynx during

whistling. The student simply used the sides of the brim of the larynx, *i. e.* the ary-epiglottic folds, in the same way that he used the lips when whistling with his mouth. The epiglottis had nothing to do with the production of the sound. He did not remember whether whistling with the larynx and the mouth at the same time could be performed.

Sir FELIX SEMON, in reply, said that although he had seen a good way down the trachea he had not seen the bifurcation. He did not think that either the epiglottis or the arytæno-epiglottidean folds had anything to do with the production of the sound. There could be no doubt that during its production the vocal cords remained a good deal apart. His own—although very theoretical—explanation was, that the boy probably had an unusual amount of control over the crico-thyroid muscles, and that it was owing to their forcible contraction, and to the unusual amount of tension of the vocal cords produced thereby, that when a forcible expiration was made the sound was produced. Mr. Waggett's idea of the syrinx was very interesting, but he could not say whether it applied to the case.

CASE OF RHINOSCLEROMA.

Shown by Dr. DUNDAS GRANT. A female æt. 26, came under my observation on July 14th, 1898, on account of complete obstruction of both nostrils. The tip of the nose was found to be hard and swollen, and the nostrils were completely blocked by a reddish growth of almost fibrous consistency; there were fine symmetrical scales on the soft palate, and the uvula had completely disappeared. It was impossible to obtain a rhinoscopic view, but the finger introduced into the naso-pharynx enabled one to detect a firm dense bar extending horizontally across the lower margin of the posterior nares. A microscopic preparation of a portion of tissue removed was made by Mr. Wingrave, and Dr. St. George Reid made a cultivation which he considered showed the capsuled bacillus typical of rhinoscleroma.

The case disappeared for about a year, but about six weeks ago she returned with the nostril quite blocked, my previous treatment of scraping and dilating having had only a temporary effect. I managed to introduce a fine tangle-tent through the diminutive orifice, and then inserted a small pledget of cotton wool dipped in pure lactic acid.

The PRESIDENT said the case was similar to one shown by Sir Felix Semon and Dr. Payne at the Pathological Society a good many years ago; that was the last case of rhinoscleroma he had heard of in London.

Dr. WATSON WILLIAMS asked if the condition of the soft palate had been modified to any great extent by treatment?

Mr. W. G. SPENCER asked if there had been any infection or any history of inoculation from any members of the family, or from any persons in the district where she lived with whom she had associated.

Sir FELIX SEMON referred to the case which Dr. Payne and he had shown many years ago at the Pathological Society, and the illustrations of which in that Society's 'Transactions' he handed round. In that case the changes were even more pronounced than in Dr. Grant's case. Two hard, red, semi-globular tumours protruded from the nostrils, whilst the palate was in a condition similar to that seen in Dr. Grant's case. The hardness of the tip of the nose in the present case was very characteristic. The result so far obtained by Dr. Grant by the application of lactic acid in one nostril was very satisfactory, but he was afraid that it would be as temporary as the one obtained by himself in his own case, by means of the galvano-cautery. In that instance directly the treatment ceased the disease returned. The patient had passed out of his hands into those of the late Sir Morell Mackenzie, who had published a note about the case in the 'British Medical Journal.' He, too, had obtained no lasting results.

Dr. STCLAIR THOMSON asked if the palate was characteristic of the disease. In the few cases he had seen in Vienna, the palate was never left so mobile as in this instance, though this was merely a question of degree; nor did the rhinoscleroma heal up so completely—it was more thickened and leathery. He also inquired if this case coincided with the pathological tests—bacteriological and histological—of rhinoscleroma.

Dr. DUNDAS GRANT, in reply to Dr. Watson Williams, said the palate was in exactly the same condition now as when the patient first came to see him; nor was she conscious of ever having had particularly sore throats. He was unaware when the change took place. In reply to Mr. Spencer, he was not aware of any infection or inoculation. The patient had had iodide of potassium, but it made no difference to the condition. Cultures had been taken and answered exactly to the description of rhinoscleroma. They were totally dissimilar to those of leprosy. They showed diplo-bacilli, with extraordinarily large capsules.

SPECIMEN OF LARYNX REMOVED ON ACCOUNT OF SARCOMA.

Shown by Dr. DUNDAS GRANT. A female, æt. 49, came under my care on 6th February, on account of loss of voice and difficulty in breathing, the former having gradually developed since the month of July, and the stridor since December. The stridor

seemed from its tone to arise somewhat deeper than the larynx; it was purely expiratory in character, and was accompanied by excursion of the larynx. There was no pain on swallowing. On examination externally I found a well-marked bulging of or on the right ala of the thyroid cartilage, and the laryngoscope revealed a rounded sessile growth underneath the right vocal cord, the surface of which was fairly smooth; the left vocal cord was immobile and almost completely hidden by the ventricular band, the left half of the vestibule being distinctly swollen. The diagnosis lying between malignant disease, probably epithelioma, and syphilis, inquiry elicited that she had had one miscarriage, then one stillborn child, then four boys, all strong and well, and afterwards one girl, who only lived for forty hours, and lastly the youngest child, now aged sixteen, and who is rather short in stature. I decided to give antisyphilitic remedies a trial, but in view of the possible danger of œdema of the larynx arising from iodide of potassium, I recommended her coming into the hospital, where for a fortnight she was treated with iodide of potassium and mercurial inunctions. Her dyspnœa seemed very slightly to improve, but practically things remained *in statu quo*, as when she moved about the disturbance in breathing was quite as bad as ever, and the voice became if anything weaker. My colleagues agreed with me that it was a case of malignant tissue, and with one exception, considered it a suitable one for extirpation of the larynx. My friend Dr. Lambert Lack kindly placed his experience, both in the diagnosis and operative treatment, at my disposal, and on the 3rd March I removed the larynx, as you see. The patient is still in hospital; the opening into the pharynx is rapidly diminishing in size, and I hope to bring her before the Society at a later date, and to give the clinical details with more completeness. Meanwhile the preparation shows the larynx opened from behind; the stump of the epiglottis is visible, as also the rounded growth under the right vocal cord, which was singularly conspicuous in the laryngoscopic image; the much larger growth underneath the left vocal cord somehow eluded inspection, probably because it was hidden by the infiltrated parts on the right side. The section under the microscope shows it to be a well-marked sarcoma, which, I presume, has grown from the

perichondrium on the inner surface of the thyroid cartilage. Had it started from the outer surface, I venture to believe that the external swelling would have attained much greater dimensions during the eight months that the disease has certainly existed.

The PRESIDENT hoped Dr. Grant would show the patient later on.

CASE OF A GIRL WITH HEREDITARY SYPHILIS CAUSING HYPERTROPHIC LARYNGITIS, AND SHOWING RECESSES IN THE NASO-PHARYNX PRODUCED BY THE APPROXIMATION OF THE REMAINS OF LUSCHKA'S TONSIL AND THE EUSTACHIAN CUSHIONS.

Shown by Dr. STCLAIR THOMSON. After the various opinions enunciated at the last meeting *apropos* of Mr. C. Heath's case, Dr. StClair Thomson feared there might have been a plethora of cases shown by members to illustrate their divergent views. He himself could easily have brought half a dozen cases from his clinic to demonstrate that what had been called "sinuses in the vault of the naso-pharynx" were nothing but depressions produced as the title of his communication described.

The case shown was selected for exhibition, as it also illustrated the laryngitis which sometimes developed with hereditary syphilis. He had found that the hoarseness and loss of tone in the voice in these cases was apt to remain in spite of specific treatment, and he would be glad of suggestions on this point. The girl had been under inunctions of mercury for some time.

Mr. YEARSLEY thought most members could bring cases forward showing the recesses formed by Luschka's tonsil quite as well. One noticed them pretty frequently in one's clinic.

SIX CASES OF FRONTAL SINUS EMPYEMA.

Dr. HERBERT TILLEY showed six cases of chronic frontal sinus empyema, upon five of which he had performed the external radical operation. Three cases were bilateral, and of these one had been operated upon on both sides; the others, as yet, on one side only.

In three of the cases, after freely removing the anterior wall, curetting away the diseased mucous membrane, and making a large opening into the nose, a Luc's drainage-tube was inserted, and the external wound sutured at the close of the operation. In the remaining two the sinuses were packed with gauze instead of inserting the tube, a method which Dr. Tilley considered far preferable to Luc's operation. The exhibitor thought that the success of the operation depended upon careful attention to three main points:

1. Removal of the anterior end of the middle turbinal and all chronic inflammatory products in the mid-meatal region before proceeding to the external operation.
2. Making a free passage into the nose.
3. Careful curetting of the diseased mucous membrane, followed by packing with gauze until a healthy lining of granulation tissue was produced.

By making the incision in or immediately below the eyebrow the scar, as in the cases exhibited, was scarcely noticeable. The sixth case was interesting in that over the region of the left frontal sinus was an expansion of the outer wall of the sinus, resembling superficially a syphilitic boss the size of a five-shilling piece. The patient had complained of very severe headaches, accompanied by profuse discharge of pus from the nose, and the nostril was blocked by many large polypi. Since these had been removed the headache had entirely ceased, and it was easy to irrigate the sinus through the nose.

[This case was operated upon the following day; the left sinus was so large that a double thickness of iodoform gauze, two inches wide and three feet ten inches in length, was easily packed into the cavity.]

Dr. Pegler asked if all these cases had been treated alike without drainage-tubing, and stuffed with gauze only?

Dr. Watson Williams asked how many of these cases were found to have the fronto-ethmoidal cells involved. The cosmetic, as well as the surgical results, were excellent in all, and surprisingly good in most of the cases. The series presented certainly reflected great credit on rhinology, and on Dr. Tilley in particular.

Dr. Powell congratulated Dr. Tilley on the most excellent results obtained. With regard to the cases that went wrong, and the dangers that had occurred after the operation, he had always been of the opinion that it was possibly due to too much interference with the

posterior wall of the sinus. The posterior wall was generally scraped too much, and the interference gave rise to septic embolism and thrombosis. Perhaps Dr. Tilley would mention his views on this point.

Mr. WAGGETT asked to what extent the lining of the sinus was removed, whether to the bone or not?

Dr. DUNDAS GRANT asked whether in operating freely through the floor of the sinus there was not great liability to damage the trochlea and the superior oblique muscle?

Dr. LAMBERT LACK wished to know if he was correct in understanding that Dr. Tilley did not open the sinus through the anterior wall. He thought there was almost if not quite as much danger in operating from the floor of the sinus as from the anterior wall. It was necessary to remove the anterior wall in a certain number of cases to obtain a proper view of the sinus; the danger resulted only in the cases in which proper drainage was not subsequently provided for. It was his (the speaker's) general procedure to detach the pulley of the superior oblique, but this had never given rise to diplopia.

Dr. SCANES SPICER asked if Dr. Tilley found he could explore every part of the sinus from the inferior wall?

Dr. TILLEY, in reply, said that he always removed the anterior wall, but not the floor of the sinus, which was really the roof of the orbit, and which, he considered, it was wise to treat with a certain amount of respect. He thought it would be impossible to treat the sinus satisfactorily if the surgeon attempted to enter it from the floor, whereas removal of the anterior wall gave free access to the cavity. The cases had not all been similarly treated; in the earliest cases he had used a Luc's tube and sewn up the external wound at the close of the operation, but he thought such a method was extremely risky. If suppuration recurred, the inflammatory products were pent up under tension, because the drainage-tube was very liable to become blocked or not to drain efficiently, and septic phlebitis of the diploeic veins had occurred in at least seven recorded cases. This complication was almost certainly a fatal one, but it was an almost impossible one if packing or free drainage through the external wound and fronto-nasal canal was permitted. As to how much of the diseased mucous membrane was curetted away Dr. Herbert Tilley said he could not give a perfectly definite answer, he curetted until all granulation tissue and obviously diseased products were removed, but a certain thickness of lining membrane would be left. Temporary strabismus was not uncommon after the operation, but passed off within a week or fortnight as a rule; it was due to disturbance of the pulley of the superior oblique muscle during the operation, and possibly to inflammatory exudation following the operation. In small sinuses, removal of the whole exterior wall produced an excellent result and obliteration of the cavity; in larger sinuses, especially in females, the surgeon would be guided by the size and conformation of the cavity as to the amount of the anterior wall he would remove.

Case of Abnormal Pulsating Pharyngeal Vessel.

Shown by Dr. Herbert Tilley. The patient is a girl æt. 6 years, suffering from enlarged tonsils and adenoids, complicated by the presence behind the right posterior pharyngeal pillar of a large pulsating vessel, possibly an abnormal ascending pharyngeal artery. He desired the experience of members as to the advisability of operating upon the tonsils and growths.

Mr. Spencer advised that the pharynx should be scraped. He saw no danger in the case; the carotid must be quite half an inch or so distant, and the pulsation was communicated.

Mr. Robinson thought it was as likely as not to be a large ascending pharyngeal artery; it was very difficult to say which it was. As far as operative measures were concerned, there was no need to fear any damage because of the position.

Dr. Scanes Spicer thought that the adenoids in this case might be safely removed—by an experienced operator. He added this because he had heard of two operations in which the pharyngeal aponeurosis was cut through, one case ending fatally from multiple abscesses and septicæmia.

Specimen of Nasal Angiosarcoma, shown at last meeting.

Shown by Dr. Herbert Tilley. The specimen was prepared by Dr. Jobson Horne, who regarded it as an angiosarcoma.

Case of Œsophageal Stricture under Tubage for Twelve Months.

Mr. Charters Symonds showed a man of 63, who came to Guy's Hospital February 24th, 1899. The symptoms had existed for a year. The stricture admitted a No. 12, and was thirteen inches from the teeth. A four-inch tube was inserted. This was removed April 21st, and left out. On April 24th he was admitted with complete obstruction. A long tube was passed and withdrawn May 1st, when a short tube was inserted. May 28th the tube was removed and another (No. 13) introduced. Since then this tube has remained in position, a period of eight months, and is still useful. The man has maintained his weight,

can attend to his business, and has no discomfort. He takes finely minced meat besides fluids and eggs.

The points of interest are, the long duration—two years—of a stricture apparently malignant in this situation; the possibility that the case is one of sarcoma; the complete relief afforded by the tube; and the durability of the silk and tube. It may be added that the silk in the mouth is protected as usual by a piece of rubber tubing.

The PRESIDENT commented on the excellent condition which the man presented—he looked the picture of health. He congratulated Mr. Symonds on the success of the case.

CASE OF EXTENSIVE NECROSIS FOLLOWING NASAL POLYPI AND SINUS DISEASE.

Mr. SPENCER exhibited a woman about 40, who, previously to being seen by him, had for many years suffered from polypi in the nose, and suppuration in the maxillary antrum and ethmoidal and frontal sinuses. Extension had taken place by the nasal duct, causing purulent conjunctivitis, which had left a central corneal opacity. The maxillary antrum and the interior of the nose had been actively treated; also the front wall of the frontal sinus, including the upper margin of the orbit, had been removed. But there remained a long sinus extending backwards to beyond the anterior sphenoidal fissure, where dead bone was to be felt. Attempts to scrape away the dead bone in this position had been attended by profuse hæmorrhage, and it seemed only too probable that the necrosis would continue.

CASE OF MALIGNANT DISEASE OF PHARYNX AND LARYNX.

Shown by Mr. MACLEOD YEARSLEY. The patient, a woman æt. 59, had been suffering from "sore throat" for some two and a half years. Recently she had been getting worse and had considerable dysphagia. On laryngoscopic examination the disease was found to involve the lower and posterior part of the left tonsil, the base of the tongue, and the upper orifice of the larynx. There was no specific history, but the case had been

placed upon antisyphilitic treatment. The patient denied that she had been under any treatment but that of her private doctor, but since her arrival at the meeting she had informed Mr. Yearsley that she had already been shown to the Society by Mr. Waggett.

Case of Tonsillar Ulceration of Uncertain Origin.

Shown by Dr. Dundas Grant. A female, æt. 39, came under my observation on the 22nd March, 1900, complaining of sore throat and deafness. The former commenced five weeks before with considerable suddenness, with pain on the left side of the throat, extending to the left side of the head, face, and the left ear. Her voice was extremely thick, and she complained of a tickling in the throat giving rise to cough and sickness; the pain in the throat was most marked during the swallowing of solids. On examination there was a considerable irregular swelling of the left tonsil, and round its outlines was an irregular sinuous, somewhat rough margin of an opalescent tinge tending to white; on the left tonsil there were irregular opalescent patches with slightly raised edges. On palpation the left tonsil was felt to be extremely hard. At the commencement she stated that there was a considerable enlargement of the glands at the left angle of the lower jaw, which lasted for about three weeks; just before she presented herself her voice became extremely hoarse, and the right side of the throat became painfully swollen. Her hair was falling to a notable extent for about a week before the throat manifestation, and continued to do so until mercurial preparations were administered. In November she was nursing what was described as a "premature baby," born at six months, and which only lived a fortnight; the child was much wasted, and suffered from erythema of the nates.

The physical aspect of the case suggested secondary specific affection of the mucous membrane, but the induration of the left tonsil had some of the characters of malignant disease. A provisional diagnosis was made, therefore, of primary infection of the left tonsil with secondary mucous patches of both. Mercurial pill with opium was ordered, and at the end of a week the

patient announced herself as considerably better, although inspection of the fauces revealed little change.

Case in which there was Difficulty in removing a Tracheotomy Tube.

Shown by Mr. Roughton. The patient was a girl æt. 5 years, upon whom tracheotomy had been performed four months previously. There was now complete laryngeal obstruction, and the tube could not be dispensed with. He asked for suggestions as to treatment.

The President referred Mr. Roughton to a paper read before the Medical Society of London by Mr. Bernard Pitts, some four or five years ago,* which dealt with intubation. It struck him at the time as giving servicable methods for treatment.

Dr. Dundas Grant said he had just operated on such a case; the patient was a little girl of about four. He tried to introduce an intubation tube, but it stuck absolutely. He then dissected down on the trachea, and worked upwards till he reached what was thought to be the level of the cricoid cartilage, where there was a narrow structure, through which it had been impossible to pass a bougie of greater size than No. 3. He then introduced the intubation tube through the larynx and stitched up the whole wound. This was done on a Tuesday, and on the Friday following she was breathing through the tube, but there was great difficulty in taking it out—on doing so, dyspnœa returned, so he again restored the tube, and was now awaiting further developments.

Dr. Davis said that obstructions occurred in the great majority of cases if adenoids were present. The child, judging from the enlarged glands, had big tonsils and so presumably adenoids. Adenoids should always be removed in every instance. Where this had been done he found that the tube could be taken out with ease.

Dr. Lambert Lack had shown a case to the Society at a previous meeting, in which intubation had been tried for a long time, and it worried the child's life out. The child could not swallow well with the tube in position, and therefore it had to be frequently removed and replaced. It was impossible to dilate any fibrous stricture unless the dilating instrument was kept in place for a long time. A tube or plug passing from the tracheotomy wound upwards into the larynx, or the T-shaped tube, was much more comfortable, and could be worn continuously. One case of laryngeal stricture after diphtheria was completely cured by this means. A solid plug was better than a tube, as it was easier to remove, and did not collect mucus.

Mr. Spencer thought an intubation tube a source of trouble. It was necessary to remove the fibrous tissue and granulations. He

* The date of paper was December, 1890.

would then insert a T-shaped cannula, made in two pieces for convenience of removal. The tube leading outwards could be blocked at will, so as to re-accustom the child to breathing through the larynx.

Laryngeal Case for Diagnosis.

Dr. Scanes Spicer showed a lad who had two months ago exhibited a distinct, small, sessile papilloma about the centre of the left cord, associated with multiple papillomata on the hands, arms, and body. The application of a spray of salicylic acid in alcohol (ʒss to ʒj) had been followed by the complete disappearance of the wart on the cord, but the hoarseness was not better, and on examination the ventricular bands were seen to be in a rough, reddened state; a thickened mass was seen on the inter-arytænoid part of the posterior wall, and the right cord did not move freely. As these latter appearances were not present two months ago, the question arose as to whether they were due to extension of the papillomatous growth, or were tubercular, or if they resulted from the irritation of the salicylic application. This had only been used three or four times, and had been discontinued for six weeks. He asked if other members had seen any similar results from application of salicylic acid in this region.

The President suggested that possibly the salicylic acid spray was responsible for the condition seen; the boy was suffering from hoarseness, and had small papillomata in the larynx. Certainly these when irritated might bring about such a chronic inflammatory condition. He advised leaving off the local treatment for the present, and in view of the warty growths on the hands, giving some arsenic, which had a wonderful power of clearing up warts on the skin; the larynx might be benefited by this treatment.

Mr. Spencer remarked upon the enlarged glands in the neck, especially the laryngeal. The sputa should be examined in view of possible tuberculous disease.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

FIFTY-EIGHTH ORDINARY MEETING, *May 5th*, 1900.

SIR FELIX SEMON in the Chair.

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

Present—32 members and 5 visitors.

The minutes of the preceding meeting were read and confirmed.

The following gentlemen were unanimously elected members of the Society:

H. Skelding, M.B., B.C.Cantab., Bedford.
Chichele Nourse, F.R.C.S.Ed., London.

The following cases and specimens were shown:

A SPECIMEN OF ACUTE ŒDEMA OF THE LARYNX.

Shown by Dr. LOGAN TURNER. The larynx had been removed from a man æt. 34, who died suddenly from asphyxia before surgical assistance could be obtained. He had suffered for some months from hoarseness, but had never had any respiratory difficulty, and had continued working as a stonemason until two days before his death. He then appeared to be in fairly good health and spirits. During the night before his death he had

experienced some slight difficulty in breathing, but on the following morning had expressed himself as feeling quite able to go out. After breakfast, however, he suddenly developed dyspnœa, and died within half an hour.

Post-mortem examination showed the internal organs healthy with the exception of the lungs, which were tubercular. In the larynx the glottic chink was invisible, owing to marked œdematous swelling of the ary-epiglottic folds, arytænoid region, and ventricular bands. The epiglottis preserved its normal contour, being free from œdema. Further examination of the larynx revealed almost complete destruction of the left vocal cord, and some superficial ulceration of the right, while an ulcer of considerable size and depth occupied the inner and upper aspect of the left ventricular band. The case is of special interest as a demonstration of a possible sudden fatal complication in the course of laryngeal tuberculosis, without any previous symptoms of difficult respiration.

Sir FELIX SEMON said that a genuine œdema of the larynx very rarely supervened in cases of tuberculosis. In this case the nature of the œdematous infiltration was quite different from the ordinary pseudo-œdematous infiltration of laryngeal tuberculosis. He was not aware that such a case had ever been described. Perhaps other members had seen similar cases?

Mr. WAGGETT had seen a case of sudden death from asphyxia occurring in the course of tubercular laryngitis, in the case of a woman suffering from myxœdema.

Dr. HERBERT TILLEY cited the case of a young girl who was under treatment for tubercular laryngitis, in which difficulty of breathing was a prominent symptom. She died suddenly of asphyxia before surgical aid could be procured.

Dr. WATSON WILLIAMS could recall two cases in which there had been considerable localised true œdema of the larynx in the course of laryngeal tuberculosis; but it was never so extensive in either case as to cause a fatal result.

Dr. TURNER (in reply) was glad to hear the remarks which had been made, because he had looked into the literature of the subject for the past twelve years, and had come to the conclusion that the case was very uncommon.

CASE OF TRACHEAL STENOSIS.

Shown by Mr. STEPHEN PAGET for Dr. Pasteur. A young man, 19 years of age, had enlargement of the thyroid gland of

three years' duration, and stenosis of the trachea, which was narrowed from side to side. The patient had been admitted to the Middlesex Hospital in October of last year, with severe dyspnœa. Mr. Paget suggested that the narrowing of the trachea might be due, not to the enlargement of the thyroid gland, but to some congenital malformation.

Dr. DUNDAS GRANT considered this a typical case of "scabbard-shaped" narrowing of the trachea, due to pressure exerted on it by the enlarged thyroid.

Dr. WATSON WILLIAMS considered that the tracheal stenosis was not a congenital stricture, but was directly connected with the enlarged thyroid gland, and that the unusually narrow appearance of the tracheal rings must be due to foreshortening. He recently had a similar case under his care, in which there was a peculiar oblique scabbard-shaped stenosis of the trachea.

Dr. FITZGERALD POWELL said that lately he had under his care a boy of 16 years of age, who suffered from considerable interference with his breathing, due to pressure upon his trachea by an enlarged thyroid. On removing the isthmus and right half of the gland, which were found to be the seat of cystic degeneration, the trachea was seen to be in exactly the same condition as in the case under discussion, *i. e.* scabbard-shaped. Complete relief to the breathing was obtained after removal of the diseased gland.

Dr. BRONNER had seen three cases in which the pressure on the trachea had been of a different kind from the cases quoted; it had been caused by fibrous bands, which crossed from one side to the other. A very small thyroid with the presence of such bands could produce tracheal stenosis. These three cases were associated with small thyroids, and operation was necessary to relieve the difficulty of breathing.

Mr. PAGET said that, in view of the opinions expressed, he withdrew his suggestion that the narrowing of the trachea was due to congenital malformation. He would watch the case, and would report on it again at some later meeting of the Society.

NEW INSTRUMENTS FOR THE TREATMENT OF ANTRAL EMPYEMA.

Shown by Mr. ACLAND (introduced by Dr. Watson Williams). Through the kindness of my colleague, Dr. Watson Williams, I am enabled to bring before you to-day some instruments which I have devised for the treatment of antral empyema.

I generally choose to perforate through the alveolar ridge, and these instruments are intended for use in this method.

No. 1. *The borer* is of special size and shape. It cuts the bone

of the alveolus very readily when rotated forwards (*i. e.* from left to right—like a screw), by reason of the fluting or grooving of its edges.

No. 2. *The measurer* may be used to ascertain the depth of the bone traversed before the antral floor is reached. So that if necessary the tube (No. 4) may be cut.

No. 3. *The tube carrier* is a modified screw-driver, on which the antral tube (No. 4) fits, and by which the tube is screwed into the hole made by the perforator.

No. 4. *The antral tube* is a silver-gilt tube which is intended to be screwed into the perforation. It has a screw-thread on its outside, and a slot on its flanged end like a screw-head. In fact it is a hollow screw, which fits on the carrier, No. 3, like a cannula on a trocar. This tube is intended to be worn by the patient during the whole time of treatment, and is provided with a split-pin stopper to keep the food out. The length as supplied is found to be satisfactory for most cases, but in young subjects it may be necessary (after measurement by No. 2) to shorten it with a fine fret saw.

No. 5. *The two-way nozzle* exactly fits the antral tube, and, having a longitudinal septum in it, provides an inlet and exit for the fluids used in washing the antrum.

The *inlet* branch has a modified Higginson syringe attached to it, and the *exit* branch a piece of rubber tubing which conveys the fluid to a receiver. My colleague, Dr. Watson Williams, and I, have each done several cases with this apparatus, and find it very successful.

I may mention that I have found it possible to extract a diseased tooth or root, bore the hole and insert the tube under one dose of gas.

I have brought with me one of our Bristol students, on whom I had to operate for antral disease, and I propose to demonstrate, with his aid, the advantages of this apparatus in free flushing of the cavity.

The PRESIDENT was sure that the Society was much obliged to Mr. Acland for the interesting demonstration he had given, and also for his kindness in coming such a distance to show his very ingenious apparatus to them.

Dr. WATSON WILLIAMS said that he knew from actual practice that

the apparatus worked as well as it gave promise of doing in the demonstration. He mentioned a case—the second in which this apparatus had been used; the patient, a child of twelve years of age, had suffered from antral empyema for some years, and the apparatus worked so completely and so satisfactorily, that after a week or two there was no discharge of pus whatever. He had accidentally discovered a method by which the tube might be removed. Feeling that the tube projected too far upwards into the antrum of this patient, he had it shortened and reinserted; it answered very well for a time, but naturally, since it did not project into the antrum, the hole had almost closed over the tube. By allowing the top of the canal to close over, it would be very easy to remove the tube from the lower half and let it fill up. There was no reason to believe the apparatus was difficult to work. He had seen Mr. Acland on many occasions remove a tooth, enter the antrum, put in the tube and stopper during a single "gas" anæsthesia, and he had never seemed to have any hitch or trouble in completing the operation before the patient recovered consciousness. For all cases in which alveolar drainage was suitable, Mr. Acland's apparatus appeared to be most simple, comfortable, and effectual.

Dr. Dundas Grant thought that if a tube of this sort was inserted for permanent retention in the treatment of empyema of the antrum, it was essential that the tube should be as perfect a one as it was possible to get, otherwise the patient was better without one at all. A good many cases did well without the retention of any such tube, simply having a wire fitting into the hole, and a syringe having to make its way through each time. At the same time he had seen great improvement take place in very obstinate cases of antral empyema, where a permanent tube was employed, although the tube was very far from being nearly perfect. He thought the spiral wire drainage-tube, which was left open all the time, very undesirable; for it did not prevent the entrance of material from the mouth, and it acted as a cause of irritation. As far as he was able to judge from the demonstration, he certainly thought Mr. Acland's apparatus was a valuable step in the right direction.

Dr. FitzGerald Powell thought the method of entering the antrum of Highmore through the tooth socket for the cure of empyema had a great deal to be said in its favour. It was necessary to have a good-sized opening to allow of free drainage, and to curette the antrum. He was afraid the drills or perforators and tube shown by Mr. Acland were too small to admit of this. He had had drills made which he had used with some success—they were the size of No. 12 to 14 silver catheters,—and had used silver wire tubes a size smaller, through which the cavity could be well flushed, and which allowed fair drainage. This method had answered well even in chronic cases, and in one case of three years' standing he got a complete cure. In this case he had had gold tubes, the size of No. 11 catheter, fixed in by a plate attached to teeth on both sides, it being a double empyema. Experience had taught him that the cavity should be curetted, and the tube should extend a good way into the antrum to prevent its being blocked by granulations. Both the tubes for drainage and the perforators were much larger than Mr. Acland's.

Mr. ACLAND was gratified by the various favourable remarks which had been made by the members of the Society about his little dodge for the treatment of antral empyema.

A NEW UNIVERSAL LARYNGEAL FORCEPS.

Shown by Dr. WATSON WILLIAMS. The essential feature of the instrument was the immobility of one blade, which could be placed in position and kept fixed in contact with the growth or foreign body to be removed, while the other blade was opposed by means of the thumb alone, the forceps being held by the fingers. Moreover the blades could be readily converted from the antero-posterior to the lateral or up and down action, or again a snare could be fitted to it.

INFLAMMATION OF CRYPTS IN THE MUCOUS MEMBRANE COVERING A DEFINED RECESS IN THE ROOF OF THE NASO-PHARYNX, GIVING RISE TO OTALGIA AND OTHER SYMPTOMS.

Shown by Dr. JOBSON HORNE. The patient, a man æt. 25, for three or four months previous to his coming under treatment had experienced pain in the left ear, likened to "a gathering," and his hearing had become impaired.

Clinically nothing was found in the ear itself, or in the mouth or fauces, to account for the pain. By means of posterior rhinoscopy, however, small circular, sharply punched out crypts or depressions, not larger than the bore of a No. 1 vulcanite Eustachian catheter, were detected in the outermost part of the roof of the naso-pharynx, directly above the cushion of the Eustachian orifice and the arch of the posterior naris; one on the left side contained pus, and the edges were inflamed and gave the appearances of an ulcer.

Dr. Horne also showed some anatomical preparations of the region mentioned, in order to demonstrate the area he wished to define. This may be described as a secondary dome in the roof, immediately above the outer part of the arch of the posterior naris and the cushion of the Eustachian orifice, and

enclosed in an arc drawn from the extreme base of the vomer to the summit of Rosenmuller's fossa. The mucous membrane covering this dome or recess has at times, and more often in elderly and thin subjects, a cribriform appearance, occasioned by the mucous membrane being carried in between the separated and superjacent fibres. Purulent matter may readily find its way into one of these crypts and set up a localised inflammation, and occasion the symptoms in illustration of which the case was shown.

Under treatment the symptoms had completely disappeared, and the hearing was restored to normal, so that the ulcerated appearance was no longer visible; but the crypts which contained the pus could be readily seen. The treatment had consisted of nasal douching, and a mixture containing quinine and iodide of potassium; but there was no evidence suggesting lues.

Dr. StClair Thomson thought that Dr. Horne had withdrawn the term ulceration entirely. There was no ulceration at the present time, although some of the members were still of that opinion. The case was very interesting as being a pendant to the case he (the speaker) had shown at the previous meeting, and to that shown by Mr. Chas. Heath at the March meeting of the Society. Mr. Heath had called attention to so-called "sinuses" in the naso-pharynx. What was visible in the present case was the remains of Luschka's tonsil, with adhesions which crossed to the Eustachian tube and intervening lacunæ If the remains of adenoid tissue were thoroughly removed with the curette, in all probability all the symptoms would disappear. He ventured to suggest that some of the changes in the anatomical specimen were post-mortem ones. The specimens showed the lacunæ he referred to.

Dr. Jobson Horne thought that the anatomical specimens which he had shown went to prove that Dr. Thomson's theory was not altogether tenable.

A Specimen of a Curtain Ring removed from the Pharynx of a Child.

Shown by Dr. Lambert Lack. The ring was an ordinary brass curtain ring, about one and a half inches in diameter, and about the thickness of a small Eustachian catheter. The upper part of it was free in the post-nasal space, the lower part free in the lower pharynx behind the arytænoids, the sides being firmly

embedded beneath the mucous membrane of the lateral walls of the pharynx. Under chloroform the upper part of the ring was forcibly pulled forwards from behind the soft palate, and the lower part then with some difficulty cut through with bone forceps. This latter part was opened out by the fingers, and the ring extracted easily by pulling upwards. The history was, that the child, who is now nine years old, swallowed the ring at nine months of age. There was much choking, etc., at the time, and the child was taken to a hospital, where, after examination, the mother was told there was nothing wrong. The symptoms had gradually passed off, and the child had enjoyed fair health, being brought to the hospital recently on account of adenoids.

Two Cases of Nasal Polypi treated by a new Radical Method, with Microscopic Sections of the Bone removed.

Shown by Dr. Lambert Lack. The first case was a female æt. 25, who had suffered from purulent nasal discharge and polypi on the left side for three or four months. The polypi had been twice removed with the snare, but without much improvement. On examination, several large polypi with pus exuding between them were seen in the left middle meatus. Under gas this region was thoroughly and firmly scraped with a large ring knife (Meyer's adenoid curette), and many polypi and loose bits of bone were removed. A large cavity was excavated in the lateral mass of the ethmoid. The patient made an uneventful recovery, the nasal obstruction was completely removed, and the purulent discharge ceased. In about a month a large dry cavity could be seen in the upper part of the middle meatus, and there has been no return of the disease and no other treatment. The operation was performed eighteen months ago.

The second case was that of a man who had suffered from polypi in both nostrils for many years, and had undergone numerous operations with only temporary benefit. Although the polypi had been recently removed, very large masses of polypoid tissue, large fragments of bone, and degenerated mucous membrane were scraped away under general anæsthesia from both nostrils. As far as could be judged almost the entire

ethmoid, with the exception of the cribriform plate and lamina papyracea, were removed. The operation was performed only six days ago; the patient has recovered well, and states that he has lost the constant headache and sense of fulness at the top of the nose from which he had previously suffered, and feels "clearer" than ever he did.

The microscopic sections show extensive changes in the bone removed. These are of the nature of a rarefying osteitis. The periosteum is much thickened, especially in its deeper layer, which consists of rows of large nucleated cells. The surface of the bone is ragged from the formation of numerous little bays, which are filled with very large, often multinucleated cells. The bone cells are larger and more numerous than normal, especially where the bone is invaded. In places the changes have advanced so far that the bone is entirely broken up into fragments, surrounded by osteoclasts, and evidently undergoing absorption.

Mr. WAGGETT wished to avoid on this occasion entering upon the vexed question of the primary lesion in cases of nasal polypus. It was, however, desirable to insist upon the well-recognised fact that in advanced cases the bony structures were in a state of rarefying osteitis, and often so far deprived of their lime salts as to be flexible and semi-transparent.

Mr. PARKER supported Dr. Lack's operation in these cases. He had watched many of his (Dr. Lack's) cases carefully during the last two or three years at the Throat Hospital, Golden Square, and he had himself been doing the same operation with results very much better than any other method of treatment would have given as far as he could see. He was now coming to the conclusion that cases of multiple polypi with suppuration had much better be treated in this way; under the more conservative methods of treatment the polypi had to be removed time after time, which constituted a frequent nuisance to the patient, the suppuration continued, the polypi recurred, and finally one had no other course but to proceed to a more radical operation in a large number of cases. The method of the operation as performed by Dr. Lack seemed fairly free from danger. Dr. Lack recommended the biggest ring knife of Meyer in the first instance, and after that the small ring knife to finish up with; thus performed the operation did not seem likely to give rise to much danger by encroachment on the dangerous regions. The great point was to make quite sure of removing all the crumbling and diseased portions of the ethmoid bone, and to get rid of the degenerating mucous membrane; if that were done, the results, as far as he had observed in his own cases and those of Dr. Lack, had been very good indeed.

Dr. Scanes Spicer also supported very strongly Dr. Lack's procedure in suitable cases. He had done it for years himself with similar good results, and congratulated Dr. Lack on the prolonged immunity from recurrence. He thought, however, the disease was not quite eradicated here; there were two or three small "buds" on the left middle turbinal, and the anterior portion of the opposite middle turbinal body appeared to be undergoing polypoid degeneration. In spite of this the results were very satisfactory, because there was no substantial recurrence for eighteen months, which would have taken place if the extensive polypoid degeneration of the middle turbinate body had been treated by simple snaring of individual polypi.

Dr. Dundas Grant thought it would be a pity if the radical operation such as described by Dr. Lack—excellent as it was in suitable cases—should be looked upon as the routine treatment of multiple polypi. If this turned out to be the case, it would be a decidedly retrograde step in rhinology. They had advanced a great deal in delicate intra-nasal manipulations, and therefore they should all the more be very jealous of any principle or method of procedure which tended to interfere with progress in that respect. He had seen many cases in which the persevering removal of polypi as they recurred resulted in a complete cure; first of all there was a longer and longer interval between the recurrences, and then finally complete cure. It was sometimes necessary to remove the anterior half of the middle turbinal body, which was done *secundum artem* with very much less laceration than would be produced by the ring knife. He would urge a strong plea for the thorough trial of the more delicate manipulatory treatment before such radical measures were adopted. He had not the slightest doubt that there were cases in which nothing short of the operation described by Dr. Lack was of any use, but from his experience, their frequency was of the slightest possible. Cases of his own might have "strayed" from his observation and care, and got into the hands of more radical operators, but he must say for the present he saw very great reason for persevering with the more conservative treatment.

Dr. Permewan did not think the discussion would be complete without the remarks of Dr. Grant. He, personally, was bound to say he was entirely in accord with the words of the last speaker. It seemed to him that there were two great objections to making this method of operation anything like the routine treatment. First of all, there was the great risk incurred; and secondly, the fact that you can never be quite sure of having removed the whole of the disease. It was true a previous speaker had insisted on the careful removal of the whole of the crumbling bone, together with the disintegrating mucous membrane, but he did not see how you could be sure of having taken it all away; consequently one great argument in favour of this treatment disappeared. The risk of it must be more or less considerable. He should think that any violent interference with the ethmoid bone might produce injury elsewhere than at the spot at which you wished or intended. In supporting Dr. Grant, he would say that he believed in the majority of cases that nasal polypi, subjected to a carefully protracted and repeated treatment, would in the long run be practi-

cally cured, if you could induce the patients to come back often enough to have them treated; he hesitated to use the word "cured" without an epithet, in face of the results of Dr. Lack's operation. There was one other point he wished to add. It was odd, when reflecting on the great number of times that this operation had been performed by various speakers, that these two cases now under discussion were the only two shown to the Society at the present time, and that it should be thought necessary to congratulate Dr. Lack on the unusually favourable termination to the cases. He thought that showed that such radical results were not obtained as one was at first apt to imagine. Nor did he think in these two cases that the tendency to polypus formation had disappeared. On the contrary, on both sides there are to be seen signs of recurrence. Personally he had had no experience of this operation, but he should, after hearing what had been said by other members, consider it in exceptional cases with a view to doing something of the kind; the warning should be borne in mind that the treatment must not be rashly undertaken, though it might, after all, be necessary in some cases.

Mr. PARKER said, "I said I was almost coming to the conclusion that in cases of *multiple polypi* with suppuration this would probably be the best treatment."

The PRESIDENT said that he thought too big a subject had been entered upon in what was only intended to be a casual discussion, particularly in view of the many cases which still remained to be discussed, and of the lateness of the hour. It, however, seemed to him an excellent subject for a general discussion by the Society, and he hoped that it would recommend itself as such to the Council. Personally he would only say that there seemed to him quite a host of questions connected with this subject: (1) Did nasal polypus arise from disease of the mucous membrane, or of the bone? (2) Was it possible that in some cases there was the one, and in others the other origin? (3) Why was there in some cases (in his own experience in a small minority only) suppuration connected with the existence of polypi, whilst in others, and indeed in the great majority, it was conspicuous by its absence?—These questions seemed to him an excellent basis for a general discussion. He agreed with Dr. Grant that the radical treatment recommended by Dr. Lack ought not at present to be taken up as a routine treatment, seeing (1) that all the questions he had mentioned had not been solved, and (2) that, according to his own personal experience, in the great majority of cases, if the patients presented themselves periodically and regularly for examination after a thorough removal of the polypi, ultimately the disease reappeared at longer and longer intervals, and finally, and by no means exceptionally only, did not recur any longer. A cure, of course, could never be promised, in view of the fact that sometimes, even after an interval of five years or more, a fresh recurrence took place; but it remained to be seen whether a similar recurrence was entirely excluded by the radical treatment proposed by Dr. Lack. In conclusion the President said that the whole discussion had revived in a very interesting manner the controversy which, many years ago, had taken place between Dr. Woakes and Dr. Sidney Martin, about the changes

seen under the microscope in the specimens removed by the former. No agreement, it would be remembered, was at the time arrived at as to whether the changes in the bone were of a primary or of a secondary nature, yet this was a question of prime importance. Could Dr. Lack, he wondered, advance the disputed point, since the adoption of his radical treatment seemed to him to mostly depend upon that very question?

Dr. LAMBERT LACK, in reply, said that the controversy between Woakes and Sidney Martin was entirely over the clinical features of the disease, and that Martin had never retracted his statements as to the pathological changes found in the bones removed by Woakes. As to whether the bone disease was primary, and the cause of polypi, or whether it was secondary to changes in the mucous membrane causing the polypi, he thought this question could be very well answered by the results of treatment. If one removed the polypi and left the bone, the polypi recurred; but if one removed the bone at the same time as the polypi, the latter did not return. The speaker had operated upon over fifty cases in the last five or six years, and that had been his experience. He quite agreed that in a large number of simple polypus cases a cure could be obtained with the snare if treatment were persisted in for a sufficiently long time, but even in the simplest cases he thought a successful result was more quickly obtained if one succeeded in passing the snare round the piece of bone from which the polypus was growing, and in removing both at the same time. If this failed in these simpler cases, he was in the habit of subsequently clipping away the bone with cutting forceps. But in the severer cases of nasal polypus, and especially in those associated with suppuration, such methods were useless. One of his cases had had polypi removed regularly every fortnight for three years, and yet the nose had never been clear; and the man shown to-night had not been able to breathe through his nose for two years, in spite of frequent operations. In such cases he advocated the clearing out of the whole ethmoidal region, by scraping with the ring knife under a general anæsthetic; in some cases he had even removed a large portion of the inner wall of the orbit. This method, which removed the whole trouble at one sitting, was surely more advantageous to the patient than the protracted treatment and frequently repeated operations that were otherwise necessary, and which were sometimes ultimately successful; and Dr. Grant's patients would probably prefer it, although it would not give him the same opportunity of acquiring operative dexterity. What some members took to be signs of recurrence of the polypi, was only granulation tissue, which now the diseased bone was removed would shrivel up, and did not require any treatment. Finally, as to the risk, he could only say that having performed the operation as extensively and frequently as he had already said, he had not yet had a result which he could describe as dangerous or serious, and he did not believe the danger was as great as the sum total of the danger resulting from the repeated small nibbling operations.

Case of Chronic Ethmoiditis simulating so-called "Cleavage" of the Middle Turbinate.

Shown by Dr. Herbert Tilley. The patient, a girl æt. 18, complained of severe pain over the nose and around the right side of the face. The middle turbinal was easily visible, and on its under side was a well-marked swelling, between which and the turbinal a probe could be passed. It was impossible to pass a probe to the outer side of the swelling referred to. Kauffman had stated that such a swelling was pathognomonic of antral suppuration, but the exhibitor thought that while such an appearance was met with in chronic inflammatory lesions located in the ethmoidal region, it was only significant of antral disease when associated with suppuration.

In the present case exploration of the antrum showed it to be free from pus.

Dr. Dundas Grant wished to ask Dr. Tilley which of the structures he saw in the nose he considered to be the middle turbinate bone. The more one saw of the nose, the more excuse one could make for anyone who considered the growth in the case under discussion to be the middle turbinal bone. He had seen many cases of hypertrophied mucous membrane over the uncinate process which resembled exactly the middle turbinate body, and could only be distinguished from it by means of the probe. He thought in Dr. Tilley's case he saw three swellings, viz. the uncinate process, the bulla, and the middle turbinate. It was sometimes extremely difficult—and it was only possible by using one of those long, very narrow specula, such as Killian's, for median rhinoscopy—to make out which was which. The question of so-called cleavage was one really of old time, which arose when the minuter knowledge of the anatomical parts of the nose was less familiar than now.

With reference to Dr. Grant's remarks, Dr. Tilley said the middle turbinal was easily visible, and could not be mistaken for any other structure. The case was shown to illustrate that it only *resembled* a cleavage of the mid-turbinal, but was in reality only a periostitis in the neighbourhood of the uncinate process.

Case of Laryngeal Ulceration.

Shown by Dr. Edward Law. The patient first came under my care on December 29th, 1899. He complained chiefly of

soreness of the left side of the throat of thirteen months' duration, and of hoarseness of three weeks' duration. For eight months he had also suffered from bad cough, with free expectoration. There was no difficulty in swallowing or breathing, and he considered that his general health was satisfactory. There was no history of syphilis. On examination a large deep irregular ulcer was seen involving the left upper edge of the epiglottis. The whole of the larynx was red and swollen, with marked impairment of movement on the left side. He would not remain in London for further observation, but promised to return in three weeks. A mixture containing Pot. Iod. grs. x and Liq. Hydrarg. Perchlor. ʒj three times a day was prescribed, along with a pastille of aristol and cocaine.

He did not return till May 4th, 1900, but the dose of Pot. Iod. had been meanwhile increased to grs. xx by his own physician. On examination the ulceration was seen to have destroyed the left half of the epiglottis, and there was almost complete fixation of the left half of the larynx.

Personally I believe the case to be malignant, but I should like to have the opinion of the members.

The PRESIDENT particularly asked members with experience of such cases to express an opinion, as the case had been shown with a special request for the opinion of members. Personally, he was afraid it was a malignant growth; it did not look to him in the least either specific or tubercular. There was extensive tumefaction and immobility of the left half of the larynx, and complete loss of the left half of the epiglottis, with considerable enlargement and fixation of the cervical lymphatic glands on the left side of the neck. All this pointed decidedly to malignant disease. Radical operation, if undertaken at all, would have to be very extensive, and the prospect was not good.

Dr. SCANES SPICER hesitated to differ from the diagnosis of the President, who had had more experience than himself in these cases, but the extent of the superficial ulceration in this case, together with the small amount of infiltration, appeared to him to favour the theory of a syphilitic process. There was, besides, the bright red colour of the growth and the man's good general health to consider. The condition had existed for several months, and if it was malignant, it would (being extrinsic) have had some effect on the man's general condition. It was true there was glandular infiltration, but this might result from the enormous surface of ulceration, which invaded the whole left side of the larynx. The left vocal cord did not seem to be involved in new growth, or to be displaced inwards, as would, he thought, be the case if the ulcerated surface were that of a malignant neoplasm.

Dr. HERBERT TILLEY had examined the growth with his finger, but was struck by the absence of that induration so characteristic of malignant disease. This fact, coupled with the long history of the ulceration and the excellence of the patient's general health, seemed to throw some doubt on the malignant nature of the case.

Dr. LACK thought it was a typical case of malignant disease. There could not be much doubt with such hard granular infiltration.

The PRESIDENT thought it was quite time that the idea was given up that the presence of malignant disease of the larynx in its early, and sometimes even in more advanced stages, *necessarily* interfered with the general health of the patient. He had seen too many instances of good general health with quite extensive malignant disease of the larynx to countenance the notion of the regular early co-existence of general cachexia, which, in his experience, as a rule occurred very late in the progress of the disease.

CASE OF ULCERATION OF EPIGLOTTIS.

Shown by Dr. FITZGERALD POWELL. A male æt. 44 came to the hospital on May 1st to seek relief for deafness and severe tinnitus, which he states came on suddenly four months ago.

On making a general examination of the upper air-passages, the epiglottis was seen to be swollen, very red and congested, and on its laryngeal surface on the right side a considerable patch of ulceration was observed, the rest of the larynx being normal.

A small hard gland was felt in the left cervical region opposite the thyro-hyoid space. On being questioned, he stated he had some pain in swallowing for two weeks.

He gives a history of having a chancre when a boy, which was treated by local applications, and which healed in three or four weeks. He had no constitutional treatment, and has had no further signs of syphilis.

He is married, and his wife has had eight children, all healthy. He has had severe cough, and has lost flesh during the last four months.

There are no abnormal signs in the chest.

Dr. JOBSON HORNE regarded the case as tuberculous. It would be as well to have an examination made of the thorax and sputa before deciding that it was not tuberculosis.

Case of Enlargement of Lingual Tonsils in a Woman æt. 39 with Secondary Syphilis.

Shown by Dr. Henry J. Davis. The patient came to the hospital in January, looking extremely ill, with ulcerative tonsillitis and marked adenitis. There was a deep kidney-shaped excavation of the right tonsil.

Faucial tonsillar tissue is now almost absent, having been undermined and destroyed by the severity of the ulceration; but if the tongue be depressed or protruded, the lingual tonsils, both of which shared in the general inflammation, though, oddly enough, not in the ulcerative process, can be seen as elevated symmetrical masses rising above the sides of the dorsum of the tongue. They are not so large as they were, though still plainly visible.

The severity of the disease has been aggravated by the fact that even the smallest dose of iodide of sodium produces a well-marked rash with the other signs of iodism. The patient is being treated with mercury; but the rash persists, though the throat is well.

The disease was contracted from her husband, a groom, who also at first had severe throat lesions, ulcerative laryngitis and tonsillitis, with mucous patches on the palate, tongue, and lips.

He stated that he was suffering from blood poisoning, resulting from the bite of a vicious horse, but as horses are considered immune against syphilis, I did not agree with his diagnosis.

Case of Growth in the Neck associated with Œdema of One Ary-epiglottic Fold.

Shown by Dr. Dundas Grant. A middle-aged labourer came under my observation on May 3rd, 1900, on account of a swelling on the side of his neck. There is a hard oval swelling at about the level of the thyroid cartilage, with its long axis parallel to the internal jugular vein. It is extremely hard, and is quite moveable, both under the skin and on the subjacent tissues, and it does not rise with the larynx during the act of swallowing. Above, below, and behind it are isolated enlarged

glands. It has taken eight months to develop to its present size, the enlargement being more rapid towards the latter part of that period. There is no pain, no difficulty in swallowing, no affection of the voice or respiration. On laryngoscopic examination the only abnormality perceptible is a slight œdema of the right ary-epiglottic fold, and such an inward bulging of the outer wall of the pharynx as to conceal from view the hyoid fossa of that side, while the opposite one is easily discernible. On palpation no hardness suggestive of malignant disease is detectable, although the finger appears to reach the ary-epiglottic fold. There is no apparent dental trouble to account for the enlargement of the gland, which at first sight seems an ordinary indolent tuberculous gland. Associated with this swelling of the adjacent portion of the framework of the larynx, the question arises as to whether the two conditions may not be connected, and that we have to deal with a malignant affection. An opinion on this point is specially requested.

Mr. SPENCER thought there was an ulcer in the lateral hyoid fossa. This and the feel of the glands in the neck, and the sickly appearance of the patient, gave most likelihood of tuberculosis. On passing the finger down the gland, there was none of that distinct nodular feel which one expected in cancer.

Dr. DUNDAS GRANT would suggest in the first place a course of iodide of potassium; if that did not produce a marked effect he would recommend excision of the enlarged gland, whether malignant or tubercular.

A CASE OF INTER- AND SUB-CORDAL GROWTH, WITH HOARSENESS OF REMARKABLY SUDDEN DEVELOPMENT.

Shown by Dr. DUNDAS GRANT. A man æt. 66 came under my care on May 3rd, 1900, complaining of hoarseness and loss of voice of four months' duration. About Christmas time he was attacked with "cold in the chest," which in a week disappeared; but the hoarseness and aphonia remained from that time to this unchanged. On inspection there is seen on the anterior part of the larynx a pale granular irregular-surfaced growth, which is bilobate, the upper part being rather the smaller, and lying between the vocal cords, the larger and lower half lying below

them. It appears to spring from the middle line anteriorly. There is a swelling on the right carotid artery at the level of the left thyroid ala. It is impossible to detach it from that vessel, and it is very doubtful whether it is an enlarged gland, being more probably an irregularity in the shape of the artery.

Mr. SPENCER thought the tumour was malignant. It was awkward that it involved the middle line in front, as, if anything were done, no unilateral operation would be sufficient. He advised an exploratory thyrotomy, and removal of the soft parts only on both sides.

Dr. GRANT would remove, as suggested by the President, a portion of the growth for examination, and act according to the results obtained. He did not know whether members of the Society would advise removal of the larynx *in toto* in a man of that age, though he was in very good health. The fact of the tumour being in the middle line made a unilateral operation impossible. He thought both vocal cords could be removed without danger.

CASE OF PHARYNGEAL AND LARYNGEAL GROWTH IN A MAN ÆT. 59 —SHOWN AT THE MARCH MEETING—WITH MICROSCOPIC SECTIONS OF PORTION OF GROWTH REMOVED.

Shown by Dr. FURNISS POTTER. The section had been reported on by the Clinical Research Association, who stated that it showed "young inflammatory formation—no signs of tubercle or malignant growth."

Dr. JOBSON HORNE had kindly also examined the specimen and expressed the opinion that "the histological structure in places was undoubtedly that of sarcoma." As regards the clinical progress of the case, the man had, on the suggestion of the President, had the dose of iodide increased to grs. xx, and had been taking this dose since the beginning of March. Looking at the throat it certainly appeared as if considerable absorption had taken place, and the patient was most decided in expressing the opinion that he felt much more room in his throat, and could swallow with very much greater ease. Dr. Potter said that he had ventured to bring the case again before the Society, as he considered it of interest, by reason of the uncertainty of diagnosis, and the difference of opinion expressed on the microscopic section.

The PRESIDENT suggested that the specimen be submitted to the decision of the Morbid Growths Committee, in view of the difference between Dr. Horne's opinion and that of the Clinical Research Society.

Dr. TURNER agreed with Dr. Horne as to the microscopical sections; the character of the cells and blood-vessels was distinctly sarcomatous. There was inflammatory tissue as well, and the clinical appearance of the case supported the microscopical diagnosis, even though the patient had improved under treatment.

Dr. POTTER said that the evidence for and against a diagnosis of malignant disease seemed to be evenly balanced. He had intended in describing the case to ask for an expression of opinion with regard to the treatment. He himself felt that the progress of the case under iodide of potassium justified him in continuing the drug. He proposed to adopt the suggestion of Dr. Thomson that mercurial inunction should be given for a time.

CASE OF LARYNGEAL GROWTH.

Shown by Dr. KELSON. A man æt. 37, a teacher, came complaining of loss of voice of five years' duration and gradual onset.

No history of tubercle or syphilis.

Laryngoscopic examination revealed the presence of an opalescent somewhat granular-looking growth, about the size of a threepenny piece, and corresponding to the anterior and middle parts of the right vocal cord, and preventing the contact of the cords on adduction.

Patient stated that two years ago portions of the growth had been removed at Gray's Inn Road Throat Hospital, with considerable, but only very temporary, relief.

Mr. SPENCER asked if the growth could be removed completely by intra-laryngeal methods. The growth was very broad, and not pedunculated, and well under the cord. He advised that laryngotomy should be performed; it was quite a trivial operation, and one would have to make only a small opening to remove the growth.

Dr. GRANT said the growth was attached below, and not above, the right vocal cord, although the mass of it was above; he had examined the case with great care, and caught one glimpse of the edge of the vocal cord in its entire length, which showed it must be subcordal. The ventricular band bulged over the cord and made it difficult to see the entire edge. The growth might be just below the edge of the cord, and his laryngeal forceps might suffice to remove it completely or sufficiently; that course should certainly be tried before laryngotomy

was resorted to. He presumed Mr. Spencer did not mean to divide the thyroid cartilage completely.

Mr. SPENCER meant no division of cartilage at all, but a little hole in the region of the crico-thyroid membrane, which would enable one to get in quite well and to remove the growth.

Dr. POWELL and other members discussed the case, and expressed great differences of opinion as to whether the growth was attached above or below the cords.

Dr. KELSON thought the growth was above the cord. He was standing by the man at the time other members were expressing the contrary opinion, which greatly surprised him.

The PRESIDENT was strongly inclined to the belief that the growth was above the cord. Would Dr. Kelson bring the case to the next meeting?

Dr. KELSON promised to bring the case again, and if possible to do nothing in the meanwhile.

CASE OF BILATERAL ABDUCTOR PARALYSIS.

Shown by Mr. WYATT WINGRAVE. A female æt. 50 came to the hospital on Tuesday last, complaining of loss of voice, attacks of difficult breathing, and difficulty in swallowing.

The onset was sudden three months ago, without any pain, and unassociated with any illness.

On examination the soft palate was almost fixed, the constrictors of the pharynx paretic, and the vocal cords immobile on phonation. The arytænoids moved slightly, but the cords were flaccid, leaving but a very narrow glottis; their edges flapped about with inspiration and expiration.

Beyond some slight swelling of ventricular bands the texture of the larynx was normal. Although sensation of the pharynx and larynx is somewhat diminished, laryngoscopic inspection produces violent inspiratory stridor.

On swallowing food returns through the nostrils. The voice is not completely aphonic, and the faulty articulation is probably due to palatal paralysis, as tongue, lips, and cheeks move well. There are no tremors of the tongue; the pupillary reflex and knee-jerks are normal.

Beyond some harsh breathing, a few bronchial râles, and the conducted laryngeal sounds, the chest affords no evidence of disease.

She has a pulsus paradoxus, and she has lost weight lately.

The PRESIDENT said there could be no doubt that the patient suffered from bilateral abductor paralysis, more developed on the right than on the left side. There also was unilateral paralysis of the palate. He should give iodide of potassium in the first place, and be guided as to further steps by the progress of the case.

Dr. GRANT said the suddenness of the lesion suggested a hæmorrhage, but perhaps the history was unreliable.

CASE OF ULCERATION OF LARYNX.

Shown by Dr. DAVIS in the absence of Mr. Paget. The man was a soldier who had syphilis twenty years ago, for which he had never been systematically treated. There were no signs of tuberculosis of the larynx. The patient in addition had a gummatous ulcer of the right lip involving the gums—it was first mistaken for an epithelioma, but was now granulating slowly under iodide of potassium; the laryngeal lesions were now also less marked than they were.

Dr. JOBSON HORNE said that, although there was undoubted evidence of syphilis, he was quite prepared to hear it suggested that there was an element of tuberculosis in the case.

CASE OF RADICAL OPERATION FOR CHRONIC FRONTAL SINUS EMPYEMA.

Shown by Dr. HERBERT TILLEY. When first seen the patient complained of severe frontal headaches, and discharge of pus from the left nostril, which was completely occluded by polypi. There was no discharge from the right nasal cavity, which seemed in every way normal. Over the left sinus there was a well-marked expansion of the bone, the size of a five-shilling piece, which closely resembled an area of syphilitic periostitis. The patient also suffered from enlarged tonsils and adenoid growths. These and the nasal polypi were removed on different occasions before the external operation was performed. The left antrum contained no pus. The headaches disappeared when the nasal polypi and the anterior half of the left middle turbinal

were removed, thus allowing free drainage from the upper sinus. It was quite easy to irrigate the latter by means of a Hartmann's cannula.

Having cleared the nose of pathological products the external operation was performed. An incision was made through the inner half of the eyebrow, curving downwards and inwards to just above the internal palpebral ligament. On retracting the soft parts a considerable portion of the anterior sinus wall was removed. The cavity was filled with a degenerate polypoid mucous membrane, in which were three definite collections of pus. A large perforation in the septum maintained a communication between the right and left sinuses. The left cavity was curetted free from diseased products, and was then found to be very extensive, passing outwards nearly to the temporal fossa, upwards to the frontal eminence, and backwards about one and a half inches in its deepest part. Some idea of the size of the cavity may be gained from the fact that it was possible to pack into it a strip of gauze two inches wide, of double thickness, and three feet ten inches in length. This was removed daily, owing to a discharge of pus which was seen to be coming through the perforation from the right sinus, but which at the operation seemed only to be an extension of the left sinus. Within a week of the original operation the right sinus was opened and dealt with, as the left had been, in both cases a free drain having been made into the nose. Small drainage-tubes were inserted into both sinuses and led out of the corresponding nostrils, lateral perforations having been made in the upper part of the tube which corresponded with the lumen of the sinus. The external wounds were stitched up with the exception of the lower inner angles, through which the drainage-tube projected. The sinuses were syringed out twice daily for a week with boracic lotion, then only once a day. During the last week of the patient's stay in hospital the right tube was entirely removed, and for the left a V-shaped piece of silver wire was substituted, which could be removed and replaced for syringing.

Exactly a month from the date of the first operation, the patient left the hospital with very slight scarring, and has not had any sign of suppuration since.

The case was interesting because of—(1) the large sinuses in so

young a patient; (2) the obvious expansion of the anterior wall of the left sinus; (3) the communication through the septum of the two cavities; (4) the absence of any sign of suppuration in the right nasal cavity, although the frontal sinus on that side was full of pus and chronic inflammatory products.

THE PRESIDENT congratulated Dr. Tilley on the brilliant results obtained in this case.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

FIFTY-NINTH ORDINARY MEETING, *June 1st*, 1900.

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

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

Present—29 members and 5 visitors.

The minutes of the preceding meeting were read and confirmed.

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

Hunter Finlay Tod, F.R.C.S.
John Norcot d'Esterre.

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

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

Dr. W. A. AIKIN then read a paper on "The Resonators of the Voice."

The following cases and specimens were shown:

A Case of Primary Sarcoma of the Tonsil in a Woman æt. 58; Successful Extirpation through the Mouth.

Shown by Dr. Walker Downie. The patient, a woman æt. 58, was seen by me on 17th August, 1899, when she complained of a swelling of her right tonsil, which had been slowly increasing in size since the beginning of that year.

Early in January she had first experienced a sense of fulness and discomfort in her throat, particularly on swallowing. It came on without apparent cause, and at first gave her no concern. But as the discomfort persisted, she used various simple astringent gargles without benefit. In March she consulted a doctor, who informed her that the tonsil was inflamed and ulcerated, and he prescribed an astringent solution to be painted over the tonsil. The tonsil at this time was evidently enlarged; there was no sharp pain, but a sense of slight difficulty on swallowing. She continued to apply the astringent referred to till June. During those three months she not only felt no local improvement, but was convinced that the affected tonsil was slowly increasing in size; and also she felt that she was losing flesh, and was becoming so weak generally that she was quite unable to perform her ordinary household duties.

In June she consulted another doctor, who proposed to excise the affected tonsil, but on her return two weeks later to have this done, the tonsil was found to have so increased in size in that interval that he deferred operation.

She called on me with a note from her doctor on August 17th, by which time there was no doubt as to the nature of the new growth.

Her temperature was normal. She appeared to be in moderately good health, though complaining of weakness and exhaustion on slight exertion. Her speech was somewhat thick, and she complained of pains shooting up from the right side of the throat to the right ear. She could swallow with comparative ease.

On examination through the mouth a tumour occupying the position of the right tonsil was seen, somewhat resembling an hypertrophied tonsil. It was nearly the size of an average

walnut; it had the form of an enlarged tonsil, was of a deep red colour, with several greyish patches of superficial erosion distributed over its surface. It was firm to the touch, non-fluctuant, and palpation caused no pain. The faucial pillars were not adherent to the tumour, which was as a consequence freely moveable; and the lymphatics in the neighbourhood were unaffected.

On 23rd August she was placed under chloroform, and with the mouth widely opened the new growth was enucleated by means of the finger-nail and scissors. Firm pressure over the raw surfaces checked what bleeding there was. Ice was given frequently for the first few hours after operation, and thereafter small doses of dilute hydrochloric acid several times daily until the parts were healed.

The report on the microscopic examination of the tumour by Dr. A. R. Ferguson was as follows:—"The cells are large, uninuclear, and spindle-shaped, with in addition numerous very irregular large rounded cells. An infiltration of the remaining tonsillar tissues with these cells singly or in small groups is also observed."

It is now nine months since the operation. There is no trace of the former growth, nor of the operation performed for its removal. There is no recurrence, and the patient is in excellent health.

Case of Perichondritis of the Larynx, following the Introduction or the Retention of a Tube in the Œsophagus.

Shown by Mr. Butlin. A man æt. 29, who was suffering from the typical symptoms of primary dilatation of the œsophagus, was admitted into St. Bartholomew's Hospital on the 3rd January of the present year. He was losing flesh and suffered severely from cough, which appeared to be due to the arrest and retention of food in the œsophagus. Mr. Butlin determined to treat him by the retention of a vulcanised india-rubber tube, so that he might be fed through the tube for a couple of months. The tube was introduced into the stomach with very little difficulty, and he was fed through it until the 28th January, when he went home, still wearing the tube. He

was at that time much better, did not bring up any food, and had almost entirely lost his cough.

On the 18th February he was seized with a violent fit of coughing, during which the tube was ejected. He at once came to the hospital, when the tube was replaced without any apparent difficulty by the house surgeon.

On the morning of February 19th he woke with difficulty of breathing, and coughed severely, when the tube was again displaced. It was not put back, but his difficulty of breathing increased until February 23rd, when he came back to the hospital, and was admitted.

During the first few days he rapidly improved. On the 1st March an attempt was made to introduce a soft tube, but he was seized with dyspnœa and the attempt was desisted from.

On the following day, March 2nd, his breathing was so bad that tracheotomy was performed.

On his admission to the hospital the posterior parts of the larynx were extremely swollen, red, and œdematous, and the interior of the larynx was in the same condition. His voice was extinct, and he suffered from slight difficulty in swallowing. The appearances were those of perichondritis of the larynx.

At the present time he is still suffering from the appearances of general perichondritis of the larynx, but especially of the back part, and the tracheotomy tube has to be permanently worn. It is proposed to open the larynx and examine the condition of the cartilages, with a view to the removal of necrosed or carious portions.

Case of Radical Operation for Nasal Polypi.

Shown by Mr. C. A. Parker. A male, æt. 30, was first seen seven years ago suffering from polypi, with suppuration apparently from the ethmoidal cells in both nostrils.

The polypi were carefully removed by means of a snare, and after six months' constant treatment, consisting of trimming up and using the cautery, the case was for the time being apparently cured. This was in February, 1893. In April, 1894, polypi had recurred, and another course of treatment was re-

sorted to again with favourable results. The patient, however, again came under treatment in 1897-98, and again with benefit. In October, 1899, the patient was as bad as ever, so on November 21st an anæsthetic was administered, and the polypi, the middle turbinate, and the ethmoidal cells were all thoroughly removed. The patient made a rapid recovery from the operation without any unpleasant symptoms.

He states that he has been far more comfortable since the last and radical operation than he has been for nearly ten years past, and is himself quite pleased with the result.

At the present time no sign of polypoid formation an be seen. On the right side there was an adhesion between the outer and inner wall, which a fortnight ago I attempted, not very successfully, to remove. It rather hides the view of the upper parts.

The patient, in writing to me, says the symptoms which used to trouble him most were—thickness of speech, obstruction of the nose, violent sneezing, especially in the morning, frequent sore throats and occasionally quinsy, loss of the sense of smell. He adds, "The first four seem quite cured, and I am gradually regaining the sense of smell."

Mr. Baber regretted his inability to attend the previous meeting, when this subject was discussed at some length. As he had not heard what was the radical operation referred to, he would be glad if Mr. Parker would briefly mention the procedure.

Mr. Parker, in reply, said that seeing that Dr. Lambert Lack, who had originated the operation, was present, he thought that the Society could not do better than ask Dr. Lack to reply to Mr. Baber's question by giving a short account of the method used in this operation.

Dr. Lambert Lack said that the essentials of the operation were to give a general anæsthetic, such as ether or chloroform, and then to remove not only all polypi, but as much of the ethmoid bone as was possible. With a large ring knife, such as Meyer's original adenoid curette, he broke up the ethmoidal cells and removed the middle turbinate, and in some cases the greater part of the ethmoid bone. The scraping was continued until all loose friable bone was removed and healthy bone was reached. The latter was easily recognised by its firmness both to the knife and finger. If this were thoroughly done, recurrence of polypi might be prevented even in the worst cases. He had never seen this operation advocated or performed by others; the curetting so often spoken of was essentially different, consisting as it did of repeated small scrapings.

Mr. Baber asked how Dr. Lack managed to avoid wounding the cribriform plate, and also whether he was liable to make an opening into the orbit. A very thorough removal of bone had been advocated by Grünwald with forceps and curette.

Mr. Butlin hoped Dr. Lack would not recommend the operation on a very large scale, because he was sure awkward accidents would occur if it was used extensively. The distance between the base of the brain and the ethmoidal sinuses was so short that even a jerk of the forceps might perforate the ethmoidal plate.

The President was glad to hear these words of caution. In inexpert hands there would be great danger of setting up septic meningitis. The operation certainly ought to be confined to men with large experience of the operative procedure; it was not an operation to be recommended as a generality for practitioners, especially beginners.

Dr. Lambert Lack thought he might add that the danger was far more apparent than real. He had operated now for six years, during which period he had done the operation in more than sixty cases; he had in many cases used considerable force, but had never any ill-results. In some cases he had removed a large portion of the inner wall of the orbit, and had exposed the periosteum in this region, but without producing any ill effect beyond a temporary black eye. He thought that with care the cribriform plate was not endangered.

Case of Chronic Frontal Sinus Empyema cured by Radical External Operation.

Shown by Dr. Herbert Tilley. A female æt. 49, on whom this operation had been performed. The symptoms of headache, nasal obstruction, and purulent discharge had lasted for five years. The left antrum also discharged pus. The patient had been in the hospital exactly three weeks. Since the antrum had been drained and irrigated through the alveolus the discharge had much diminished, and if it did not entirely cease in the course of a few weeks, he thought it would be wise to advise a radical operation upon the antrum.

Case of Double Frontal Sinus and Antral Empyema with Great Distension of Bridge of Nose.

Shown by Dr. Herbert Tilley. A young man æt. 18, presenting symptoms of multiple sinusitis. It was quite easy to irrigate the frontal sinuses and wash out a quantity of pus. Both antra were being irrigated and drained. The nostrils had been cleared

of polypi, and a considerable portion of the diseased ethmoids had also been removed. Dr. Tilley purposed operating on the frontal sinuses in the course of a few days. The interesting feature in the lad's appearance was the great broadening of the nose, which was probably an evidence of chronic ethmoidal inflammation.

Case of Laryngeal Occlusion in Typhoid Fever.

Shown by Mr. Waggett. A man of 30, in whom tracheotomy had been performed some two months ago during typhoid fever. The larynx, though pale, was tumefied throughout with the exception of the epiglottis. The cords remained fixed in apposition, and were partly concealed by the ventricular bands. In the region of either vocal process was an eminence, presumably a granulation, the size of half a pea. These no doubt pointed to the presence of ulceration in this the typical region, but the actual seat of ulcer was hidden by the conformation of the parts. The whole of the posterior cricoid region was in a state of voluminous pale œdema. Probing at the seat of ulcer had failed to detect a fistula leading to the cricoid cartilage. Assuming that necrosis of the cartilage was present, was it advisable to cut down and remove the sequestrum, as would be done in any other part of the body?

The President asked Mr. Waggett if it was a case of so-called secondary affection of the larynx, or whether the laryngeal affection was primary. He could only recollect one case of complication of the larynx in typhoid fever; it was certainly rare in this country. It was that of a man with supposed acute laryngitis, but of a different type to that he was accustomed to see. There was high temperature and a good deal of pain. The diagnosis was cleared up in a few days, the man developing typical enteric fever. It seemed as if the larynx were primarily affected, the abdominal symptoms occurring later.

Dr. Clifford Beale said the question of laryngeal ulceration in typhoid fever had been discussed at the Society some three years ago, and since then he had taken every opportunity that offered itself—and these were fairly numerous—of examining the larynx in cases of typhoid fever where hoarseness was present. He had not been able to detect anything in the way of ulceration either of the epiglottis or within the larynx itself; the general condition was one of simple, general congestion. In one case, however, there had been decided

swelling of the epiglottis. He remembered on the occasion of the former discussion that Mr. Bowlby gave the Society the experience he had gained from *post-mortem* examinations at St. Bartholomew's Hospital to the effect that laryngeal ulceration was outside his experience. Personally, he could not help thinking that laryngeal ulceration was a very uncommon complication of typhoid fever in this country.

Dr. Jobson Horne inquired whether it was possible to state how soon after the occurrence of typhoid the laryngeal lesion developed, and also whether the patient had been subject to any infection other than that of typhoid.

Mr. Waggett said, in reply to Dr. Horne's questions, he would not be certain when the laryngeal occlusion commenced, because the patient did not come to the hospital till late; nor did he obtain a definite clinical history. He was inclined to think it was rather late in showing itself. Remembering Dr. Horne's remarks at a previous meeting, he had inquired into the question of possible tuberculosis in this patient, but had found no evidence of it; the sputa contained no tubercle bacilli. He wished for the opinion of members as to the cause of the great amount of œdema on the back of the cricoid. There was no doubt in his mind that the man had inter-arytænoid ulceration. He had been in hopes of finding that it represented the orifice of a fistula, and that a probe on insertion would come upon necrosed cartilage. The probe had failed to find any fistula, but should necrosis be subsequently proved, would it not be well to remove a sequestrum after thyrotomy before the larynx was permanently ruined?

Dr. Dundas Grant said if the evidence of necrosis were fairly complete it would be a good operation to do a thyrotomy, and remove the sequestrum from the front.

Female Patient, æt. 49, from whom the Larynx had been completely removed on account of Sarcoma.

Shown by Dr. Dundas Grant. This was a patient the preparation of whose larynx was shown to the Society on April 7th, 1900, and the history of the case will be found in the proceedings of that meeting. I performed the operation on the 3rd March. She underwent with great cheerfulness and courage a long and somewhat tedious course of after-treatment, involving feeding by means of a tube. The wound in the neck was plugged at first with iodoform gauze, then with gauze moistened with red wash; now there remains only an elliptical slit, about half an inch in length, below the hyoid bone; by pinching the sides of this together with her fingers, the patient is able to consume liquid food of any kind. There is no sign of recurrence either locally

or in other parts of the body, and the question now arises as to whether it is most desirable to revive the edges of the opening and effect its complete closure, or to allow it to contract at its present slow rate, leaving the aperture for the introduction of an artificial larynx. The opinion of the members on this point will be gladly received.

Dr. LAMBERT LACK suggested that most of such patients were more comfortable with the fistula wholly closed. It could easily be done by some small plastic operation.

CASE OF TONSILLAR ULCERATION OF UNCERTAIN ORIGIN (SPECIFIC).

Shown by Dr. DUNDAS GRANT. This patient was brought before the Society on April 7th. There was some uncertainty in regard to the possibility of the case being one of epithelioma. A provisional diagnosis was made of a primary infection of the left tonsil with secondary mucous patches on both.

Since the last occasion on which she was brought before the notice of the Society, she has been treated by means of mercurial inunctions, at first at home, and latterly in hospital, with the result that the circinate edges have entirely lost their opalescence and their everted character, and although the left tonsil is still swollen it is quite soft, and the floor of the depression corresponding to the excavated ulcer has acquired the tint and smoothness of the surface of the normal tonsil.

CASE OF INTERCORDAL TUMOUR (TUBERCULAR) OF THE LARYNX IN AN ELDERLY MAN.

Shown by Dr. DUNDAS GRANT. John S. came under my care May 3rd, 1900, complaining of hoarseness and loss of voice of four months' duration. About Christmas-time he was attacked with "cold in the chest," which disappeared, but the hoarseness and aphonia remained unchanged. On inspection, there is seen on the anterior part of the larynx, a pale, granular, irregular surfaced growth, which is bilobate, the upper part being rather

the smaller, and lying between the vocal cords, the larger and lower half lying below them. The growth appears to spring from the middle line anteriorly. There is a swelling on the right carotid artery; it is impossible to detach it from that vessel.

At the last meeting, May 4th, when this patient was seen, the nature of the growth was considered extremely doubtful, and it was generally agreed that there was a great probability of its being epitheliomatous, and the question of removing it by thyrotomy was discussed, subject to microscopical confirmation as to its nature. The growth appeared to originate at the anterior commissure. I endeavoured to remove it by means of a snare, but with this instrument I only detached a very small portion of it, and I then, without much expectation, tried my own forceps of the form opening from side to side. By means of the late McNeil Whistler's forceps, however, I succeeded in removing a large mass presenting the outward appearance of papilloma, which I hand round, and a portion of which was submitted to Mr. Wingrave for microscopical examination. He reported it to consist chiefly of small round-cells interspersed with fibrous tissue, but containing very well marked giant-cells, the whole being fairly typical of tubercle. On staining a section for bacilli a confirmatory result was obtained. It is evident, therefore, that we have to deal with a tuberculous tumour, although the pulmonary evidences are almost negative; there is, however, a suspicious comparative diminution of resonance on percussion at the right apex. The sputum has, from an oversight, not been examined for bacilli, but the diagnosis seems to be sufficiently certain. On laryngoscopic examination it will be found that the growth had its origin not merely in the anterior commissure, but also on the anterior fourth of the edge of the right vocal cord. The larynx is now being submitted to daily applications of lactic acid in from 40 to 60 per cent. solution, and some improvement has taken place.

Specimen Mounted to show Ulceration of the False Cords, True Cords, and Interarytænoid Region.

Shown by Mr. Bergin for Mr. Lake. The specimen was

removed from a man æt. 52, who died at the Consumption Hospital, Hampstead. There was a large cavity in the upper lobe of the right lung, and miliary infiltration of the rest of the lungs. There had been difficulty in swallowing for two years.

Specimen showing Tubercular Ulceration of the Larynx.

Shown by Mr. Bergin for Mr. Lake. The larynx was obtained from a patient who died of pneumothorax supervening on pulmonary tuberculosis.

Case of Carcinoma Laryngis.

Shown by Mr. Waggett. The patient is a man æt. 60, with a large carcinomatous mass involving the epiglottis. The voice is deep and hoarse; the glottis is not to be seen. There is no glandular enlargement. The base of the tongue appears to be slightly involved. As radical operation seemed impossible was it advisable, on account of the dysphagia present, to remove the epiglottic mass with the hot snare, or merely to perform tracheotomy?

Mr. Butlin did not think the radical operation would do good. He would not do anything if the case were under his care.

Case showing the Orifice of the Sphenoidal Sinus.

Shown by Mr. Waggett. The patient was a man æt. 40, in the last stage of atrophic rhinitis, in whom the orifice of the left sphenoidal sinus could be very beautifully seen, and the dimensions of the cavity could be made out with the probe.

Mr. Waggett ventured to bring the case before the notice of the Society in view of the discussion which arose about certain crypts in the naso-pharynx at a previous meeting, and in order to demonstrate that the sphenoidal sinus opening is a long way in front of the post-nasal space. One was liable to think that it was at the top of the post-nasal space; as a matter of fact the osteum was at the anterior end of the sinus: this was very well exemplified in his case.

Case of a Male æt. 29, with Tubercular Laryngitis.

Shown by Mr. Hamilton Burt. Three years ago patient first noticed a small ulcer the size of a pea on the post-pharyngeal wall; despite treatment under several doctors it continued to spread. Loss of voice was first noticed eighteen months ago, when I saw him. The condition then was a sharply-cut deep ulcer, the size of a sixpenny bit, covered with grey slough; other parts of mouth and pharynx were healthy.

Larynx.—Ulceration of left cord and left ventricular band, œdematous-looking swelling of left arytænoid and interarytænoid space as far as middle line, and also some swelling of ary-epiglottic fold. Voice only a whisper.

Treatment.—Painted larynx with solution of lactic acid, beginning with 10 per cent. solution. There was no specific history admitted, but the pharyngeal ulcer suggested syphilis, so potassium iodide was administered in increasing doses up to ʒss t. d. s. In six months all the swelling in larynx disappeared and ulceration healed; the ulcer of pharynx also completely healed, and no sign of it could be seen. Patient remained well for over a year.

The President thought the laryngeal condition looked syphilitic rather than tubercular.

Dr. Burt said that the ulceration had cleared up completely under iodide of potassium, given in doses increasing to half a drachm *ter die.*

Case of a Male æt. 20, with Distension of the Maxillary Antrum.

Shown by Dr. Lambert Lack. This patient was sent to me by Mr. J. G. Turner, who also conducted the transillumination of the antrum. He presents the following points of interest. The upper wall of the left antrum is pushed upwards, can be felt bulging into the orbit, and the left eyeball is at a higher level than its fellow. The inner wall of the antrum is bulging into the nose, and the nasal fossa is partially obstructed. There is a nasal

polypus in the opposite nostril. The other walls of the antrum appear normal. There is no trace of pus in the nose. Both antra are equally translucent on transillumination. There was no pus on puncturing and irrigating the antrum. The cavity was, therefore, opened freely from the canine fossa and found to be filled up with ordinary mucous polypi. These were removed, and part of the antro-meatal septum cut away. The antrum distension is now apparently subsiding. The case is of a diagnostic interest, as the presence of antral distension combined with translucency led to a confident diagnosis of cyst or hydrops of the antrum.

Dr. DUNDAS GRANT thought it a very important addition to the knowledge of transillumination that a mass of polypi was translucent, because hitherto it had been generally believed that only a cyst could distend the antrum and at the same time be translucent.

Mr. CRESSWELL BABER asked whether a strong or rather weak light was used in transilluminating; by using a weak light and graduating its strength, one could often see a difference between the two sides, which was otherwise undetected.

Dr. LAMBERT LACK, in reply, said that the light used was a strong one, but that there was absolutely no difference between the two sides.

CASE OF A CHILD, ÆT. 3, WITH A CYST AT BASE OF TONGUE.

Shown by Dr. FITZGERALD POWELL. This child was brought to the hospital by his parents, who stated that he had a lump in his throat.

Three months ago they noticed that he had some difficulty in swallowing, and on looking into his mouth saw that he had a lump far back on the tongue. It was then about the size of a large hazel-nut, and appeared to fill up the throat. They say the lump was much larger, but that it burst, remaining small for a fortnight, and then filling up again.

When seen by me the first time the lump was very small, and was situated on the dorsum of the tongue, about the position of the "foramen cæcum." It has continued to fill up and burst, when the tissue covering it gets thin and transparent. Latterly it does not get so large, and does not appear to give rise to inconvenience.

Mr. Butlin believed the case to be one of cystic dilatation of the glossal portion of the thyro-glossal duct. He had seen cases of mixed cystic and solid growth in that situation, and had described two cases in the Clinical Transactions some years ago. But, he had never seen the pure cystic form. In the new edition of 'The Diseases of the Tongue,' Mr. Spencer had collected accounts of cases of that kind. The cysts are generally lined with ciliated cylindrical epithelium, and the wall contains a little thyroid gland tissue. Hæmorrhage appears to be a common occurrence in connection with them. He believed that in this case, the best treatment would be to cut the cyst away with a galvano-cautery loop under an anæsthetic, and to cauterise the depression of the foramen cæcum freely.

Case of Pedunculated Tonsil.

Dr. Herbert Tilley showed a woman æt. 43, in whom the left tonsil, or a large portion of the same, was attached by a pedicle, which caused the patient to complain of what seemed to her a foreign body in the throat. The pedicle seemed to originate in the upper part of the tonsil, and possibly grew from the region of the supra-tonsillar fossa. The exhibitor considered it consisted of tonsil substance and was not a papilloma, and he based his belief on the ground that the left tonsil, which was broad and flat, was undergoing a similar kind of change, *i. e.* the free portion consisted of an association of small pedunculated masses. The right tonsil will be submitted to microscopic examination, and reported upon at the next meeting.

The President thought that on the right side it was a papilloma rather than a pedunculated tonsil. It seemed to him a new growth. He supposed the question could be easily settled by removal of a piece of the growth for microscopical examination.

Mr. Waggett had seen a similar case, but it was not such a beautiful specimen; the tissue proved microscopically to be tonsil tissue.

Dr. FitzGerald Powell thought the growth was a papilloma. Its origin was from the "supra-tonsillar fossa," from which it grew by a narrow pedicle, hanging down in front of the tonsil. It certainly had the appearance of a papilloma. One frequently saw small papilloma growing from about the tonsil and soft palate, and he thought this was of the same character, only, of course, much exaggerated in size.

Dr. Jobson Horne thought the left tonsil had more of the appearance of a papilloma than the right, but that the histological structure of a papilloma would be met with in neither.

Case of Lupus of the Nose in a Female æt. 35.

Shown by Dr. Edward Law. Dr. Law wished to ask the opinion of the members of the Society as to whether they would feel disposed in this case to do anything to the posterior margin of the septum, which was also involved, as well as the anterior naris. Could one get sufficiently far forward in the nostril by operative interference through the posterior naris to eradicate all the disease, which was situated behind the contraction just within the nostril and in front of the infiltrated posterior margin of the septum.

Mr. Waggett had a case exactly resembling this one, in which the lupus had not recurred. He adopted the plan of making a careful drawing under cocaine of all the lupus growth, and of keeping the plan in front of him during the operation. In this way one could make fairly certain of removing all the diseased parts without forgetting any portion.

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