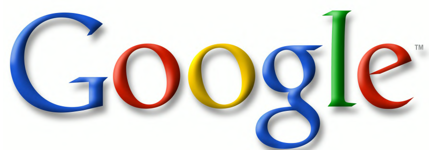

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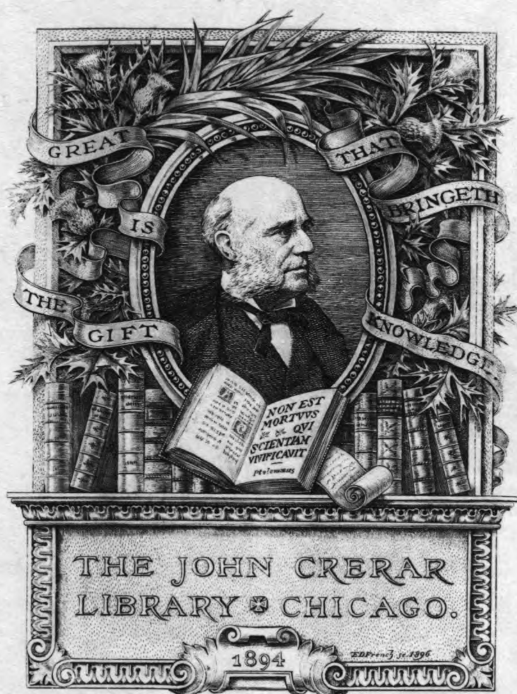

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PROCEEDINGS

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.

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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

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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.

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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

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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

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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

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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.

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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-

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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

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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.

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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

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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.

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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

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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.

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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., } Secretaries.
LAMBERT LACK, M.D., }

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

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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.

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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

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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

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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

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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

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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

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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

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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

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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.

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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

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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

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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.

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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

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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

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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

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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

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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

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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 fore-gut, 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

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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.

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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.

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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.

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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.

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'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 änlichen 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.

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Gleitsmann, J. W., M.D.

A Case of Unusual Laryngeal Growth.

Frankenberger, Dr. O.

Un case de double rétiécissement 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.

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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.

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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

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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 iridoplegia. 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

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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.

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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

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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

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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

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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

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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

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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

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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.

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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

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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

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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

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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.

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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., } Secretaries.
ERNEST WAGGETT, M.B., }

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.

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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.

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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,

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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

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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

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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

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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

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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-

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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.

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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."

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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

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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

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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

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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

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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.

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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

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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

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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

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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

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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.

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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.

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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

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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

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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).

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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.

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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

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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.

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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

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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

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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.

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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

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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

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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 ennunciated 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.

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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

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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.

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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,

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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

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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

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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.

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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 ℥j) 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.

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PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

Fifty-eighth Ordinary Meeting, *May 5th*, 1900.

Sir Felix Semon in the Chair.

Lambert Lack, M.D., } Secretaries.
Ernest Waggett, M.B., }

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

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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

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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

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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

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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.

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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

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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

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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

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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.

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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-

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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

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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.

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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

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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.

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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.

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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

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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

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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.

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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

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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.

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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

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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

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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.

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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."

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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

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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

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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-

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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.

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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

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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

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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

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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

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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

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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.

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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

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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.

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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.

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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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