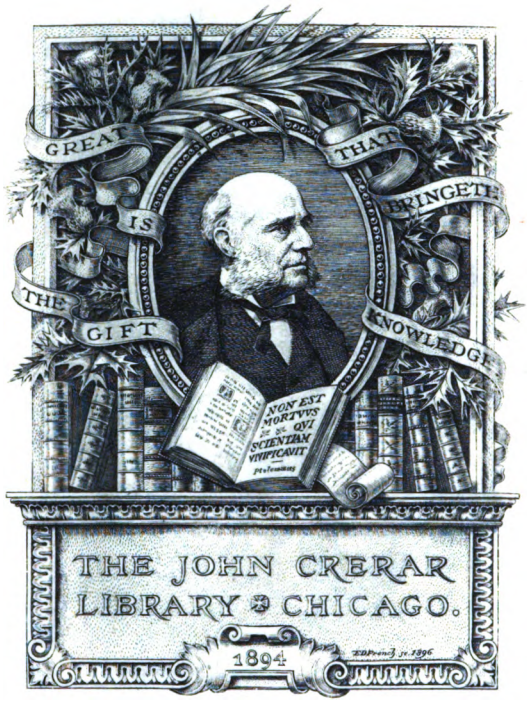

# PROCEEDINGS

OF THE

# LARYNGOLOGICAL SOCIETY

OF

# LONDON.

VOL. VIII.

1900—1901.

WITH

LIST OF OFFICERS, LIST OF MEMBERS, ETC.

LONDON:
PRINTED BY ADLARD AND SON,
BARTHOLOMEW CLOSE, E.C.

1901.

# OFFICERS AND COUNCIL

OF THE

# Laryngological Society of London

ELECTED AT

THE ANNUAL GENERAL MEETING,

JANUARY 4TH, 1901.



## President.

E. CRESSWELL BABER, M.B.

## Vice-Presidents.

A. A. BOWLBY, F.R.C.S. GREVILLE MACDONALD, M.D.
E. LAW, M.D.

## Treasurer.

E. CLIFFORD BEALE, M.B., F.R.C.P.

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J. DUNDAS GRANT, M.D., F.R.C.S.

## Secretaries.

E. B. WAGGETT, M.B. C. A. PARKER, F.R.C.S. (Edin.)

## Council.

F. DE HAVILLAND HALL, M.D. WILLIAM HILL, M.D.
HERBERT TILLEY, F.R.C.S. SIR FELIX SEMON, M.D.
BARCLAY BARON, M.B. LAMBERT LACK, M.D.

# PRESIDENTS OF THE SOCIETY.

*(From its Formation.)*

| ELECTED | |
|---|---|
| 1893 | Sir George Johnson, M.D., F.R.S. |
| 1894-6 | Sir Felix Semon, M.D., F.R.C.P. |
| 1897-8 | H. Trentham Butlin, F.R.C.S. |
| 1899-1900 | F. de Havilland Hall, M.D., F.R.C.P. |
| 1901 | E. Cresswell Baber, M.B. |

# PROCEEDINGS

OF THE

# LARYNGOLOGICAL SOCIETY OF LONDON.

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SIXTIETH ORDINARY MEETING, *November 2nd*, 1900.

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

LAMBERT LACK, M.D.,
ERNEST WAGGETT, M.B., } Secretaries.

Present—39 members and 3 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:

Herbert William Carson, F.R.C.S., Craigholm, Upper Clapton, N.E.
Edward John Budd-Budd, Eagle House, 73, South Side, Clapham Common.

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

Frederick J. J. Wilby, M.B., B.S.Durh., 23, Henrietta Street, W.
Braine Hartnell, Cotswold Sanatorium.
George Jones, 8, Church Terrace, Lee, S.E.
J. Stewart Mackintosh, St. Ives, Platt's Lane, Hampstead.

The following cases and specimens were shown:

### A Case of Mucous Polypus of Larynx.

Shown by Mr. Stewart. A woman æt. 78, for eleven years has had catching of the breath when laughing, and for three years increasing hoarseness. Examination shows a mucous polypus occupying the whole of the right vocal cord. In my experience laryngeal mucous polypi are comparatively rare, and very rare in old people. They usually occur in middle life. Mackenzie in his book gives only one case over 50, and that was in a woman aged 70.

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The President suggested the removal of the growth. It was a cyst and could be readily taken away.

Mr. Stewart had suggested operation, but the patient said the tumour had been present from birth, and she would rather keep it.

### Specimen of Cancer of the Œsophagus, causing Complete Laryngeal Paralysis.

Shown by Mr. W. G. Spencer. The patient from which the specimen was taken was admitted into hospital with rapidly progressive laryngeal dyspnœa. It was difficult to examine the larynx on account of the dyspnœa, and therefore no exact diagnosis could be made, but it was particularly noted that there was no dysphagia.

I explored the larynx by thyrotomy and found the left cord absolutely immobile and the right scarcely moving at all. The left vocal cord was completely removed and the patient recovered apparently well, his breathing being quite relieved. But soon after the wound had healed he developed a tracheo-œsophageal fistula which was quickly fatal.

The specimen shows extensive epitheliomatous ulceration of the œsophagus which has extended to the trachea and the glands so as to involve the recurrent laryngeal nerves. The position of the left vocal cord is occupied by a fine scar. The temporary relief to the patient was even more satisfactory than a tracheotomy could have been.

The PRESIDENT said that the case was originally under his care. The causation of the paralysis was extremely obscure, nothing definite being ascertainable. The operation of thyrotomy and excision of the vocal cord as performed by Mr. Spencer, though objected to in the past, certainly gave the patient considerable relief, and it was, perhaps, the best thing that could be done.

Sir FELIX SEMON said they all knew that in cases of thyrotomy for malignant disease when a vocal cord was removed a cicatricial band formed at the level where the vocal cord was removed. Under these circumstances the advantage of the operation so far as the relief to breathing was concerned seemed to him very doubtful. If the patient had lived a little longer than he did, one would have expected a recurrence of the stenosis to occur. This theoretical reasoning found a practical corroboration in the experience that when a vocal cord was cut out in roaring horses no lasting benefit whatever to the breathing was effected.

Mr. SPENCER questioned whether in thyrotomy sufficient growth was always removed. In the specimen only a fine scar was to be seen. Had this patient lived longer would he have had a cicatricial band?

Sir FELIX SEMON remarked that it was impossible to remove more than was done in a case of malignant disease where everything in the neighbourhood of the growth was removed.

The PRESIDENT suggested the occasional devotion of a meeting to the exhibition of sequelæ of cases previously shown to the Society; such cases were apt to be lost sight of and much valuable information was thus wasted.

## CASE OF PROGRESSIVE SINKING OF THE BRIDGE OF THE NOSE, FOLLOWING BILATERAL HÆMATOMA OF THE SEPTUM.

Shown by Mr. W. G. Spencer. About two years ago the boy had a fall on his face. There was no displacement nor fracture of the nose, but on each side a well-marked hæmatoma just within the anterior nares. These were absorbed without suppuration and the nose appeared to be unaltered by the accident; but a month ago the boy was again seen, as a progressive sinking of the bridge of the nose had occurred. On examination the septum is seen to be twisted, the muco-periosteum thickened, and the nasal passages much narrowed. There is no evidence of inherited syphilis.

The case is exhibited because the injury seems to have set up a chondritis and softening such as may happen in joints after slight injuries. There is always much doubt as to whether spurs

and deviations of the septum are congenital or traumatic in origin. The case shows that these deformities may arise gradually some time after a slight injury and yet be really due to it.

The PRESIDENT related the case of a lady of about sixty, who had complained of a swollen septum which interfered with nasal respiration, and of pain in the arch of the nose, which was somewhat reddened. At the time he had not taken a grave view of the case. Ten days after seeing the patient there was a rapid increase of the swelling. An abscess formed; the cartilage came away, and in a fortnight the bridge of the nose was sunken. At his examination of the case he had used cocaine, to the application of which the patient had attributed the subsequent trouble. This was an extremely rapid case, in which there was no history of syphilis, and absolutely no cause to explain the mischief. It formed a considerable contrast to the gradual progression which had taken place in the case under discussion.

Dr. STCLAIR THOMSON asked the President whether in his case the nasal bones fell in or the end of the nose.

The PRESIDENT said the nasal bones had fallen in.

Dr. STCLAIR THOMSON had watched carefully one or two cases of hæmatoma of the septum. One was of interest by reason of the suppuration which had occurred: it seemed to be a hæmatoma, but was in reality an acute abscess. He attributed it to infection from a suppurating maxillary antrum. A portion of the cartilage came away. All the cases recovered without any injury to the appearance of the nose. He would suggest in this case that the collapse of the bridge was due to inherited syphilis. Certainly there was no distinct history, but the mother had had miscarriages and dead children, and she states that there is sometimes a nasty smell from the boy's nose. There was still a good deal of purulent matter about the middle turbinals.

Mr. PAGET said it was surely inconceivable that loss of the cartilaginous septum could have any effect on the shape of the arch of the nose.

Dr. DUNDAS GRANT asked what degree of disfigurement there was at the time of the injury? Might not the distortion be part of the original injury?

Dr. WATSON WILLIAMS had seen a patient in whom he could find no portion whatever of the cartilaginous septum. There was no external deformity of the nose. The patient was open and frank and denied any history of syphilis.

Mr. BABER said it was commonly held that no amount of destruction of cartilage was sufficient to account for collapse of the nose; the tip of the nose might be affected but not the bones. He was of opinion that it would be most interesting for members to see a photograph of the patient taken before the accident.

Dr. LACK said that nearly every hæmatoma and abscess of the septum was due to an injury. In his experience such injury was always attended by some subsequent deformity and depression of the

tip of the nose, though he granted it might not be evident for a few weeks, until the swelling produced by the injury allowed the result to be seen.

Mr. VINRACE asked whether the pharyngeal condition existed at the time of the accident. There was now present a condition of the naso-pharynx which he thought must be of constitutional origin and not the result of injury.

Dr. WYATT WINGRAVE considered that deformity was not surprising since the structures were only partially developed. In adults deformity was rare, unless the traumatism or subsequent inflammatory changes involved more than the septum, such as the nasal bones and nasal process of the maxilla.

Mr. SPENCER, in reply, said the boy's nose was mainly altered in the cartilaginous portion; there was no alteration in the roof or bony part. He had watched the hæmatoma disappear, until the nose was quite free. Then arose marked progressive nasal obstruction, and later appeared a discharge of muco-pus and crusts, which he had left alone to show the members. There was no ulceration or abscess. Inquiries had been made as to congenital syphilis with negative results; but it was impossible to exclude it with certainty. One heard of general practitioners being blamed for not having the nose put straight in such cases. Here was a case where, although there was no obvious damage at the time or a month after, after two years had elapsed there was distinct deformity of the nose. In adults there might be destruction of the lower end of the septum without any alteration in the shape of the nose.

## CASE OF LARYNGEAL GROWTH IN A MAN ÆT. 49.

Shown by Dr. BARCLAY BARON. Patient, a man æt. 49 years, who has drunk hard, but denies syphilis, noticed a little dryness of the throat about a year ago, and some obstruction in May last, when he had a good deal of nose bleeding. Since then the difficulty in swallowing has increased, but he can still swallow well-masticated meat; the breathing is obstructed, the voice is altered and there is pain shooting up into the right ear; the larynx is practically filled up with a large growth, with irregular surface covered with creamy secretion; the epiglottis is pushed towards the left side. The growth increases in size, but it is believed to be an innocent tumour.

The PRESIDENT said he had never seen such a large growth in the larynx.

Dr. WILLIAM HILL said that tracheotomy would probably be done unless members thought it unnecessary. Dr. Baron did not think it

was malignant and asked for a diagnosis. It had not yet given serious trouble to the patient.

Dr. Dundas Grant asked if there was any certainty as to which part of the larynx it grew from.

Sir Felix Semon said there was a distinct margin between the epiglottis and the growth.

Dr. Watson Williams said it was attached low down and laterally to the ventricular band.

### Ethmoidal Cell-cutting Forceps.

Dr. Watson Williams showed some cutting forceps for opening up the ethmoidal cells, which had been made for him by Messrs. Mayer and Meltzer. The cutting ends were sharp-pointed, and turned up at an angle of 50° with the shank, so that they readily pierced the thin bony walls of the cells. He had found these forceps of great service in opening either the anterior or posterior ethmoidal cells in sinusitis and in radical operations on nasal polypi.

### Case of Laryngeal Tumour.

Shown by Dr. Herbert Tilley. A female æt. 39, whose chief symptom was hoarseness. She also had a troublesome cough. Laryngoscopic examination showed a sessile tumour, occupying the anterior two thirds of the left ventricular band. It was congested, considerably raised above the surrounding surface, and had a granular mammilated surface. The vocal cords moved freely, although the left was sluggish compared with the right.

In answer to Dr. StClair Thomson, Dr. Tilley said that suspicions of pulmonary phthisis existed, but that he was anxious to gain the unbiassed opinion of members who had only seen the growth, as many of its features did not suggest its tubercular nature.

### Case of Probable Primary Specific Ulceration of the Tonsil.

Shown by Dr. Dundas Grant. A woman æt. 32, was first seen on October 11th, 1900, complaining of sore throat of three months' duration. It was followed at an interval of about one month by the appearance of a few brownish spots on the skin;

more recently there has been a slight falling of the hair. On examination there was an enlargement of the right tonsil and an irregular ulcer occupying the region of its upper third. The glands at the angle of the jaw were slightly enlarged, and according to the patient's account had previously been larger still. The pain was most marked during swallowing. On the right anterior pillar there was an ill-pronounced opalescent patch, and the same, in a slighter degree, on the left one. There were no symptoms of genital inoculation, but the husband's tongue presented ample evidence of old-standing tertiary changes, with a slight erosion on each side. The primary inoculation dated more than twelve years back. During the first week the patient was treated by means of pills of mercury and opium, but the effect produced was comparatively slight. During the following week mercurial inunction was practised, with the result that at the end of that time the discomfort in the throat had very markedly diminished, and the ulceration on the tonsil had become less pronounced. The patient has advanced six months in gestation. Dr. Eddowes, who saw the rash during the first week, gave the opinion that it was a syphilide, but at present it is too indistinct to afford ground for a very definite opinion. The diagnosis is somewhat open to question, but there seems little doubt that it is specific, and of a primary rather than tertiary nature.

The PRESIDENT thought they were all agreed as to the diagnosis.

Dr. DUNDAS GRANT said that the change which had taken place had deprived the case of much interest. If members had seen the case a fortnight ago, before the treatment which had confirmed the diagnosis so absolutely, he thought the opinion of the Society would have been the same as his own.

The PRESIDENT had seen a case of undoubted primary chancre of the tonsil in which the result of the treatment was very rapid. The patient was thought to have malignant disease of the tonsil, but the improvement was so great that after a week the tonsil regained its normal size. Four or five weeks later the diagnosis was confirmed by the appearance of a secondary eruption.

## CASE OF ALVEOLAR EPITHELIOMA OF THE ETHMOIDAL CELLS AND ANTRUM.

Shown by Dr. DUNDAS GRANT. The patient, a woman æt. 53, was first seen in October, 1900, on account of blocking of the

left nostril, discharge, and loss of smell, with pain in the left nostril and cheek, swelling of the left cheek and in the orbit, pushing the left eye upwards and outwards. Her illness was of about nine months' duration, commencing with symptoms of cold in the head, and the formation of a polypus. At the end of July a polypus was removed, but on the next day the blockage was as complete as ever. Dr. Grant made a diagnosis of malignant disease, probably sarcomatous; but a specimen removed for microscopical examination was found by Dr. Wingrave to be of the nature of alveolar epithelioma. It was decided that a radical operation should be performed without delay. The superior maxilla was exposed. The disease was found to have eaten away the anterior wall of the antrum and a large portion of the floor and inner wall of the orbit. The incision was continued upwards on the inner side of the orbit, and the whole of the diseased tissue was scraped away from the ethmoidal cells, the lachrymal bone and os planum of the ethmoid being almost completely removed. The floor of the antrum was found to be free from disease, and the alveolar and palatal processes were therefore left in position, the rest of the superior maxilla being extracted. The raw surfaces were swabbed with chloride of zinc, grains thirty to the ounce; iodoform was insufflated, and the cavity was packed with iodoform gauze from the mouth, the external wound being carefully sutured. The packing was removed two days later, and the cavity was washed out with a weak Sanitas lotion. After other three days the stitches were removed, the whole wound having united with the exception of a small opening at the inner angle of the eye. The patient was discharged on the fourteenth day after the operation, and returned home complaining of no other discomfort than conjunctivitis of the left eye.

Mr. Spencer said that the saving of the alveolar process was an advantage. The growth was a burrowing carcinoma of the most malignant type, and one which offered a very poor prognosis. If Dr. Dundas Grant had succeeded in removing the whole of it he was very fortunate.

Mr. H. Betham Robinson referred to a case recently under his care where the growth in the antrum extended into the ethmoid, and before operating it was impossible to define its exact limits. He had removed the ethmoid freely up to the cribriform plate, but even then

the disease was not eradicated, for the growth appeared again some weeks later.

Dr. DUNDAS GRANT, in reply to Mr. Spencer, said that he thought he removed all the growth, but it extended so close to the cribriform plate that discretion had to be used in scraping it away. Up to the present there is no sign of recurrence.

## CASE OF SARCOMA OF THYROID GLAND, EXTIRPATION, FATAL RESULT.

Shown by Dr. DUNDAS GRANT. The patient, a nurse æt. 64, was the subject of an intensely hard swelling of the thyroid gland of about six months' duration. There was a slight myxœdematous swelling of the face, and considerable dyspnœa with tracheal stridor, worse on exertion. The larynx was displaced to the left side and œdematous to such an extent that the vocal cords could not be seen. Swallowing was partially obstructed, and fluids tended to regurgitate into the larynx, giving rise to troublesome cough. There was no enlargement of the glands, and the thyroid rose during swallowing, though to a less extent than normal. The dangers of the operation being placed before the patient, she decided to submit to it rather than continue as she was. During the detachment of the left lobe of the thyroid, extreme laryngeal stridor supervened, and it was necessary to perform tracheotomy. The thyroid body was removed in its entirety, and on microscopical examination was found to be infiltrated with sarcoma. The patient rallied from the operation, but speedily began to acquire a very troublesome cough; fluids appeared to enter the air-passages through the larynx and through the tracheotomy wound in the trachea; the right lung became completely dull, and death took place on the fourth day. Regurgitation of fluids into the larynx is probably a very unfavourable symptom when operations on the air-passages are carried out, involving great risk of septic pneumonia. In this case it might have been better if a tampon cannula had been introduced instead of a simple tracheotomy tube, and if the extirpation wound had been left open and plugged with antiseptic gauze instead of being closed up. Tracheotomy could not have been performed before the thyroid gland was removed.

### Case of Malignant Disease of the Larynx.

Shown by Dr. Dundas Grant. The patient, a man æt. 57, came under observation on August 2nd, 1900, complaining of hoarseness and pain in his neck, of gradual onset, and of three months' duration. The larynx externally was normal to the feel, but now Dr. Grant thinks it is slightly spread out. On laryngoscopic examination the epiglottis was seen to be folded in to a considerable extent on the left side. The arytænoids were much swollen, especially the left one, which shaded off into a large thickened aryepiglottic fold; the left cord was invisible, but there was seen with great difficulty in the midst of the thickened tissue, a fringe of a somewhat granular appearance, corresponding to the anterior half of the left vocal cord, or it might be growing out of the ventricle of the larynx. The right ventricular band was swollen somewhat, overhanging the cord. There was no history of specific infection and no history of phthisis in his family, although it was somewhat doubtful whether or not his father died of that disease. In his case, however, there was no evidence in the thorax, nor did the sputum contain tubercle bacilli. The nature of the case was not at all obvious, although the probabilities were in favour of its being carcinoma. The patient was put upon iodide of potassium (ten grs.) with perchloride of mercury (one drachm of the solution) three times a day. His weight decreased slightly, but when seen again in September there was practically no change in the condition; subsequently dyspnœa became marked, and it was necessary to perform tracheotomy. Dr. Grant had postponed this in view of the doubt which he felt that the disease might be tuberculous, in accordance with the impression it made upon an experienced colleague. The patient has improved very much in general condition since the tracheotomy, which is sufficiently exceptional in tuberculosis to make it justifiable to exclude that disease. There is little doubt that the disease is malignant, epithelioma or sarcoma, the extent of infiltration as compared with the amount of ulceration affording some probability in favour of the latter. The exhibitor abstained from the removal of a portion for microscopical examination, as the patient had not consented to a radical operation.

Mr. SPENCER remarked that the man complained of pain in the ear, indicating infiltration of the posterior third of the tongue. He considered the case too advanced for successful removal.

Dr. LAMBERT LACK was doubtful about the diagnosis, but even if it were an epithelioma he thought it better left alone.

Dr. GRANT was anxious to elicit an opinion as to whether this case was best left with the tracheotomy tube as at present, or whether the risk of removing the larynx was justifiable.

The following microscopic specimens illustrating Dr. Grant's cases were shown by Dr. WINGRAVE:

1. Squamous epithelioma of larynx.

2. Alveolar epithelioma of maxillary antrum and nose. It apparently commenced in the glands of the inner wall of the antrum near the ostium.

3. Sarcoma of thyroid gland. Round-celled (small) variety, evidently commencing in the stroma. It had involved the whole of the gland, since none of the normal structure could be found. It was interesting, as it followed closely upon a sarcoma of the larynx, also under Dr. Grant's care, in which the thyroid gland was probably invaded secondarily, as much of its normal structure remained.

## CASE OF LARYNGEAL PAPILLOMATA.

Shown by Dr. WYATT WINGRAVE. A girl æt. 8, was first seen in June, 1898, complaining of thick voice with occasional aphonia, gradual in onset, and of two years' duration.

Several small papillomata were seen at the anterior commissure, and one on the left cord in its anterior third. There were no adenoids, but the faucial tonsils were slightly enlarged. Since that date as many as twelve fragments have been removed, after each time the larynx appearing clear of growth.

The warts were treated also with formalin (one per cent.) and salicylic acid, the latter affording the better result but not removing the growth. In removal the ring curette proved more efficient than forceps or snare. Histologically each fragment was a digitated squamous papilloma. With regard to their pathology, Dr. Wingrave was inclined to consider them relics of

an exaggerated vocal commissure, notwithstanding that the symptoms did not become marked until six years of age. Although there were no adenoids she was a confirmed mouth breather, a habit of which her mother has nearly broken her.

The slightly enlarged tonsils were removed in January last, but this did not seem to materially influence the course.

When last seen her voice was fairly clear and strong, and the larynx had been free from growth since October 2nd, when the last fragment was removed. At present there is a slight thickening in the anterior commissure.

Dr. Herbert Tilley inquired what anæsthetic was used in the case, and if a general one, what position was the patient placed in during the operation. He had recently removed a large papilloma from a child's throat (four years old) which on two occasions had almost caused asphyxia, and had been struck by the ease with which the operation could be performed when the patient was chloroformed deeply and maintained in the sitting position. Under such circumstances it was necessary to push the chloroform until the laryngeal reflex had just disappeared, and during the thirty seconds or so following to remove as much growth as possible before the reflex returned again.

Mr. Vinrace inquired why Mr. Wingrave ascribed the condition to a congenital cause, no symptoms having presented themselves until the child was five years old. It was difficult to understand how the original structure in its entirety failed to cause symptoms and alteration in the voice.

Mr. Wingrave, in reply, said that he had found cocaine was simpler, since the patient well tolerated inspection and manipulation. He did not consider the absence of voice symptoms for the first three years as evidence against congenital origin, since he remembered an instance in which symptoms of a congenital web of the anterior commissure were not recognised till the age of twenty-seven. He felt that the situation of the growth was much in favour of its congenital origin.

## Laryngeal Case for Diagnosis (? Tubercular).

Shown by Dr. StClair Thomson. The patient is a draper æt. 48, who states that he has been hoarse for twelve months. There is slight though not marked dysphagia, but his weight has fallen from ten stone ten pounds to nine stone four pounds. The right vocal cord is nearly entirely concealed by a smooth, round, red, soft-looking swelling of the right ventricular band, aryepi-

glottic fold, and arytænoid. This swelling on phonation impinges on the left ventricular band, on which it appears to have caused some abrasion. Glands are not enlarged. There is a specific history. The pulse is hurried (110), the temperature is 100·2°, but the chest sounds are normal. The sputum has not yet been examined. Under small doses of iodide of potassium the obstruction has in a week sufficiently diminished to show a small portion of both cords, which are now seen to be pale and slightly ulcerated. Dr. Thomson was therefore now inclined to the diagnosis of tuberculosis.

The PRESIDENT considered the appearance was that of malignant disease.

Dr. DUNDAS GRANT wished to support Dr. Thomson's own diagnosis of tuberculosis.

Dr. STCLAIR THOMSON said he had only seen the patient twice. There was so much obstruction and catarrh that he did not at first like to give him iodide, but on five-grain doses there had been some improvement in the last week. He wished for suggestions as to treatment. Probably everyone was agreed as to the necessity for tracheotomy. He would report again on this case at a later meeting.*

## CASE OF FRACTURE OF THE LARYNX.

Shown by Mr. WAGGETT. A female æt. 52, in whom fracture of the thyroid cartilage had occurred as the result of severe pinching of the larynx between the fingers and thumb of a persecutor. Severe dyspnœa lasted for some days, external swelling was present, and much pain experienced.

At the present date, some two months after the injury, nothing abnormal could be seen by the mirror. External palpation of the somewhat enlarged larynx caused pain, and indicated the presence of an ununited fracture of the thyroid cartilage, separating the upper half of one ala from its fellow close to the anterior angle. The fracture was vertical above, curving to the right at its lower end. The semi-detached antero-superior portion of the right ala could be made to ride over the left ala. The voice was stated to have altered in character since the receipt of the injury,

* Since the date of meeting the report on the sputum shows the presence of tubercle bacilli.

but the action of the vocal muscles showed no gross sign of impairment. He did not propose any surgical interference.

Dr. HERBERT TILLEY very much doubted if the feeling of crepitus in this case was not entirely due to the movement of the larynx on the vertebral column. He had, while the patient leant well forward, lifted the larynx away from the column, and could not obtain the crepitus, however carefully he manipulated the larynx, but immediately the latter touched the spinal column the crepitus at once became evident. It was difficult also to conceive that the inflammation, which was evidently produced by the traumatism, should have so completely resolved as to leave the cartilaginous fragments loose. One would have expected the traumatic perichondritis to have firmly welded them together.

Dr. FITZGERALD POWELL thought if fracture of the cartilage existed it would result in severe and continuous dyspnœa.

Mr. PARKER said that he quite agreed with Dr. Tilley with regard to the possibility of obtaining crepitus on lateral movement of the larynx in most people, but in this case the crepitus was even more marked on the patient's swallowing, which was unusual. He therefore thought there was a fracture of the thyroid cartilage.

Dr. DUNDAS GRANT thought he felt a crepitus, as if there was fracture of the lower cornu of the thyroid cartilage, just above where it articulated with the cricoid.

Mr. WAGGETT, in reply to Dr. Tilley, said that he believed the crackling or crepitus of which the latter spoke had nothing to do with the fracture, but was such as could be detected when the larynx of any thin person was pushed from side to side over the underlying structures. In the present instance a fine crackle was produced when by lateral pinching the thyroid cartilage was distorted, an act which caused a portion of the right ala to ride over the left, leaving a sharply defined groove between the two.

In answer to Dr. Powell he drew attention to the history of severe dyspnœa confining the patient to bed for three weeks.

## CASE OF HÆMORRHAGE ON THE VOCAL CORDS.

Mr. CHARLES PARKER showed a case of hæmorrhage on the vocal cords in a woman æt. 35, a school teacher. The hæmorrhages were situated about the middle of the upper surfaces of either cord. The patient complained of hoarseness and aching of the throat after using her voice. There were no signs of any tendency to hæmorrhages elsewhere.

In answer to Dr. Lack, Mr. PARKER stated that he felt confident that when he first examined the case there was a hæmorrhage only on

the left cord. She was examined by several people, and being rather intolerant strained and choked a good deal, and on finally examining the case Mr. Parker found that a hæmorrhage had occurred on the right cord. This was more than a month ago, and yet both hæmorrhages remained unaltered.

The PRESIDENT had never before seen such an interesting example of this condition.

Dr. GRANT had brought before the Society the case of a young lady with sudden loss of voice—as if an hysterical attack of aphonia—which was accompanied by an effusion under the mucous membrane of the cord.

# PROCEEDINGS

OF THE

# LARYNGOLOGICAL SOCIETY OF LONDON.

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ORDINARY MEETING, *December 7th*, 1900.

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

LAMBERT LACK, M.D., ERNEST WAGGETT, M.B., } Secretaries.

Present—35 members and 5 visitors.

The minutes of the preceding meeting were read and confirmed.

The following gentlemen were unanimously elected members of the Society:

John Stewart Mackintosh, St. Ives, Platt's Lane, Hampstead.
Frederick J. J. Wilby, 23, Henrietta Street, W., and The Wych, Avenue Road, Highgate.

THE PRESIDENT said that Sir Felix Semon, who was unavoidably absent, was anxious to point out that the treatment of nasal polypus depended on its precise variation, and hoped the result of the discussion would be to draw some distinction between the different forms of nasal polypi, which required different treatment. The title of the subject under discussion suggested only nasal polypi in general, without any reference to the various forms.

He then called upon Dr. Lambert Lack and Mr. Cresswell Baber to open the discussion upon

## THE TREATMENT OF NASAL POLYPUS.

Dr. LAMBERT LACK said:

Mr. President and Gentlemen,—I deeply appreciate the high honour conferred on me by the Council in inviting me to open the discussion on this important subject. Many members will no doubt have interesting remarks to make, and therefore I shall detain you as short a time as possible while I briefly enumerate the results of my own investigations, and leave the discussion to others.

The rational treatment of polypus must depend upon the view we take of its pathology. This subject was fully discussed at the meeting of the British Medical Association in London in 1895, when the general opinion seemed to be that polypi were in some way the products of inflammation, but both Woakes's theory of "necrosing ethmoiditis" and Grünwald's of sinus suppuration were considered disproved or inadequate, and in fact the discussion only showed the truth of Mackenzie's statement that the cause of polypus was still unknown.

The theory I wish to maintain is that the ordinary nasal polypus is essentially a *simple localised patch of œdematous mucous membrane*, and that this œdema is a result of disease in the underlying bone.

The first point is proved by both clinical and microscopical examinations. Histologically polypi consist of loose fibrous tissue, the meshes of which are filled by serous fluid. The growth contains vessels and glands, and is covered by the normal epithelium of the part. The glands are more numerous near the attachment of the growth, and vary in number in different polypi, sometimes, particularly in chronic cases, being very numerous. In addition to this there are signs of inflammation, the vessel walls are enlarged and thickened, and there are scattered collections of round-cells, especially marked around the vessels and glands. The glands are sometimes healthy, sometimes undergoing degeneration. The acini may be dilated from obstruction of the ducts due to pressure of the inflammatory exudation, and the cysts commonly seen in polypi are thus derived. Thus it is seen that polypi contain all the structures of the normal mucous membrane *plus* a certain amount of

inflammatory exudation, serum, and round-cells; and further, a polypus passes gradually and imperceptibly at its edge into the normal mucous membrane.

It is obvious that growths containing such diverse and highly differentiated structures are neither tumours nor granulations. The latter in the nose, as elsewhere, consist of round-cells, spindle-cells, young vessels, and the early stages of fibrous tissue. Moreover, as seen after intra-nasal operations, or when produced by the irritation of a foreign body, a sequestrum, etc., they are quite different from polypi. Again, clinically there is every stage between œdema of the mucous membrane and a polypus,—a slight œdema, a marked localised œdema, a broadly sessile polypus, and a typical pedunculated polypus. It is purely a question of degree, a small diffuse, non-moveable mass being usually described as œdema, whilst a larger, more sharply defined, more moveable growth is considered a polypus. Also the microscopic structure of the two is identical. Grünwald asserted that by tightly packing an antrum œdema of the lower lip of the ostium maxillare could be produced, and that this œdematous tissue had the microscopical characters of a polypus.

The second point, that polypi are due to disease of the underlying bone, was first, I believe, definitely asserted by Woakes; but his views have obtained very little credence. However much exception may be taken to Woakes's own work and investigations, it seems to me his theory of bone disease is the most adequate explanation hitherto offered of polypi, and especially of their tendency to recur, and further that the independent evidence of Thurston and Martin, based upon microscopic examination, ought not to be lightly overlooked.

More than two years ago, when I took up this work, I collected pieces of bone from over thirty cases of nasal polypi and prepared them for microscopical examination. In every case bone changes were found of the nature of a rarefying osteitis. Briefly, the sections showed that the process commences as a proliferation of the cells in the deeper layer of the periosteum. In places numerous large cells or osteoclasts appear in contact with the bone, and gradually eat it away, forming irregular little bays along its edge. At the same time the bone cells themselves enlarge and become more numerous, and give the bone a more

cellular appearance. As this process of rarefying osteitis extends the bone ultimately becomes disintegrated, and the fragments, surrounded on all sides by osteoclasts, are slowly eaten away and absorbed. No true necrosis was seen. The appearances were found in both extensive and simple cases of polypi. Thus the pathological evidence supporting that of Thurston and Martin is fairly complete, in spite of some few contrary observations of Zuckerkandl, Luc, etc.

Since this paper was written these observations have been confirmed by Cordes ('Archiv für Rhin. und Laryng.' of last month), who has described some investigations with almost identical results, except that he did not always find bone changes in mild cases of polypi.

The following are some of the clinical signs of bone disease:

(1) Digital examination under general anæsthesia. If the finger be passed carefully up into the ethmoidal region in cases in which no operation has ever been performed, it often impinges on soft jelly-like tissue in which spicules and loose pieces of bone can be plainly felt, although it is very rare to feel rough bare bone.

(2) The probe may be used in a similar way, but it is obviously much less reliable. Very great care must be taken in employing it and in drawing deductions from its use. A blunt ended probe and one which can be easily bent to pass in any direction must be used, and even then it is difficult to avoid perforating the softened mucous membrane. The ease, however, with which this is done, and the feeling of bare bone obtained, is quite different from the normal condition.

(3) In a severe case of polypus in which no operative interference has ever been attempted, if the polypi be carefully removed with the snare without touching the bone in any way, it is sometimes possible to observe that the entire middle turbinate has disappeared, and its place has been filled up by masses of small polypoid-looking growths.

(4) The results of operations as regards recurrence when the diseased bone is completely removed. This further proves that the bone disease is the cause of the polypi, and not *vice versâ*, as some have stated.

The probable history of a case of polypus is as follows:

In an acute inflammation of the ethmoidal region, and especially in the severer and more lasting forms of it occurring in connection with the exanthemata, erysipelas, influenza, and septic affections, such as sinus suppurations, it is probable that the periosteum covered only by the thin mucous membrane, and even the bone may be involved. In such cases the middle turbinate is especially liable to be affected, and on examination this structure appears large and rounded, and covered by a thickened œdematous mucous membrane. Microscopical examination of such a middle turbinate shows the early stage of the rarefying osteitis above described, and the overlying œdematous mucous membrane has all the microscopical characters of a typical nasal polypus.

As the disease slowly progresses the bone becomes disintegrated and at the same time expanded, and the cell commonly present in its anterior end may become distended and form a bony cyst.

The osteitis spreads to the neighbouring parts until the whole ethmoid may become affected. The outlines of the bone are lost, the middle turbinate can be no longer recognised, but loose pieces of bone, polypi, œdematous granulations, and gelatinous mucous membrane fill the whole upper part of the nose. In this extremely slow but progressive process the bone is slowly but surely eroded and absorbed. In some cases the disease is ultimately arrested, and then the bone becomes very dense and sclerosed. Such a condition is found in cases in which only a single polypus or perhaps two polypi are present, and in these cases, as is well known, recurrence of the growth after removal is rare.

As just said, the œdematous mucous membrane overlying the affected bone in the early stage is indistinguishable microscopically from a polypus, and clinically the two conditions pass from one to the other by imperceptible stages, and can only be artificially divided. Moreover œdematous infiltration in these parts is apt to become large and bulging, as the mucous membrane is extremely loosely attached and easily thrown into folds. After a time these swellings, well supplied with nourishment, apparently take on a more or less independent growth; the increase in size is doubtless assisted by the dependent

position of the growths and the action of gravity. Their tendency to become pedunculated is also partly due to the action of gravity, and partly, perhaps, to the effect of blowing the nose, which would tend to make the growth swing about. These considerations explain the chief facts in the clinical features of polypi, their liability to recur after simple removal, the fact that they grow only from the ethmoidal region of the nose where the bone is covered by a thin muco-periosteum, and that they are more common on the middle turbinate and about the regions of the ostia of the accessory sinuses where the mucous membrane is excessively lax.

*Treatment.*—If this theory of the pathology of nasal polypus is accepted the whole question of treatment must be re-considered, for it follows that our efforts must be directed towards the eradication of the bone disease and not simply towards the removal of the polypi, one of its effects.

For the sake of convenience the following four groups of cases may be taken:

(1) Cases in which one or two polypi only are present, which are of long standing, in which there is no sign of active disease still present, and in which it is probable that the initial bone disease has completely passed off. In such cases simple removal with the snare may be practised. It is a matter of every-day experience that recurrence in such cases is rare.

(2) Simple cases of early bone disease, in which there is enlargement of the anterior end of the middle turbinate, with overlying œdema of the mucous membrane, or the early stage of polypous formation. The affected part should be removed, and this generally resolves itself into a typical amputation of the anterior end or more of the middle turbinate.

(3) Cases in which a few polypi only are present, and in which there is apparently a very limited area of bone disease. These cases may also be treated with the snare, but an attempt should always be made to hitch the wire loop as high as possible round the base of the growth, so as to encircle the piece of bone from which it grows. After the polypi and as much bone as possible have been removed in this way, at a subsequent sitting the affected region should be thoroughly examined by probing and illumination, and all diseased bone and mucous membrane

should be clipped away by Grünwald's forceps. The middle turbinate should be removed if diseased, or if necessary to give access to the affected region. In other cases it may be necessary to scrape away the affected part, and in such circumstances nitrous oxide anæsthesia should be employed, and the operation performed with a ring-knife under good illumination.

The results of operation in these three groups of cases is almost invariably good, and the operation itself apparently in no way a serious one.

(4) In the cases of extensive bone disease in which there are many polypi involving an extensive part of the ethmoid a more radical procedure is necessary. In such cases simple removal of polypi is useless, as recurrence rapidly takes place, and I believe it is better in the first place to give a general anæsthetic, and to remove not only the polypi but the whole of the affected part of the ethmoid bone.

This operation should also be practised in cases in which recurrence has followed other operations for the removal of polypi, and cases associated with suppuration in the ethmoidal cells or in other accessory sinuses. In the former case it is necessary to open the ethmoidal cells for the suppuration itself, and in the latter it is especially necessary to clear the approach to the ostium of the affected sinus.

The operation is performed as follows. The patient being anæsthetised, the ethmoidal region is thoroughly examined by the finger, both through the nose and also through the post-nasal space, to determine as far as possible the extent of the disease. If the middle turbinate be present it may be removed by means of the spokeshave, and any large polypi should be removed by means of the forceps. Then the lateral mass of the ethmoid should be thoroughly scraped away by means of a large ring-knife, such as Meyer's original adenoid curette. This is the only effective instrument; sharp spoons are quite useless. In this way large masses of polypi, degenerated mucous membrane, and fragments of bone are removed. The finger is introduced from time to time to observe the progress, to feel for any spicules of bone and soft patches, and the scraping is continued until all friable tissue has been removed. Healthy parts of the ethmoid are easily distinguished by the finger and even by the curette,

as they are smooth, firm, resistent, and give little hold to the knife. In some cases the operation is completed by a smaller ring-knife, but this must be employed with the greatest care. Of course great caution must be used when it is felt that the region of the cribriform plate is being reached, but the whole inner wall of the orbit may be scraped away with impunity.

The operation should be performed with the patient turned well over on to his side, and in cases where the posterior part of the ethmoid is unaffected a large sponge may be pushed up into the post-nasal space. Directly the operation is over hæmorrhage is arrested by packing the nose with a strip of gauze soaked in glycerine-iodoform emulsion, and a piece of lint soaked in evaporating lotion is then applied to the face. This gauze packing should be changed every second or third day, and the nose irrigated. If it is easily tolerated it may be continued for a fortnight, in other cases it should be omitted earlier.

*Results.*—The large majority of cases run an afebrile course. In a few cases numerous granulations appear in the field of operation, and may even become exuberant. If the operation has been thoroughly performed these usually disappear spontaneously in a few weeks, and meantime the patient experiences no discomfort from their presence. After five to eight weeks a large dry cavity, lined by healthy adherent mucous membrane, will be seen in the upper part of the nose.

One would theoretically expect operation in such a region to be somewhat dangerous, but although I have operated now between fifty and sixty times, and others have also performed it, no symptoms causing real anxiety have yet been seen. Of ill results following the operation the following have been noted. A black eye is not uncommon, but usually subsides in three to four days, under cold applications. In one or two cases acute suppurative otitis occurred, but passed off under treatment. Such a result may follow any similar operation. In a few cases a considerable rise of temperature has occurred, but only in cases in which sinus suppuration has been present. Such cases have readily yielded when the packing has been omitted and nasal irrigation adopted.

In one case of extensive ethmoidal caries, with suppuration in the ethmoidal cells, and probably also in the frontal sinus, an

orbital abscess accompanied by necrosis of a portion of the inner wall of the orbit followed some three weeks after the operation, and a week or ten days after the patient had left the hospital. This is not a very rare occurrence in cases of ethmoidal cell suppuration, but it may have been due to or hastened by the previous operation. The abscess was opened externally, a sequestrum removed, and a cure followed.

In no cases have any cerebral symptoms been noted, and no death has occurred. Even if the operation entail some danger there is some, and probably a greater risk in leaving the disease alone, or in employing the small nibbling operations which are commonly recommended. The risk of operating is probably greater in cases in which suppuration is present, but the necessity for it, and the danger of leaving the disease alone, is also greater. I am more fearful, if the operation is widely adopted, that it should fail to cure from want of being practised with sufficient thoroughness, than that it should cause fatalities by being performed too boldly.

The results as regards recurrence are very good. In all simple cases of polypi a cure has resulted, and this has been permanent for several years in some cases, in which snare operations had been repeatedly followed by recurrence. Such cases I have already shown here, and I hope at later meetings to show more. In suppurative cases recurrence has been rare, and when it has occurred the disease has not been the intractable affection it was before operation. In such cases occasional removal with the snare will usually give immunity for months, until if the suppuration be cured the polypi no longer recur. In a few cases I have operated a second time, but in every case in which I have performed the first operation myself, the bone has appeared quite firm and dense, and there has been practically nothing to remove.

The only alternative procedure—repeated small operations, such as nibbling away with forceps, so commonly advocated—may perhaps effect a cure in time, but it has many and great disadvantages. The operation is always painful, as cocaine acts by no means satisfactorily in these cases. Ten, twenty, and even more sittings are often required, as very little can be done at a time. This is extremely tedious and discouraging to the patient,

and the constant pain and dread of it causes general ill-health. Little or no benefit following the earlier operations, the patient often abandons treatment. In cases associated with suppuration each operation exposes a raw surface, over which pus flows, and there is necessarily a tendency to septic absorption, and to the spread of the bone affection. Finally, fatal results have occurred from meningeal infection apparently directly due to operation, and I believe these repeated timid procedures are more dangerous than a single severe but curative measure.

In conclusion, then, I would urge that this operation, carried out with due precaution, should be performed in all cases of nasal polypi in which there is extensive disease of the ethmoid bone, in which recurrence of polypi has repeatedly followed other methods of removal, and in which suppuration is present in the ethmoidal cells or other accessory cavities.

[Dr. Lambert Lack's paper was illustrated by (1) a series of diseased middle turbinate bodies, showing the transition stages between simple œdema and true polypus, and (2) a series of microscopic slides of sections of the bone underlying polypi, showing various degrees of periostitis and osteitis.]

Mr. Cresswell Baber said: Gentlemen, the subject of the treatment of mucous polypi of the nose is one of perennial interest, because of the exceeding commonness of these growths, and of the difficulty they often present in treatment.

*The Treatment* resolves itself into two stages: (1) removal of the growths; (2) after-treatment with the view to preventing their recurrence.

(1) Removal of the growths. It is pretty generally agreed this should be carried out with a snare, hot or cold. I am always in the habit of using the cold snare, and with a rather thick steel wire. I have repeatedly made up my mind to use the galvanic loop, but have always, after a short trial, come back to the cold, chiefly because I find no special advantage from the hot, and considerably more trouble in using it. My own practice is to snare out the growths as carefully as possible at sittings with about a fortnight's interval, even removing small roots in the middle meatus by this method. The adjustment of the snare

when a somewhat thick steel wire is used scarcely ever meets with any difficulty, but in the event of such an occurrence the polypi may be drawn forwards with a sharp hook or a fine pair of catch forceps.

In getting the loop round a polypus projecting through the choana a finger in the naso-pharynx is of course invaluable, and if it be impossible to secure a polypus in this position, by this method, Lange's blunt hook may be used, or, if necessary, a pair of forceps guided by the finger. The use of forceps for the removal of polypi is not, in the ordinary way, to be recommended.

(2) After-treatment. The routine after-treatment hitherto adopted consists in burning the so-called roots of the polypi with the galvanic cautery. This method is only suitable for cases in which the point of origin of the growths is visible, for to plunge a cautery blindly into the interstices of the ethmoid bone seems to me a useless and dangerous proceeding. The same remark applies, perhaps with less effect, to the use of a chemical caustic, such as chromic acid. It has been my habit for some years to use a spray of rectified spirit (as first recommended by Miller), varying from 25 per cent. to full strength, for its shrinking properties on the mucous membrane, and I think with benefit.

A word of caution is necessary to the effect that in old people (those over seventy) it is advisable either to leave the growths alone, or to operate on a small amount at a time, partly on account of shock, and partly on account of the hæmorrhage, which, though it may be minimised by extract of supra-renal capsule used in addition to cocaine or eucaine, is not a negligible quantity. The question of shock is more important still in galvanic cautery operations on the middle turbinate body, and should always be considered, especially as these growths are often found in persons with asthma and weak hearts.

We next come to the question whether any further treatment is advisable. This must depend on the diagnosis which we are able to make in each individual case. Mucous polypi, which according to most recent authors may be defined as the result of an inflammatory serous infiltration of the mucous membrane of the ethmoid, seem liable, speaking clinically, to be produced by almost any irritation. They may be caused not only by disease

confined to the ethmoid, but also by the irritation of the discharge from an empyema of the antrum, or of the frontal or sphenoidal sinuses, and by such different conditions as foreign bodies in the nose and malignant disease.

They are not, as assumed by some observers, necessarily associated with suppuration of an accessory sinus, or even with suppuration at all. These different conditions must therefore be carefully searched for before any further treatment is undertaken.

Having excluded non-ethmoidal causes, the form of the disease in which the morbid changes are confined to the ethmoid remains to be considered. Our knowledge of the pathology of this affection is still imperfect; but it is generally considered by recent observers that the inflammatory trouble giving rise to mucous polypus may be limited to the mucous membrane, or that chronic proliferating periostitis, and osteoplastic or rarefying osteitis (or both), may also be present. Hajek considers that, except in constitutional dyscrasiæ (tuberculosis and syphilis), these processes result from the extension of the inflammatory infiltration of the mucous membrane and the periosteum into the bone and its medullary spaces. According to the latest published researches, those of Cordes, the bone may be primarily affected from typhus, influenza, scarlet fever, and other exanthemata; or secondarily from the mucous membrane. This author, by the way, does not confirm the presence of rarefying osteitis, although he admits that absorptive changes constantly accompany the osteoplastic processes. When all the polypi have been thoroughly extirpated, and the exposed mucous membrane either burnt or removed, and no recurrence takes place, it is assumed that the mucous membrane only is implicated, and no further treatment is necessary. It is impossible to ascertain the percentage of these cases, because, as a rule, the patients do not return to the surgeon more than once or twice for inspection. It must also be borne in mind that very long intervals between the recurrences (if not actual absence of the same) occur in cases in which to all appearance the ethmoid bone has undergone distinct hyperplastic changes. A single polypus projecting into the choana often does not recur in my experience, but as a rule it is impossible to foretell the likelihood of recurrence. If

frequent and rapid regrowth occur, we may take it for granted that the bone is affected with osteitis, as above mentioned, or at least that the mucous membrane in the cells, which escapes our vision, is participating in the disease. In these cases the only method of preventing recurrence is to remove the affected bone and cells, and this is indicated whether we regard the bone or the mucous membrane as the starting-point of the disease.

In the former case, the bone requires removal, as the source of irritation, in the latter because without removing the bone, the mucous membrane in the cells, which is giving rise to the trouble, is inaccessible. The first step is the removal of the anterior half of the middle turbinated body with forceps or scissors, and snare, if it has not been done already for examination or treatment of the frontal or maxillary sinuses. This little operation renders the anterior ethmoidal cells more accessible. If this is insufficient, the ethmoidal cells and walls may be removed with Grünwald's or similar forceps, and curetting them with scoops of various shapes, due regard being had to any possible injury to the cribriform or orbital plates. In my experience the removal of the middle turbinated body is satisfactory, but the other measures are less so, on account of the hæmorrhage which so rapidly obscures the view, and prevents much being done at one time. Neither of these measures, however, as far as I know, gives a certain guarantee against recurrence. When the discharge from the ethmoidal cells is distinctly purulent there is more necessity for opening them freely, as suppuration in these cavities is not devoid of danger to the surrounding parts. Of the exact procedure recommended by Dr. Lack, *i. e.* the removal of all the ethmoidal cells at one sitting with a Meyer's ring knife, I have no personal experience; I presume that such an operation would only be employed in cases of frequent and rapid recurrence, but even in these cases I think it is only to be recommended under two conditions: (1) if it can be shown that the operation gives immunity from recurrence; (2) if it can be performed without risk of injury to the contents of the cranial or orbital cavities. Whether it has a deleterious effect on any remaining sense of taste or smell perhaps Dr. Lack will be able to tell us. At the same time it must be admitted that any operation which, without danger, will prevent recurrence

of these growths will be a great boon to sufferers from this disease.

Although for the sake of clearness I have divided the ethmoidal cases from the cases of polypus due to disease in the other sinuses, it must be understood that the two conditions often co-exist, and that the relation between them is not yet clearly established.

On the whole, I think that the chief advance in the treatment of mucous polypi lies in the direction of a more accurate diagnosis of the cause in each case, which is the only guide to rational treatment.

In these few remarks I have omitted all reference to papillomata and other non-malignant growths which are sometimes called polypi, in order to keep the discussion to the important subject of mucous polypi, neither have I made any reference to the treatment of empyema of the larger accessory cavities, or of polypi contained in them.

If the discussion draws forth the opinions of members on the comparative value of the different methods of removing mucous polypi, and of the various forms of after-treatment, especially in regard to the removal of bone from the ethmoid, it will not have missed its object.

Mr. W. G. Spencer agreed with the treatment set forward by Dr. Lack, but not with his pathology of polypus, which, he thought, remained unknown. The inflammatory theory required a great deal of further evidence for its firm establishment. By the acceptance of the latter, the pathology of the nose was entirely separated from the pathology of other mucous membranes, and of the polypi which occurred in them. No doubt the nose was the favourite locality for the formation of muco-polypoid growths, yet there were varieties of this formation in other mucous membranes, *e. g.* of the rectum, bladder. In the latter there was fairly strong evidence that they originated in the submucous tissue, whether they began as actual fibromata or were always of a myxomatous nature. It was generally agreed that the shape of polypi was due to the action of gravity, but their occurrence in several places, and sometimes on each side of the nose, in the frontal and ethmoidal cavities and maxillary sinuses, afforded little clinical evidence of a previous primary inflammation of the bone or periosteum. When this was present the resulting growths were not typical mucous polypi, although, as in the case of other tumours, inflammatory conditions and incomplete removal promoted recurrence. But there must be an essential difference between the

vascular granulations, however œdematous, which occurred after, *e. g.* syphilitic necrosis, injury, or the presence of a foreign body in the nose, and an ordinary mucous polypus. Again, the mucous polypi were certainly the most frequently occurring, and Dr. Lack had referred to the difficulty in some cases of distinguishing them from inflammatory conditions of the inferior turbinate, which was of course very commonly inflamed, yet not the common site of the polypi. There was no sharp line of distinction between true mucous polypi (nasal or naso-pharyngeal) and those which ultimately turned out to be sarcomata. Even carcinomata in the nose had very often projecting polypoid masses indistinguishable microscopically, or very nearly so, from the simple polypi.

Turning to the question of the bone change, it was an oft-discussed matter, and difficult to prove either way. In the specimens shown by Dr. Lack, which he had not very carefully examined, he saw no reason which would cause him to make up his mind on the subject. The changes in the bone were secondary, but not primary in his opinion. Polypi in other situations had nothing to do with the periosteum or with the bone, yet Dr. Lack would try to show that nasal polypi were the result of perichondrial or periosteal disease. Changes in the bone varied, but a great deal of the permanent bone of the nose was cancellous, and some of the specimens appeared to present this normal cancellous bone. Very little information on this point had been added to the subject of the old controversy between Dr. Woakes and Dr. Sidney Martin. No doubt many of the specimens showed secondary atrophic osteitis occurring in connection with the pedicle of the polypus; the larger the polypus became the more marked the appearance was. So he thought that very little trustworthy clinical evidence had been adduced to prove that polypi were preceded by inflammatory changes. The true untouched muco-fibromatous polypus had more the appearance of a real benign tumour, single or multiple as the case might be.*

With regard to treatment, he was in accord with Dr. Lack's method in extensive cases, where it was of great value to commence the treatment by a thorough removal under an anæsthetic. He thought, however, that recurrence might take place in some cases. Its value lay in the reduction of the number of sittings hitherto necessary for the patient when there was extensive change present. It was necessary to remove the pedicle of the tumour, and because of the convoluted structure of the nose to remove a large amount of bone in order to get at the pedicle. He preferred to insist upon the necessity of removing the whole of the pedicle, viewing it as a tumour, rather than, as Dr. Lack held, of removing bone primarily diseased.

Mr. Charles Parker said: I should like to add what weight I can to the reasonings and conclusions advanced by Dr. Lack. I have, I think, seen every case on which he has operated during the last

* Gérard Marchant, in 'Traité de Chirurgie,' Duplay et Reclus, 2me ed., 1898, t. iv, p. 670.

Ziegler, 'Lehrbuch d. allg. u. spec. pathol. Anat.,' 9te Aufl., 1898, Bd. ii, S. 626; also H. Mackenzie, "A Case of Diffuse Papillomatous Degeneration of the Nasal Mucous Membrane," 'Lancet,' 1896, vol. ii, p. 460.

three years, and have watched their progress afterwards; moreover I have myself frequently adopted the measures he advocates for the cure of polypi. The microscopic specimens before us to-night clearly prove that accompanying polypi there is a bone disease, presumably of the nature of rarefying osteitis. The fact that simple removal of polypi does not cure the disease points to the conclusion that the origin of the trouble has been left behind; and on the other hand, the old and recognised fact that if the bone underlying the attachment of a polypus can be removed with the polypus recurrence is far less likely to occur, suggests that in this case the cause *has* been removed. Again, it is undoubtedly possible to trace clinically every stage of a polypus, from a mere œdema of the mucous membrane covering the anterior end of the middle turbinated bone, to a definite fully formed pedunculated polypus, and to prove that there are as definite, though less marked, bone changes when the mucous membrane is only œdematous as when it has degenerated into true polypus; from which it is, I think, fair to argue that the bone trouble precedes the polypus. Therefore one must conclude that both the microscope and clinical experience favour the view that the bone disease is the cause rather than the result of polypi. This being so, operative measures must have for their object the removal of every portion of diseased bone, and this in a confined cavity like the nose can only be done by some such method as that put before us to-night. In several cases in which I have adopted Dr. Lack's treatment I have had reason to realise the futility of my previous efforts to cure the case with a snare; for having by this latter means removed all visible definite polypi and brought the case to that point where on examination one sees only a lot of small polypoid excrescences springing from the ethmoid bone, and situated where the middle turbinated should be, I have proceeded to the more radical operation, and have been astounded by the quantity of large polypi removed by means of the ring-knife—literally handfuls. It was evident that directly the lower, visible polypi had been removed, and thus pressure relieved, others had descended by gravity to take their place, and, judging from the number afterwards taken away with the ring-knife, there were sufficient polypi to last these patients a lifetime had I continued treatment by means of the snare. As to the operation, I follow the same procedure as Dr. Lack, and do not think his methods can be improved upon. As to the results, I think they are very satisfactory. In all my own cases, and those of Dr. Lack's which I have observed, there has invariably been very great improvement, and in the majority of cases I think the word "cure" is none too strong. Considering the chronicity of these cases, and the frequency with which they are operated upon, I think the patients themselves become good judges of the results, and after this more radical operation they all agree in saying that they have not been so comfortable for years, even if they cannot be classed amongst the cured; and so far I have never seen any really serious ill results. Finally, I think this operation should be employed in all cases where recurrence has occurred more than three or four times, in all cases of multiple polypi accompanied by suppuration, from whatever source, and in those cases where the

middle turbinated has disappeared and its place been taken by mucous membrane in a state of polypoid degeneration. In these latter cases there is sure to be very extensive disease hidden from view.

Dr. DONELAN desired to add his tribute of congratulations to the readers of the two papers. He thought the operation described by Dr. Lack would prove a valuable one in the severer cases, while in others the snare would continue to be used. Notwithstanding the specimens, he felt the theory that the disease originated in the bone was "not proven;" and the fact that one of the authorities quoted by Dr. Lack had admitted that the bone was not affected in the slighter cases, led one to believe that the disappearance of the turbinals was due to more familiar causes, such as pressure and impaired blood-supply, rather than to a rarefying osteitis. Instances had been given of mucous polypi in the rectum, and at another point in the antipodes of our interests, where the only "osseous" structure was the os uteri; but he thought examples of mucous polypi unconnected with bone might be found nearer home—as, for instance, on the soft palate,—and he had at present a case in which he had removed five or six polypi from the angle between the cartilaginous septum and the ala, and at some distance from the nasal bones. If the rarefying osteitis were admitted to occur as extensively as Dr. Lack claimed, he would like to ask him what prevented the process from extending more widely through the cranium.

Dr. SCANES SPICER had hoped that, in order to promote the fullest ventilation of the subject, some one would have risen to advocate the opposite side of the case to that put forward by Dr. Lack. He himself could not do so, for he agreed with Dr. Lack practically *in toto*. But, in justice to previous workers on nasal problems, he must point out that operative procedures identical with those described by Dr. Lack had been performed in suitable cases both in England and Germany, at all events, for many years. Ever since an advance copy of Grünwald's work on 'Die Lehre von den Naseneiterungen' had been sent to him for review in 1895 he had tentatively used all the methods and instruments described by that author, and amongst them his method of attacking severe cases of polypus and suppuration of ethmoidal labyrinth—surely the same thing as polypus and suppuration of lateral mass of ethmoid. [See cases 149, 151, 155, which can now be read in Lamb's English translation of Grünwald's work.] Further, after a large experience of these methods, he had himself exhibited cases at the Laryngological Society in which these very procedures had been carried out on the ethmoid body for multiple polypoid degeneration combined with ethmoidal suppuration,* *i. e.* after having formally excised the middle turbinated bones, to curette away with due caution any diseased tissue in the subjacent ethmoidal labyrinth; and he had further supported and advocated the adoption of these measures (*loc. cit.*) in suitable severe cases—which a further experience now enables him to even more strongly recommend. He therefore felt it incumbent on him to make it clear that in consequence of Grünwald's work these methods were known to some nasal

* 'Proc. Laryng. Soc. Lond.,' vol. iv, pp. 79—81, 1897.

workers at least five years ago, and have been tried, and to a large extent adopted—in order to clear English rhinology from the unjust imputation of being so many years behind the times.* Nevertheless he heartily congratulated Dr. Lack on his bold and powerful advocacy of the application of sound surgical principles to these nasal disorders, on his admirable re-statement of the whole problem, and on his painstaking re-investigation of the histological changes. Here Dr. Lack's results appeared to him to agree with those of Grünwald and Woakes, except for the difference with the latter as to the amount and frequency of necrosis. As far as he knew, he believed the credit of first maintaining the causal connection between ethmoid bone disease and polypus belonged to Dr. Woakes. He had the more pleasure in stating this, for he was by no means a supporter of the latter in his use of the term "necrosing ethmoiditis." In a few cases the speaker was well aware of real necrosis—large sequestra—in cases quite free of syphilitic taint, and it was the comparative rarity of genuine necrosis that had led him to question the propriety of applying the epithet "necrosing" to a condition of which necrosis was only a late and occasional accident. He feared that Dr. Woakes had delayed that recognition of his work (which was justly his due) for many years by that unfortunate term—unfortunate in that it was taken to imply that he taught there was some special necrosing pathological process found in the ethmoid and confined to it, which was essentially different to any known to occur elsewhere in the body. The speaker thought that if the changes observed had been originally described in terms of general surgical pathology as "muco-periostitis," "rarefying osteitis," "sclerosing osteitis," "dry caries," etc., and had been recognised as not affecting the ethmoid only, but many of the adjacent bones of the head, the meaning would have been at once grasped, and full recognition accorded. With reference to the performance of the operation in question, the speaker has from the first adopted the methods and instruments of Grünwald, with some modifications. The neck of the middle turbinated is first cut through with Grünwald's forceps;† the cold wire snare is then passed well into the slit made, over the genu, and back over the middle turbinated as far as possible, and then tightened up so as to cut off the anterior half. The posterior half is then removed with the turbinotome when diseased. Polypi, cysts, abscesses, granulations, cholesteatomatous débris, soft bone, and necrotic pieces, are then cautiously but thoroughly curetted and removed with Grünwald's spoons and curettes,‡ until no polypus or other diseased tissue is left, and healthy firm bone is felt. Of course great caution is necessary to avoid getting into the orbit or through the cribriform plate. The speaker nearly always operated under a general anæsthetic and in the sitting posture, and staunched hæmorrhage as he went, so as to have the parts well in view, and kept the anatomical relations well in mind. Occasionally he operated with cocaine only. He had seen no bad result. On the other hand, the patients had been mostly well satis-

* Speaker's review of Grünwald's 2nd ed., 'Journal of Laryngology,' May, 1896.

† Table II, fig. 1, 2nd German ed.

‡ Table II, *loc. cit.*

fied with the result of the operation, in the way of much greater relief of symptoms, of prolonged freedom from recurrence, and of diminished suppuration, and in many cases of cure lasting now over three or four years. He preferred not to plug after the operation, and it was very seldom necessary. He insufflated iodoform, and applied parolein and soothing ointments freely, to prevent the secretions consolidating into hard dry scabs, which were difficult to get away, and sometimes led to epistaxis in dislodging. After the first day he used sprays and irrigations of weak warm alkaline antiseptic lotions. To revert to the ætiology of polypus, each speaker had referred vaguely to "disease of the bone" without giving any clue as to what the cause of this disease was. There was too great a tendency to avoid this vital point. One must not assume that disease is some inexplicable inherent vice until the position has been excluded that it is a departure from the normal due to some defective adjustment of the organism to the external, or some traumatism from outside. Are such to be found in traumatisms due to falls and blows, initiating changes in the muco-periosteum which are not recovered from, and become chronic? Are polypi, etc., more common in erect humans than in quadrupeds, which are less liable to nasal injury from falls and blows? Are not the rapid and extreme variations of temperature of our inspired air, the irritation of dust and pathogenic organisms, and the chronic congestion due to nasal stenosis enough to explain the persistence of an existing traumatic muco-periostitis, if not to initiate the latter, with its sequels of polypus and bone disease?

Mr. DE SANTI, whilst admitting the excellence of the paper by the opener of the discussion, could not but feel some disappointment that there was nothing new in it. Firstly, as regards the treatment of nasal polypi, he had for a long time past considered and taught that more radical measures for their removal were required. The removal of polypi by galvano-caustic loop, or by the cold wire snare, was extensively practised up to the present time, but he considered that, though in certain cases these methods were suitable, they were generally only palliative and not curative in result. Certainly, in his opinion, the cold-wire snare was infinitely preferable to the galvano-caustic loop, as the *fons et origo* of the polyp could be torn away by it, whereas with the galvano-caustic loop the origin of the polyp was left. Taking into consideration the great frequency of recurrences in these cases, the numerous sittings required if the snare be used, Mr. de Santi strongly advocated removal by some such radical measure as described by Dr. Lack. To say that radical measures were new was totally wrong; the older surgeons, such as Mitchell Banks, Jacobson, etc., had strongly advocated removal of the middle turbinals with all the polypi that might be growing from them, and though it had been the custom for laryngologists to decry these operations and speak of them as barbarous, Mr. de Santi was glad to hear at this meeting that laryngologists were inclined to favour the more frequent use of general operative measures. Dr. Lack's operative procedure was hardly new; the speaker himself had on several occasions scraped out masses of polypi under general anæsthesia, sometimes with the sharp spoon, sometimes with the ring-knife, and he also used

forceps and scissors. In Mr. de Santi's opinion, therefore, radical operation should be resorted to much more frequently for the cure of nasal polypi. Under the older methods of treatment by the snare the patient became a regular "annuity" to the surgeon, and at the end, after an expenditure of much time and money, and suffering a good deal, was often no better. As regards the pathology of nasal polypi, he considered there was not the slightest evidence of rarefying osteitis as the cause. Why should there be rarefying osteitis? Surely such a condition would have an origin such as syphilis, injury, etc. He looked upon any rarefying osteitis that might be present as secondary to the polypi, and not a primary condition. As a matter of fact he came to the conclusion that nothing was really known as to the pathology of nasal polypi; at all events he himself was quite ignorant of their causation, and he believed that to be the condition of most members of the Society present.

Dr. HERBERT TILLEY thought that Mr. de Santi should have drawn a definite distinction between Dr. Lack's operation and the somewhat promiscuous intra-nasal operations with which Mr. de Santi had credited other surgeons. In the presence of so distinguished a surgeon as his former teacher, Mr. Christopher Heath, the speaker hesitated to deprecate too strongly the use of forceps in the removal of nasal polypi, because in his student days he had constantly seen them used. He was constrained, however, to point out the ease and perfection with which nasal polypi could be painlessly removed by means of a wire snare, guided by means of a reflected light. This was a very different proceeding from the use of forceps. Under the latter circumstances he had frequently seen healthy mucous membrane and pieces of middle and inferior turbinate bones removed, while more often than not, only a few polypi were removed, and inefficient removal was talked of as "recurrence of the growths." The operation advocated by Dr. Lack was an entirely different procedure, in that it was scientifically conceived, and should be carefully and skilfully executed; furthermore, the operation was limited to diseased structures. The speaker could testify to the efficiency of the operation in those cases where careful removal by means of a snare had failed to produce immunity from recurrence. He had obtained some excellent results in such cases. He thought that in some cases, possibly the majority, mucous polypi originated in the mucous membrane, and that the bone was secondarily involved. The inflamed bone would then keep up the formation of polypi, even though the latter were from time to time removed. In support of this view he adduced those somewhat exceptional cases where mucous polypi grew from the septum, and those common cases in which they lined the walls of suppurating accessory cavities in which the underlying bone was not as a rule diseased. As to the primary cause of the inflammation, he had as yet no definite opinion to offer. That well-marked bone changes were met with in cases of nasal polypi seemed obvious, and he could not understand how members could differ from this view after examining the microscopic specimens illustrating these bone changes which had been placed at their disposal by the introducer of the debate.

Dr. StClair Thomson still suspended his judgment on the subject of debate, and would therefore limit his remarks to some side points. He knew that it had gone out of fashion to quote authorities on scientific, and particularly on medical mattters; any appeal to authority might savour of dogma. Still, he thought it would be well before entirely accepting the views which had been advanced in the debate to recall the teaching of two well-known and trustworthy rhinologists. Hajek had thoroughly investigated the pathology of polypus, and had consistently taught that the inflammation spread from the outside inwards, and not from the bone outwards. Then Grünwald, in the latest edition of his book, which showed enormous research, expressed the opinion that "polypi, in a majority of all cases, are almost as good as pathognomonic of empyemata of the accessory cavities, or focal suppuration in the nasal passages." From his own experience the speaker was inclined to agree with this, for the more expert he became in recognising empyemata, the fewer cases he had of recurring polypi. In cases where the polypi had been most persistent, their growth ceased at once when the offending accessory sinus had been drained. Possibly the operation recommended owed some of its success to the fact that the removal of the middle turbinal facilitated drainage from the frontal and maxillary cavities, and for suppurating ethmoiditis it was, of course, particularly suitable. He understood Dr. Lack to say that one of the indications for the operation was suppuration in an accessory sinus. Unless the sinus happened to be the ethmoidal cells, Dr. Thomson thought the detection of suppuration elsewhere was, on the contrary, a contra-indication. Mr. Baber had drawn attention to a practical point, which the speaker did not remember to have seen mentioned in most text-books. This was the danger of collapse and also of hæmorrhage in operating on nasal polypi in elderly subjects. Those who had not met with this occurrence would hardly believe what alarming symptoms sometimes ensued from removal of a simple nasal polypus in an old person.

Dr. FitzGerald Powell said that he thought they were under a debt of gratitude to Dr. Lambert Lack for having brought forward this scientific and practical method for the treatment of nasal polypi. Although he may not have been the first to remove by scraping diseased bone and polypi from the nose, he was, undoubtedly, the first to teach them, in a systematic and scientific manner, the best method for obtaining an early and radical cure. He had himself, since its introduction by Dr. Lack some years ago, been in the habit of practising this operation, from time to time, in suitable cases, and his experience was that it was most efficacious, entirely safe, and having the great advantage that it caused much less suffering to the patient than the repeated sittings, with the application of cocaine, and the cold snare, with their attendant pain and mental agitation. Much had been said as to the danger of the operation, and the likelihood of injury to the cribriform plate of the ethmoid, but, having regard to the anatomy of the skull, it would be a difficult matter, and force would have to be used to push a large Meyer's ring-knife up so far. On the other hand, it would not be difficult to injure the orbit, but with care this can be avoided. With regard to the pathology, he

had no doubt that in a large number of cases, a condition of rarefying osteitis, or perhaps necrosis resulted, the causation of which might well be ascribed to syphilis, tubercle, traumatism or sepsis. But on the other hand, he thought it quite possible that a condition of inflammatory œdema might arise in the mucous membrane, blocking the orifices of the mucous follicles, and to this cause he ascribed in some cases the presence of one or two small polypi, such as he had found growing from the septum or the upper edge of the posterior choana and projecting into the post-nasal space. He had removed them with the cold snare at one sitting, and had had no recurrence after two years. During the operation there was a considerable amount of hæmorrhage, and after the commencement of the curetting he was not able to see very much, and had to rely on what he could feel with the finger and the curette. He considered it very necessary for the control of the hæmorrhage to plug the nose, and he always did so, using strips of iodoform gauze, which he kept in the nose generally for two days, changing the gauze after the first twenty-four hours. Occasionally a recurrence of the polypi did take place after the operation, but they were few in number, and could be removed by the snare or a second scraping, which effectually removed the tendency to recur.

Mr. Waggett said that *apropos* of Dr. StClair Thomson's remarks *re* ethmoidal cell disease, it was interesting to note a paper by Lichtwitz, in which attention was drawn to the unexpected frequency of accessory sinus empyema, as detected in the *post-mortem* room. That author stated that, whereas in the Special Clinics of Chiari and himself, only 2 per cent. of the total number were noted as empyema cases; the evidence of general *post-mortem* rooms showed that class of disease to be vastly more frequent. The reports of Harke, E. Fränkel, and Lapelle recorded over 100 cases from a total of 700 autopsies. Among sixty-three cases detected in the *post-mortem* room only one had been suspected during life. With regard to the general question of the relation of mucous polypi to bone changes, it was interesting to note that some of the speakers, while admitting such a relation, asserted that the bone changes were of secondary origin and due to the polypoid degeneration of the mucous membrane. In the face of Dr. Lack's thesis the assertions of dissentients should be supported by evidence. It was not surprising that the ethmoid bone, which differed in many respects from any other bone in the skeleton, should be subject to a pathological change of the character of a rarefying osteitis not met with elsewhere.

Dr. William Hill hoped that a wrong impression would not be created outside the Society by reason of the general terms in which those who approved of radical measures on the ethmoidal cells had spoken on this occasion. The object, of course, of those who attacked a case of polypous disease with ethmoidal suppuration, whether according to the method of Lack or Grünwald, or other operation similar in principle, was to remove the whole of the disease under general anæsthetic at one sitting. As a matter of personal experience, however, he felt bound to admit that this ideal was not always attainable, even at a long sitting. He had the advantage of possess-

ing a slender little finger, with which he explored the nasal fossæ during the course of an operation; but in spite of every precaution he had often either left some polypi behind or insufficiently opened the ethmoidal cells, so that further operations under anæsthesia were sometimes necessary; and there was generally some trimming up to be done with snare or punch forceps at subsequent sittings under cocaine. The snare operation alone was only useful in simple cases, and was rarely, if ever, radical in recurrent and suppurative ones. In clinical teaching, whilst calling the attention of students to the inartistic and sanguinary methods of treatment adopted by those general surgeons who used *blindly* to push forceps up the nose and remove all they could lay hold of, including an occasional turbinal, diseased or otherwise, the speaker had always been careful to call attention also to the fairly good results attending such measures, in spite of the absence of technique; and what was more remarkable, as far as he could gather, no fatal result had attended the use of the forceps, even in inexpert hands; and generally speaking, the operation had not led to harmful sequelæ, though doubtless it often failed in its object from imperfect removal. In conclusion, he agreed with those speakers who insisted that where ethmoidal suppuration was present some radical measure, such for instance as that advocated by Dr. Lack, was essential to insure a cure of nasal polypus.

Dr. Dundas Grant said that there could be no doubt that Dr. Lack's operation ought to be looked upon as a received surgical procedure, the only possible difference of opinion being with regard to its indications. Those laid down by Dr. Lack pointed to suppuration of the ethmoidal cells. With regard to the necessity for radical operation in cases of recurrent polypi, he thought it might sometimes take other forms, *e. g.* there were cases in which the polypi could only be eradicated after an opening had been made into the antrum. Dr. StClair Thomson indicated that free washing out of the antrum had caused disappearance of polypi; he had himself also observed this. In other cases that had not occurred, and several times he had thought it justifiable to open the antrum of Highmore and clear away its entire inner wall with the unciform process for the purpose of eradicating polypi situated in the middle meatus. Sometimes there might be polypi growing from the front of the sphenoid bone. He related a case in which he had removed such a polypus. With regard to polypi in the post-nasal space, a general anæsthetic was in his opinion necessary, the left forefinger being introduced into the naso-pharynx. The difficulty in putting the snare round such a polyp was considerable, and the forceps, passed through the nose under the guidance of the finger in the naso-pharynx, was the only instrument which could be used under a short anæsthesia like that of nitrous oxide gas. In order to get complete removal of polypi and to get a snare applied to as many polypi as possible, it was often necessary to remove the anterior part of the middle turbinate body. There was sometimes another form of obstruction which had to be removed, and that was the polypoid swelling on the anterior lip of the hiatus semilunaris, which sometimes projected to a considerable degree into the nasal cavity; and the only way of removing it satis-

factorily was that recommended by Killian, which he (Dr. Grant) had himself done several times. It was to pass the point of a sharp pair of scissors right into the middle of the growth, and to remove the upper and lower half separately by means of the snare. This had enabled him to reach and remove a polypus which was inaccessible both to vision and to touch until that was done. Nobody, he was sure, would regret more than Dr. Lack if it became the custom for all and sundry to perform his operation on every patient who had polypi of the nose. In a wisely selected number of cases, however, it was absolutely indispensable and offered the most promising results.

Dr. Bond heartily supported Dr. Lack in his method of operating, but there were certain cases in which one might come to grief. Dr. Lack's method of operating was different from Bank's, which latter consisted in taking hold of the middle and upper turbinates and pulling away with forceps as much as possible from the top and middle of nose. Dr. Lack's operation was a different thing altogether, but one might have trouble in operating if one did not pick one's cases somewhat carefully. The most serious cases were those referred to by Dr. StClair Thomson, namely cases of polypi occurring in old women over sixty. In such a case the front of the nose on each side was commonly seen to be filled with what seemed to be ordinary polypi, but the case was often one of malignant disease with polypi in front. If in such a case Dr. Lack's procedure was used under the belief that the case was one of general nasal polypi the operator would be surprised at the result. There were other cases where the nose was very much obstructed, and a little œdema and granulomatous tissue might be seen in front, with syphilitic necrosis, etc., behind. On scraping away vigorously in such a case a violent hæmorrhage might occur. He had seen one instance of such a case. Somewhat active treatment at the posterior part of the nose was carried out, and the sphenoid cavity opened and packed, but with damage to the vessels inside the skull. Dr. Lack's operation was, in his opinion, an admirable and successful one. He wished to mention that there was no danger of damaging the cribriform plate, etc., if the operation were done with ordinary skill; such danger was in large part imaginary. The second point he remarked on was that the cautery had ceased to be used and recommended, as in times past, in the treatment of nasal polypi. It was recommended in the text-books as of use in treating polypi, and cauterisation of the stumps was advocated. He believed the latter to be a great factor in the production of bone disease. He thought curetting of the mucous membrane should be employed more than it had been. In conclusion, he thought the individual factor played a very important part in the comparative success of the operation; one operator would get good results from Dr. Lack's method, whilst another would get much the same result from operations with extensive curettings carried out at several sittings.

Dr. Wyatt Wingrave said, with reference to the pathological aspect of the discussion, Dr. Lambert Lack's specimens illustrated one phase only of polypus formation. Many of the sections showed only normal cancellation changes, a process of osteoporosis which is essential to the development of the accessory sinuses, and continues

until very late in life. The "osteoclastic" operations so well seen in this rarefying process are often misinterpreted as being morbid; but it is only when greatly exaggerated that it should be so construed. In some of the slides the periosteal and osteoblastic activity was well marked, but this he considered as bearing only a coincidental relationship to the simple form of polypus. For all practical purposes polypi might be divided into two groups:—(1) simple; and (2) granulation. While the first group retained to a great extent many of the local histological features, the second group consisted almost entirely of small cell tissue in various degrees of myxœdematous degeneration, so that when fully developed they could not easily be distinguished from the simple variety. It was in the granulomatous group that the osseous changes were the more marked, so that the polypus was only symptomatic of deeper sinusal changes. Reference had been made to the necessity for exercising care when removing polypi in the aged. Whilst emphasising this, he thought that in addition to the risk of hæmorrhage from senile changes in the blood-vessels, there was also a danger due to advanced cancellation. The rarefication was often so extensive that the turbinals proved to be as brittle as "biscuit," and great care had to be exercised in limiting the amount of bone removed with the polypus.

The PRESIDENT congratulated the Society on a most useful discussion; he thought that from this time forward a more or less new departure would go forth to the world as being the view held by certain members of the Society, stamped with the approval of the Society. The only thing to be afraid of was that this somewhat radical method of treatment might be adopted by men who had not the skill of the great majority of the members of the Society. It was a point which ought to be emphasised, and which had been emphasised at a previous meeting of the Society. It was a method only to be employed in exceptional cases, and by those who had an exceptional amount of experience of intra-nasal disease. Another important point was the care to be exercised when polypi occur in old people. This had been overlooked in the past. The stress laid upon this was an additional gain to science and medicine.

Dr. H. LAMBERT LACK, in reply, thanked the members of the Society for the reception of his paper, which was more favourable than he had expected. In reply to Mr. Baber, he said he had watched some of his cases as long as six years, and so far from destroying the power of smell, in some of the most chronic cases, in which the patient had smelt nothing for years, it had returned after the operation. With Mr. Spencer's remarks he could not agree; but there was not time to go into them all. He doubted whether anything at all comparable to a nasal polypus ever arose apart from bone, for the rectal polypus was an adenoma, and these and other similar "polypi" were true tumours. The old idea that nasal polypi were tumours he thought had been given up years ago, and therefore he had not considered it worth while to allude to it. The structure and whole history of nasal polypi quite precluded such a theory. He had, however, very carefully separated granulation and inflammatory growths from nasal polypi, as they were both microscopically and clinically

quite distinct. Again, Mr. Spencer said that there were all stages between a nasal polypus and sarcoma. There was no evidence to support that view. A nasal polypus might be removed year after year and still never become a sarcoma. Several speakers, whilst reluctantly admitting that bone changes take place, claim that they are secondary to, and not the cause of, polypi, and yet can bring no evidence. On the contrary, when the diseased bone was removed, recurrence of polypi did not take place, but when the polypi alone were removed the bone changes continued and the polypi recurred. He had not claimed that he was the first to advocate the removal of bone. This was done one hundred and fifty years ago by Morgagni and Valsalva. Morell Mackenzie had published (in his book on 'Diseases of the Horse') notes of several cases of recurring polypi in which, after he had removed the underlying bone, recurrence no longer occurred, in spite of which Mackenzie advocated the cautery in all cases. Further, Ferguson and Pirogoff had recommended the removal of the bone. But they had not advocated the thorough operation which the speaker had proposed, and neither had Grünwald. When he started to investigate the subject of the pathology of polypus he had an open mind, but on discovering the changes in the bone which were illustrated under the microscope to-night, he came to the conclusion that Woakes's views were in large part correct. Where Martin had not found bone changes, perhaps it was because Woakes had removed the bone in other than polypus cases, as he ascribed many diseases to "necrosing ethmoiditis." He agreed with Dr. Powell that it was not at all easy to push a large ring-knife through the cribriform plate, and such an accident could be avoided with a little care. Dr. Tilley had said that in cases of polypi in the accessory sinuses bone disease was not always present, though the bone had never been removed for microscopical examination, and thus there was no conclusive evidence that osteitis was not always present. He could recall cases of polypi in the sinuses in which bone disease was undoubtedly present. In two cases the sphenoidal sinuses were affected, and in both the anterior wall of the sinus was extensively carious; and in two other cases in the antrum the inner wall was extensively destroyed. This evidence, as far as it went, contradicted Dr. Tilley's statement. Dr. Thomson seemed to approve Grünwald's theory. He did not think it was the general experience that sinus suppuration was invariably present in polypi. With the most careful examination it was in all probability found in less than 50 per cent. of the cases, and probably the same cause that produced the one might produce the other. Mr. Waggett had quoted *post-mortem* evidence to show the enormous frequency of sinus suppuration, which only showed that *post-mortem* records could not be accepted. The reasons of this frequency seemed to be that the accessory cavities had their openings at the top, and therefore the secretion formed depended entirely on the action of the ciliated epithelium for its removal. Thus when just previous to death this action ceased, or became inefficient, fluid accumulated in the cavity, and German authors seemed to accept the least trace of any sort of fluid as evidence of sinus suppuration. He agreed with Dr. Hill that one might have to trim up

the case afterwards with a snare; but in most of his cases he had removed everything at one operation. He would try and avoid Dr. Bond's three classes of dangerous cases, and certainly would never operate in the old or the feeble. In replying to Mr. Wingrave, Dr. Lack said that although some of the bone in his sections was normal, abnormal places were to be found in every section if looked for.

Mr. Cresswell Baber, in reply, said, with regard to the question of the starting-point of the inflammatory trouble causing polypi, whether in the mucous membrane or in the bone, he thought the clinical evidence seemed in some cases to favour the former theory, the reason being that, as he had pointed out, mucous polypi were met with under so many different conditions. Two of the latest observers, Hajek and Cordes, found cases in which the mucous membrane only was affected; in these cases, then, how could the bone be the cause? He was interested in Dr. Lack's operation, and thought it was one to be tried in suitable cases; before it was done the state of the larger sinuses ought to be investigated. He was glad that several members agreed with him as to the necessity for caution when removing polypi in the aged.

# PROCEEDINGS

OF THE

# LARYNGOLOGICAL SOCIETY OF LONDON.

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ANNUAL MEETING, *Friday, January 4th*, 1901.

F. DE HAVILLAND HALL, Esq., President, in the Chair.

Present—17 members.

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

Drs. Bronner and Brown Kelly were appointed scrutineers of the ballot, and the following officers were appointed for the year:

*President.*—E. Cresswell Baber, M.B.
*Vice-Presidents.*—A. Bowlby, F.R.C.S.; E. Law, M.D.; and Greville MacDonald, M.D.
*Treasurer.*—Clifford Beale, M.B.
*Librarian.*—Dundas Grant, M.D.
*Council.*—F. de Havilland Hall, M.D.; Herbert Tilley, F.R.C.S.; Barclay Baron, M.B.; William Hill, M.D.; Sir Felix Semon, and Lambert Lack, M.D.
*Secretaries.*—Ernest Waggett, M.B., and Charles A. Parker, F.R.C.S.(Ed.).

The report of the Council was then read and adopted.

REPORT OF COUNCIL.

The Council has the pleasure to report that the Society continues in a most prosperous condition. During the year thirteen new members have been elected, while one member has resigned and two have died. In April the Society received with deep regret the news of the death of Dr. McNeill Whistler, a former Vice-President and an original member.

The attendance of members at the Ordinary Meetings has been exceptionally large, and the clinical material abundant. The Ordinary Meeting in December was devoted to a discussion on "The Treatment of Nasal Polypi," which was well attended by members, many of whom took part in it.

Increased facilities have been provided for the exhibition of micro

scopical sections which have been freely taken advantage of, and a Cabinet to contain the specimens has been purchased and placed under the charge of a curator.

At a Special Meeting in March it was resolved that "it was desirable that at all International Congresses there should be full and separate sections for Laryngology and Otology."

The Council have been recently engaged in the consideration of the rules of the Society, which, owing to alterations and additions at various times, required general revision and rearrangement.

The following report of the Treasurer was read and adopted:

The total receipts of the Society from subscriptions, entrance fees, etc., during the past year has been £134 8*s*. There are still ten subscriptions outstanding and one entrance fee, but nearly all the outstanding subscriptions for 1899 have now been paid in.

The total expenses amount to £133 13*s*. 2*d*., leaving an excess of income over expenditure of 14*s*. 10*d*. for the year. To this has to be added the balance brought forward from last year, viz. £215 16*s*. 3*d*., making a total credit balance on January 1st, 1901, of £216 11*s*. 1*d*.

The Balance-sheet, duly audited and found correct by the auditors, Dr. Jobson Horne and Dr. Furniss Potter, is appended.

BALANCE-SHEET, 1900.

| Income. | £ | *s*. | *d*. |
|---|---|---|---|
| Balance from 1899 | 215 | 16 | 3 |
| 10 Entrance Fees | 10 | 10 | 0 |
| 110 Subscriptions | 115 | 10 | 0 |
| 5 „ (1899) | 5 | 5 | 0 |
| 2 „ (1901) | 2 | 2 | 0 |
| 1 Subscription overpaid | 1 | 1 | 0 |
| Total Receipts for 1900 | £134 | 8 | 0 |
| Balance Jan. 1st, 1901 | 216 | 11 | 1 |
| | £350 | 4 | 3 |

| Expenditure. | £ | *s*. | *d*. |
|---|---|---|---|
| Rent | 31 | 10 | 0 |
| Adlard | 56 | 0 | 3 |
| Reporting | 18 | 18 | 0 |
| Baker—Microscopes | 6 | 10 | 0 |
| Newton—Lantern, etc. | 2 | 10 | 0 |
| Pulman—Binding | 4 | 7 | 2 |
| Entertainment at Annual Dinner | 5 | 5 | 0 |
| Cheque returned (Dr. W. Williams) | 2 | 2 | 0 |
| Clarke—Indexing | 1 | 10 | 0 |
| Burgoynes—Chemicals | 0 | 14 | 7 |
| Rogers—Spirit Lamps, etc. | 0 | 11 | 11 |
| Mathew (porter) | 1 | 1 | 0 |
| New Cheque Book | 0 | 8 | 4 |
| Hon. Secretary's Expenses: | | | |
| Dr. Lack | 1 | 1 | 9 |
| Mr. Waggett | 0 | 11 | 7 |
| Hon. Treasurer's Expenses | 0 | 11 | 7 |
| Total Expenditure for 1900 | 133 | 13 | 2 |
| Balance | 216 | 11 | 1 |
| | £350 | 4 | 3 |

*Dec.* 31*st*, 1900.

Audited and found correct, { W. JOBSON HORNE. E. FURNISS POTTER.

E. CLIFFORD BEALE, *Treasurer*.

The Librarian's report as under was then read and adopted.

The following "Exchanges" have been regularly received during the year 1900:

Archiv für Laryngologie und Rhinologie.
The Journal of Laryngology, Rhinology, and Otology.
Revue hebdomadaire de Laryngologie, d'Otologie, et de Rhinologie.
Archivii Italiani di Laringologia.
Annales des maladies de l'oreille, du larynx, du nez, et du pharynx.
Bollettino delle malattie dell' orecchio, etc.
The Laryngoscope.
Archivio Italiano d' Otologia.

It has been found impossible to have them all bound up to the present date, but this will be effected with the least possible delay.

The following works have been presented to the library:

*By the President (Dr. de Havilland Hall).*

Morell Mackenzie—Semon. Die Krankheiten des Halses und der Nase.
Gustav Spiess. Kurze Anleitung zur Erlernung einer richtigen Tonbildung in Sprache und Gesang.
Gustav Spiess. Ueber den Einfluss einer richtigen Stimmbildung auf die Gesundheit des Halses.
L. Schrötter. Vorlesungen über die Krankheiten des Kehlkopfes.

*By Sir Felix Semon.*

Internationales Centralblatt für Laryngologie for the year 1899.

I have also communicated with the editors of the 'American Annals of Laryngology, Rhinology, and Otology,' and of the 'Revue Internationale de Laryngologie,' but without success.

The following have been presented by the authors:

Pini, Alberto. Sulla olfattometria.
Goldstein, M. A., M.D. Modern Therapy of the Tympanic Cavity.
" " Nasal Hæmorrhage and the Hæmophilic Diathesis.
" " The Radical Treatment of Follicular Tonsillitis.
" " Otitis Media—Diagnosis and Treatment.
" " What not to do in Ear, Nose, and Throat Work.
Grazzi, Prof. V. Gli effetti dei bagni in generale sull' organo acustico.
" " Ricordi de VI° Congresso Otologico Internationale.
" " Sulla Laringite Tubercolare.
Hajek, Dr. M. Pathologie und Therapie der entzundlichen Erkrankungen der Neben höhlen der Nase.
Perez, Dr. Fernand. Recherches sur la bactériologie de l'ozène.
Pieniazka, Dra Przemystawa. Laryngoskopia oraz Choroby Krtani i Tchawicy.
Polyak, Dr. Ludwig. Jahrbücher der Gesellschaft der ungarischen Ohren- und Kehlkopfärzte, 1899.
Semon, Sir Felix. Die Nervenkrankheiten des Kehlkopfes und der Luftröhre.
Udden, J. A. An Old Indian Village (2 copies).

The following PROCEEDINGS OF SOCIETIES, etc., have also been added:

Sitzungsberichts der Wiener Laryngologischen Gesellschaft, 1899.
American Laryngological Association, 1899.
Brighton and Sussex Medico-Chirurgical Society, Session 1899-1900, Fifty-third Annual Report.
Sixth International Otological Congress.
Gesellschaft der ungarischen Ohren- und Kehlkopfärzte.

Niederländische Gesellschaft für Hals-, Nasen-, und Ohrenheilkunde.
Verhandlungen der Laryngologischen Gesellschaft zu Berlin.
Medical Society's Transactions, vol. xxiii.
Catalogue of Accessions to the Library of the Royal College of Physicians.
The Hospital (autumn special number).
Journal of the International Pyschical Institute (November, 1900).
Bibliographia Medica, Index medicus, tome 9, No. 1, janvier 1.
Voyages d'études médicales, 1900.

Several members have availed themselves of the resources of the library, and in several cases where these resources have fallen short I have had the pleasure of lending works to members out of my own private collection.

I propose bringing before the meeting the question of procuring more extensive accommodation for our books in the rooms of the Royal Medical and Chirurgical Society, and have been negotiating with Mr. MacAlister in regard to it.

The suggested new rules were then read, discussed, and confirmed.

The meeting then adjourned.

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SIXTY-SECOND ORDINARY MEETING, *January 4th*, 1901.

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

LAMBERT LACK, M.D., ERNEST WAGGETT, M.B., } Secretaries.

Present—32 members and 2 visitors.

The minutes of the previous meeting were read and confirmed.

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

Eugene Steven Yonge.
Arthur Ainslie Hudson.

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

J. C. R. Braine-Hartnell, Cotswold Sanatorium.
George Jones, 8, Church Terrace, Lee.

The following cases and specimens were shown:

## Clonic Spasm of Palate, Pharynx, and Larynx in a Woman æt. 30.

Shown by Sir Felix Semon, M.D. I am indebted to my colleague, Dr. Risien Russell, under whose care the patient is at present at the National Hospital for Epilepsy and Paralysis, for permission to show her to-day. In order to avoid the case being duplicated, I beg to state expressly that the same patient was demonstrated by Dr. Russell before the Neurological Society a few months ago.

The patient, a married woman, who has had six children, of whom three are dead, and one miscarriage, and whose previous and family history are unimportant, came to the hospital in January, 1900, complaining of clicking noises in her head and curious movements in her abdomen. These movements were darting in character, as if there were something alive, and passed from the stomach into the throat, head, back, and limbs with great rapidity. In October, 1899, she first noticed the clicking noise in her throat, which has continued ever since. It has apparently nothing to do with the darting movements in the abdomen.

On examination, the patient is a fairly well-nourished woman with red hair, who lies or stands with her head thrown well back, the neck and chin thrust forward, the latter generally inclined to one side or the other, and the mouth is kept slightly open. A constant slight clicking sound goes on with an average frequency of about four per second. On looking into the mouth this sound is seen to be produced by rapid vertical movements of the soft palate associated with similar movements of the floor of the mouth. These movements go on whether the jaws are open, even widely, or closed; but if the chin is depressed into its natural position with the mouth closed the noise ceases, and the movements of the floor of the mouth cease, although she says she can still feel the palate moving.

The clicking sound is audible when she speaks, between the single words, but is said to cease, as well as the movements, during sleep. The movements on the whole are rhythmical, but

are occasionally interrupted by momentary irregular intervals, hardly lasting longer than a second or two, after which they recommence.

The epiglottis makes similar movements synchronous with those of the soft palate. These movements also take place in a vertical direction. The arytænoid cartilages and the vocal cords move with equal frequency and very energetically, but their movements are from side to side, not up and down; like those of the palate and the floor of the mouth, they are occasionally interrupted for a moment, after which they begin again. Usually they are so energetic that, during quiet respiration, the inner surfaces of the arytænoids, when the inward movement is executed, touch one another, but the oscillatory movements continue even when the glottis is wide open. During phonation everything appears normal.

Externally the mylo-hyoid can be seen and felt contracting, whilst the whole larynx is constantly being spontaneously moved a little up and down, and at the same time somewhat forwards and backwards, the movements being energetic enough to be communicated to the examining finger.

Her memory, attention, and intelligence are good, but she is distinctly depressed. She has no delusions except that she is sure she has something alive inside her.

The optic discs are healthy, the muscles everywhere well developed, and the movements well performed without incoordination or tremor. Reflexes everywhere normal, gait normal except for the position of the head described above, and nothing abnormal found on examination of the abdomen.

Speculation as to the cause of this peculiar clonic spasm, as to its mechanism, and as to the exact localisation of the focus of irritation appears, in the present state of our knowledge, idle.

It is only desired to put the case on record.

Dr. Lambert Lack wished to call the exhibitor's attention to a paper he contributed to the 'Laryngoscope' in 1898, in which, under the title of "Pharyngeal Nystagmus and Allied Conditions of the Pharynx and Larynx," he had described several cases similar to the one now shown. The speaker and Dr. Bond had each brought a similar case before the Society, although their cases were less marked and the movements were limited to the pharynx and soft palate,

As far as Dr. Lack had been able he had collected in the paper referred to all the previously recorded cases of spasmodic and tremulous movements of the pharynx and larynx. He found they could be divided into two distinct classes: (1) the most severe and extensive cases, which were usually due to some gross lesion of the central nervous system, *e. g.* cerebellar tumours, etc.; and (2) the milder cases, which were of reflex origin and apparently due to some small local lesion, *e. g.* post-nasal catarrh, pharyngitis sicca, etc.

Dr. HERBERT TILLEY related a minor case of the same affection occurring in an adult, in which only the left side of the pharynx showed constant spasmodic movements which extended the whole length of the pharynx. The affection supervened on a carriage accident—the patient was thrown out and suffered severe concussion and bruising. The patient's speech was becoming very indistinct, knee-jerks absent, tongue tremulous, and the pupils responded to Argyll-Robertson's test. The diagnosis in the case referred to seemed to point to incipient general paralysis of the insane.

Dr. WATSON WILLIAMS believed that instances of clonic pharyngeal spasm were not so very uncommon in general paralysis. The vocal cords were more rarely implicated. It seemed to him that these convulsive tics were possibly the analogue (bulbar) of psychic tics (cortical), and they were sometimes associated, for echolalia and coprolalia had been observed in association with clonic pharyngeal spasm by Kellogg.

Dr. CLIFFORD BEALE called attention to the fact that the movement of both larynx and pharynx ceased directly the patient's attention was drawn to the acts of phonation or respiration. The cases which Dr. Lack had referred to differed in this respect from the one under discussion.

Dr. SCANES SPICER considered the sucking noise to be produced in the larynx by the separation of the moist opposed surfaces of the arytænoid pyramids, for the sound continued unaltered when the soft palate was firmly pinned against the spine. He had an impression that Sir Felix Semon had shown a somewhat similar case before, but unilateral, and in which the orbicularis palpebrarum of the same side was affected.

Mr. CRESSWELL BABER remarked that pharyngeal spasm was not uncommon; it was described as a clicking noise, and as objective tinnitus; he had not seen laryngeal spasm, or any case in which the spasm took place so rapidly.

The PRESIDENT was sure that they were all thankful to Sir Felix Semon for bringing forward this unique case.

Sir FELIX SEMON, in reply, agreed with Mr. Baber's observations. He had seen several cases of "clicking" palate, but in these the spasm was limited to the soft palate and did not affect the larynx. He was grateful to Dr. Lack for drawing his attention to his paper in the 'Laryngoscope,' which was unknown to him. He was unaware that anything like his case had been previously described, although he knew that Gerhardt had mentioned tremulous movements of the vocal cords as the only sign of a cerebral tumour pressing upon the temporal convolutions.

[*P.S.*—Since making the above statements, I have learned from Dr. Lack's very interesting paper in the 'Laryngoscope,' June, 1898, that several similar though not quite identical cases have been described.—F. S.]

## Chronic Frontal Sinus Empyema treated by Kuhnt's Radical Operation.

Shown by Dr. Herbert Tilley. A woman æt. 46, upon whom this operation had been performed. The symptoms complained of were constant left supra-orbital headache, chronic discharge of pus, and nasal obstruction (due to polypi) upon the left side.

In performing the external operation the anterior bony wall of the sinus was completely removed, the pathological products curetted away, a large opening made into the nose, the sinus walls painted with chloride of zinc, gr. xl ad ℥j, the cavity packed with iodoform gauze, and the soft parts finally sutured with catgut for the other half of the wound. The end of the gauze was led out of the inner angle of the wound.

After five days some six inches of the gauze were removed, and the remainder of it after a further interval of four days. The sinus cavity seemed quite healthy, and external pressure was now applied to the soft parts so that they were pressed on to the posterior wall of the sinus, to which they had firmly adhered, thus obliterating the cavity. The patient was in the hospital seventeen days, and there has been no discharge of pus from the nostrils since the day of operation, five weeks ago.

## Case of Cured Maxillary (Double), Ethmoidal, and Frontal Sinusitis.

Shown by Dr. StClair Thomson. The patient was a gentleman æt. 41, who had suffered from nasal suppuration for eight years. Twice in Natal, where he lived, he had had the alveolar tooth socket drilled, and the right antrum washed out for some months. The pus soon returned when the washing was discontinued. It was found that the frontal sinus on the same (*i. e.* right) side was affected, and in hopes that the maxillary antrum only acted as a reservoir, it was simply drained through a tooth

socket while the frontal sinus was opened from the outside. As a result of this operation pus ceased to descend from the fronto-nasal duct which was obliterated, and the exposed part of the sinus filled with cicatricial tissue. But still pus oozed from the external corner of the frontal wound, and on placing the patient again under chloroform it was found that this proceeded from a diverticulum of the main frontal sinus, with which it communicated by a narrow neck which had been overlooked at the first operation. This pocket, running outwards and backwards above the outer orbit, had been opened up and plugged so that it healed from the bottom, just as a mastoid wound does. It was a slow process, taking three months, but there was no disfigurement.

The maxillary sinus on the same side had been treated by the Caldwell-Luc operation, and the ethmoidal cells had been curetted. The left maxillary antrum was simply drained, as it appeared to be only of recent infection from the right side.

It would be seen that the patient was not disfigured externally, as the incision was well under the eyebrow. Internally the right nasal chamber had not been interfered with physiologically by the removal of the anterior ends of the inferior and middle turbinals. There was no pus in the nose, but a little dry scab formed daily over the ethmoidal-cells opening. The patient expressed himself as struck by the recovery of the sense of general well-being. He said that he felt ten years younger than at the beginning of treatment, and now knew that he was then growing prematurely old.

Sir Felix Semon suggested to Dr. Tilley that it would be worth while in cases of this nature, in which the whole of the anterior wall of the frontal sinus was removed, to put in a plate either of aluminium, platinum, decalcified bone, or of ivory. Such devices acted well in other parts, and why should they not in the frontal sinus region? Disfiguration might thereby be lessened considerably, or even be totally avoided.

Dr. Watson Williams remarked that at the Portsmouth meeting of the British Medical Association in 1899 reports of two cases of diffuse suppurative osteitis, following operations for frontal sinus empyema, were reported. He desired the opinion of members of the Society as to the possibility of increasing the risk of such an occurrence by putting pressure upon the frontal sinuses, after opening, curetting, and cleaning them, as in the radical cure.

Mr. Cresswell Baber said it seemed as if surgeons were now coming

back to the operation of Kuhnt, who removed the whole of the anterior wall of the frontal sinus. He himself had shown at the Society a most refractory case, in which cure had resulted from resorting to this radical operation after all other measures had failed. The depression was not marked in his case, and the results were satisfactory. He asked, was it advisable to make a large opening into the nose or not? In the radical operation the discharge escaped on to the surface, and the sinus was filled with healthy granulation tissue. He took it for granted that the anterior part of the middle turbinate was removed previous to operation on the frontal sinus.

Dr. Scanes Spicer thought that in both of these cases he would himself have removed much more completely the front part of the middle turbinated and anterior ethmoidal cells before operating externally on the frontal sinus. He had seen many cases presenting all the symptoms and signs of frontal empyema get well after this procedure without the need of an external operation; and had found that even if this did not happen, the drainage of the frontal sinus into the nose was much facilitated by such free removal. While acknowledging the necessity for complete resection of the anterior wall in rare cases, he dreaded the deformity resulting, and thought that clearing out the anterior ethmoidal region well would render it still less often necessary.

Dr. StClair Thomson, in reply, said that the anterior half of the middle turbinate was removed before the operation on the frontal sinus. The suggestion of Mr. Baber was one to be considered—whether it was not much more desirable to obliterate the fronto-nasal duct, and cut off all communication with the nose. He started in this case with the Ogston-Caldwell-Luc operation on the frontal sinus, and passed his little finger up the nose into the sinus. During the treatment he changed his mind, and succeeded, by exerting a little pressure, in cutting off the frontal sinus from the nose The patient ran no risk of being reinfected because he now had no sinus. The idea of Sir Felix Semon was worthy of attention. He had a patient who told him that the bank clerk next to him had a platinum plate in his forehead, and feels very well. Other substances besides platinum might be used. In the 'Medical Press and Circular' of recent date solidified vaseline was suggested for this purpose.

In answer to various questions Dr. Tilley said that he would only recommend so complete an operation in exceptional cases, because of the deformity produced. In some seven cases which he had previously shown to the Society equally good results had been attained with no deformity, and in these instances far less of the anterior wall had been removed. He had performed Kuhnt's operation in this case really to satisfy himself as to how much deformity it produced. He considered that there was very little, in fact no risk of septic osteomyelitis ensuing if the external wound was not sewn up at the close of the operation. To avoid the complication it was also wise to make a large opening into the nose, which had the additional advantage of breaking down the anterior ethmoidal cells, which were always diseased, and which, if left alone, were very liable to reinfect the sinus, however carefully the latter was treated by curetting and disinfection.

## Case of Epithelioma of the Tonsil and Glands in the Neck; Operation; Recovery.

Shown by Dr. Lambert Lack. The patient, a man æt. 50, came under my care one month ago, complaining of a painful lump in the throat. An ulcer was seen in the position of the right tonsil, about the size of a florin. It spread on to the posterior pillar of the fauces, slightly on to the lateral wall of the pharynx, and downwards to within a quarter of an inch of the tongue. The edges of the growth were hard and everted. No enlarged glands could be felt in the neck. As the man was willing to be operated on, and the case appeared to be an eminently suitable one, a piece of the growth was at once removed for microscopic examination. The sections showed the growth to be an undoubted epithelioma.

The operation that was performed may be divided into four stages:

1. An incision was made along the anterior border of the sterno-mastoid, and the large vessels in the anterior triangle freely exposed. Some enlarged glands were found, and, together with the fascia over the vessels, were cleanly cut away. Ligatures were placed on the external carotid and some of its branches, but were not tightened. A pad of gauze was packed in between the carotids and the lateral wall of the pharynx.

2. Tracheotomy was performed, and a Hahn's cannula inserted.

3. The cheek was slit back from the angle of the mouth to the ramus of the jaw. A large sponge, with tape attached, was pushed into the larynx.

4. The pillars of the fauces were cut through with scissors, and the growth partly cut out with scissors and partly separated from the lateral pharyngeal wall by dissection with the finger. The wound in the mouth remained separated from the wound in the neck by a thin layer of fascia. There was no bleeding to speak of.

The temporary ligatures on the carotids were removed, and the wound in the neck and cheek sewn up. The tracheotomy tube was retained until the following day. After twenty-four hours the patient was able to swallow, and his further progress

was uneventful. The wounds in the neck and cheek healed by first intention. The patient was allowed up on the seventh day, and left the hospital on the fourteenth day.

The patient was brought forward to illustrate the excellent immediate result that can be obtained by such an apparently severe procedure. The whole safety of the patient depends upon the wound in the neck not communicating with, and being infected from, the wound in the mouth. The danger of hæmorrhage is entirely avoided by the temporary ligature of the vessels and the tracheotomy. The case also illustrates again the fact that even considerably enlarged glands in the neck may not be palpable, and the consequent necessity for an incision in the neck in every operation.

The PRESIDENT thought they would all agree in congratulating Dr. Lack upon the success which had attended his case. It was a perfect result, and one could not wish for a better either with regard to the completeness of the removal or the rapidity of the healing.

## BILATERAL WEBBING OF THE FAUCES.

Shown by Dr. HENRY J. DAVIS. This is a woman, æt. 52, with bilateral webbing of the fauces. The webbing may be entirely the result of old ulceration, but the symmetrical appearance of these fine bands of tissue would seem to indicate cicatrisation following ulceration of some congenital malformation of the faucial pillars, *e. g.* an accessory palato-pharyngeus.

Since childhood speech has been indifferent, and she had "a sore throat for ten years at one time," which favours this supposition. She is suffering from tinnitus and deafness.

The PRESIDENT had no doubt at all that this was a case of ulceration of scarlatinal origin. He had seen a similar case following small-pox, but scarlet fever was the most frequent cause. He did not think for one moment that its origin was congenital.

Dr. STCLAIR THOMSON had seen a similar case, which was even and regular, in which he could discover no history of syphilis or scarlatina. He had discussed the case with Mr. Bland-Sutton, who informed him that this defect did not correspond to any developmental defect.

Dr. FITZGERALD POWELL had shown a somewhat similar case to the Society some time ago. At the time he thought the abnormality must be developmental in character, the posterior pillars of the fauces being attached low down to the posterior wall of the pharynx

on both sides, each being very regular in outlines. The trend of the opinion of the Society on that occasion was that it was probably the result of scarlatinal or other ulceration. He thought Dr. Davis's case was due to this cause.

Sir FELIX SEMON, with great respect for Mr. Bland-Sutton's opinion, begged to differ from the statement attributed to that authority. He thought that such cases might be developmentally explained; there was no doubt of the existence of quite a number of cases with slits in the anterior pillars of the fauces, absolutely symmetrical, without any ulcerative agency to account for their presence. He promised to bring before the Society a drawing of a case of his own bearing on that point, and he remembered that similar cases had been described by Professor Lefferts. With regard to Dr. Davis's case he would be probably found to be in a great minority; but he agreed with Dr. Davis that this case very likely represented a mixture between arrested development and acquired ulceration.

Dr. WATSON WILLIAMS' impression was that this was a mixed case, in which there had been nine or ten years ago a sore throat with an ulcerative process going on; but the symmetrical condition of the faucial webbing suggested a congenital origin. The patient said she had not noticed it before. He himself had had a patient brought before his notice who did not know he had anything the matter with his throat, but he was found to have almost absolutely symmetrical webbing on either side of the fauces, very similar to this patient; in that case the condition was of congenital origin. He promised to show the Society a drawing of this case.

Dr. CLIFFORD BEALE thought it was a matter of considerable interest to determine whether these cases were due to scarlatinal poison in the first instance. In favour of such a view was the distribution of the splitting of the palate, which followed the lines of inflammation of the soft palate, so often seen at the onset of scarlatina. Against the theory, however, was the fact that, although in the course of hospital practice, one may examine a very large number of throats which have been affected at some time with scarlet fever, such clefts, apart from cicatricial contraction, were rare.

Dr. HERBERT TILLEY was of opinion that the pharyngeal appearances were the result of ulceration, and most probably post-scarlatinal in origin. He had recently seen an almost identical case in a lady who had consulted him for deafness, which was also post-scarlatinal in origin.

Mr. BABER had no doubt that it was due to previous ulceration in the throat.

Dr. DUNDAS GRANT suggested that a drawing should be made, because the case presented its features in a remarkably striking way. It seemed to him that the congenital condition was represented on the right side of the throat, but on the left side that there had been an abscess contemporaneously with the acute suppurative otitis due to scarlet fever, which she had as a child. He had seen in the fever hospitals several cases among children where such a condition existed as that on the tonsil of the left side produced by scarlatinal peritonsillar abscess.

Dr. DAVIS said the patient had always had some impediment of the speech and a periodical sore throat; one such "had lasted for ten years about fifteen years ago." What she complained of was tinnitus and internal and middle-ear deafness. He would try and get a drawing.

## CASE OF ENLARGED THYROID CURED BY IODIDE OF POTASSIUM.

Shown by Dr. DAVIS. This young woman came under my care last June, at the London Throat Hospital, with a large pulsating asymmetrical swelling of the thyroid, causing dyspnœa, stridor, and considerable functional derangement; a very rapid pulse but only slight proptosis were present. The "tumour had been growing for eight years, but had suddenly grown rapidly, getting larger whenever she had a cold."

The patient asked for time to consider operation, which at that time seemed the only treatment. She was treated with five grains of Potass. Iod., five grains of Ferri et Ammon. Cit. in a mixture; and she was ordered to rub equal parts of Ung. Potass. Iod. and Ung. Hydrarg. Biniodidi into the neck every night. She also inhaled the vapour of iodine crystals in a saucer.

In six weeks the tumour disappeared, all other symptoms rapidly subsiding. The iodide treatment was left off four months ago, and the thyroid showed signs of swelling, which again vanished under the same treatment.

The girl, beyond being slightly anæmic, is now perfectly well.

Mr. SPENCER said he should not use the word "cure," although good results, as in this case, did very often follow treatment by iodide of potassium and thyroid tabloids; but recurrence happened sooner or later, and surgery ultimately had to be relied on for the treatment of the masses containing cysts, etc. The tumours had a tendency to subside and come back, especially in young patients, such as that of Dr. Davis.

Dr. DAVIS said he did not literally mean "cure," which perhaps was not quite correct. All symptoms had disappeared under iodide, then recurred; and under a further course of iodide and ointment (biniodide) had again disappeared. The patient was now under no treatment. There was a small cystic swelling on the right side, which was hardly noticeable. When he first saw the patient, in June, the goitre was a very large one.

Dr. STCLAIR THOMSON said that in decided thyroid tumours medicinal treatment was of little use. He had lately had the opportunity of discussing the subject with Professor Kocher, of Berne,

whose experience in the question was unsurpassed, and who said that patients must make up their minds between putting up with the inconvenience of the growth or submit to the knife. He preferred cocaine as an anæsthetic.

Dr. FitzGerald Powell said in his experience medicinal treatment by iodides and iron was certainly of great use. He had had a number of cases of cystic goitre in which the cysts had been reduced, but this was not always the case, and then operation became necessary. The iron was largely answerable for the improvement in some of the cases, especially those occurring in young women with menstrual disorders and anæmia.

Dr. Bennett supported the last speaker. He believed that permanent benefit frequently followed the use of iodides. One case especially occurred to him, in which the patient consulted a leading London specialist, who advised operation. The patient afterwards desired to try medical treatment first, and he had given iodides with excellent result. The patient had remained free from the trouble now for several years.

Dr. Ball said that formerly he was in the habit of treating those cases with iodides internally and iodine preparations externally, and that he often got apparent cures. For the last seven or eight years he had completely abstained from employing any special treatment, and he had got precisely the same results. Some cases improved spontaneously, as they did formerly under iodide treatment. He had absolutely no belief in the efficacy of any specific medicinal treatment of goitre.

Dr. Donelan remarked that medicinal treatment produced no permanent benefit. It caused a contraction of the gland, which might be compared to the effect of the injections which were formerly so much in vogue. The gland diminished, and remained small for a considerable time, and treatment was abandoned; but later the growth increased more rapidly than previously. These cases, in his opinion, did as well without as with medicinal treatment; the severe cases all eventually came into the hands of the operating surgeon.

Sir Felix Semon called to mind that Sir Morell Mackenzie once told him that he had injected iodine in the case of a patient who had previously asked him if there was any danger in it. Sir Morell Mackenzie, speaking from the experience of hundreds of cases, had replied decidedly in the negative. The patient thereupon consented, but died five minutes after the injection in the consulting room. Speaking from twenty-five years' experience, he could say that he had cured a good many cases permanently by iodide.

Dr. Scanes Spicer wished to emphasise the view that many of these thyroid enlargements were inflammatory in origin, being attended with local pain, tenderness, and rise in temperature. Such symptoms soon disappeared on rubbing in some mild preparation of iodine, even if they were accompanied by some of the signs of Graves's disease, such as tachycardia, palpitation, and exophthalmos. He had no doubt they sometimes went away by themselves, as Dr. Ball had observed.

Sir Felix Semon wished to define his previous statement a little

more accurately. His experience was that soft and absolutely parenchymatous goitres, especially when occurring in young girls, were favourable for the iodide treatment. With iodine and iodide of potassium—internally and externally—in the form of ointment and mixtures he had effected a good many cures. In cases where cysts or fibroid elements developed, the medicinal treatment, needless to say, was not nearly so successful. In the case under discussion he could not see any inflammatory action whatever.

Dr. BRONNER said many cases which had resisted iodide of potassium were controlled by tabloids of iodothyrin.

Dr. WATSON WILLIAMS mentioned a case of goitre which had been cured many years previously by purely medicinal treatment at the hands of Sir Felix Semon. There was now not a vestige of the tumour.

The PRESIDENT referred to the injection of iodine. At one time he had used it extensively, but entirely abandoned it, owing to the death of a well-developed young guardsman, who died within a minute of the injection.

## A CASE OF SWELLING OF LEFT CHEEK AND EYELID.

Shown by Dr. DAVIS. For two years this patient, a female æt. 23, has had a puffiness of the left lower eyelid, with swelling over the root of the nose and left upper jaw. On the supposition that she had antral disease the antrum was opened through the socket of an extracted molar. She wore a plug, and was under treatment for nine months. No disease was found, and nothing in the nose—beyond some slight enlargement of the middle turbinals—can be found to account for the disease. The nasal duct is free. The swelling is worse in the morning and late at night, but varies in the course of the day, and it appears to me to be lymphatic in nature. Her condition is unaltered by treatment. There is no albumen in the urine, and the general health is good. It may be a case of angioneurotic œdema.

Dr. BRONNER said these cases were fairly common, but seen more by ophthalmic surgeons. They always occurred in young women. Their nature was unknown, and they were generally unilateral.

Dr. SCANES SPICER had seen the condition associated with ethmoidal cell suppuration.

Dr. WATSON WILLIAMS regarded it as a case of recurrent erysipelas. It occurred in fairly definite attacks at the outset, followed by periods of quiescence, and leaving more and more persistent thickening. He

had had two or three cases, but did not know what to do for their treatment.

Mr. DE SANTI had shown a case to the Society in a similar condition, except that it was more extensive; it resembled the description given by Dr. Watson Williams. His case was apparently due to a mosquito bite. He considered the condition was one of lymphatic œdema, and probably due to the specific cocci of cutaneous erysipelas.

Dr. DAVIS said the swelling had gradually increased eight years, and had then suddenly grown more rapidly. After taking iodide internally, and Ung. Pot. Iod. and Ung. Hyd. Biniod. externally, for about a month, it began to disappear rapidly.

## RECURRENT ANGIOFIBROMA INVOLVING VENTRICULAR BANDS AND VOCAL CORDS.

Shown by Dr. FURNISS POTTER. The patient, a man æt. 42, came under observation in the summer of 1899, complaining of hoarseness, which had come on gradually. On laryngoscopic examination the anterior third of the glottic space was seen to be filled, and the anterior thirds of both cords were obscured by (what appeared to be) a trilobed tumour, which on further examination with probe, and on subsequent removal, was found to consist of two parts, one attached to the left ventricular band —on microscopic examination reported as simple papilloma,—the other attached chiefly to the right ventricular band, and involving also the right vocal cord, the upper surface of which presented a ragged, torn-looking surface.*

The case has been under constant observation, and has continued to recur, notwithstanding that several removals have from time to time been effected with snare and forceps whenever the growth has become sufficiently protruding to be seized with instruments.

The surface now involved is more extensive than when first seen, the anterior commissure and left ventricular band and cord (?) being considerably affected.

During the last few months the patient states that he has had several attacks of hæmorrhage, on which occasions he has coughed up about a teaspoonful of blood. He suffers from much vocal disability, which seriously interferes with his occu-

* A section of this was exhibited at this Society November, 1899, and was reported on by the Morbid Growths Committee as angiofibroma.

pation—a builder's foreman,—which necessitates much use of the voice.

He would be glad to have any suggestions for further treatment other than what had been pursued.

The PRESIDENT would call this case by another and more grave name, *i. e.* malignant disease of the larynx.

Dr. CLIFFORD BEALE commented on the free movement of the cords in the case, and asked how far one was justified in ignoring the rule that cancerous growths of the larynx usually produced impaired movements. The appearance of the growth itself certainly suggested malignant disease.

Sir FELIX SEMON said he had defined his position with regard to the question of mobility of the affected vocal cord in malignant disease of the larynx so often and so precisely before, that he was sorry there could still be any doubt on that point. It depended entirely on the depth of the infiltration whether or not there was any impairment of movement. If the disease was somewhat superficial there might be free movement, even though the affection be already rather extensive; whilst, on the other hand, in a case of deep infiltration there might already be defective movement, though the actual outgrowth was still small. The question, therefore, stood thus: the absence of defective movement was no counterproof to the existence of malignant disease, whilst its presence in cases where it was doubtful whether a growth was innocent or malignant was a valuable aid to diagnosis.

Mr. WAGGETT said Dr. Potter asked him to get the opinion of the Society whether it was desirable to do a thyrotomy, in order to see what the condition really was.

Mr. SCANES SPICER inquired if the patient had had a course of iodide of potassium.

Mr. DE SANTI said the sooner thyrotomy was done the better. He advised an exploratory thyrotomy.

## RECURRING NASAL POLYPI.

Shown by Mr. DE SANTI. A girl, æt. 18, suffering from persistently recurring nasal polypi. She had been under constant treatment at various hospitals for four and a half years before coming under his care at the Westminster. The polypi had been removed innumerable times by means of the snare.

He found large masses of toughish polypi in both nostrils, occupying the whole of the cavities; there was marked "frog face;" microscopically they consisted of mucous and fibrous

tissue. He took the patient into hospital, and under a general anæsthetic turned up the nose by dividing the reflection of the mucous membrane of the lower lip and gums, and thus got at the polypi; these were removed with the aid of suitable forceps and curetting. The patient remained free from the growths for some six to seven months; they then recurred, and subsequently another free removal under an anæsthetic was carried out: there was immunity from the growths for eight months. Now the patient is again in much the same condition as before. From the general appearance of the polypi and the free suppuration going on, Mr. de Santi considered there was accessory sinus suppuration. In connection with the last meeting of the Society, when the treatment of nasal polypi was under consideration, he brought the case forward as showing the results of the different methods of treatment and their failure. He was anxious to know if Dr. Lack's method of operation would be generally recommended, though one of Mr. de Santi's two operations consisted, in his opinion, in very much the same technique as Dr. Lack's.

Dr. Herbert Tilley had no doubt but that the case was one of chronic suppurative inflammation of the accessory sinuses. He had proved this as regards the frontal sinus, because the withdrawal of a probe passed into it was followed by a free flow of pus. Unless these accessory cavities were efficiently dealt with the polypi would continue to recur as they had done formerly. The breadth of the upper portion of the patient's nose was very suggestive of chronic ethmoiditis.

Mr. de Santi asked Dr. Tilley if he was of opinion that the nasal polypi were secondary to frontal sinus suppuration in his case.

Dr. Tilley said emphatically that this was his view.

### Growth of Right Cord in a Man æt. 35. (Patient and Specimen.)

Shown by Dr. W. H. Kelson. Patient was shown at the end of last summer session, and, as there was some difference of opinion about the case, the President had requested that it be shown again, but as the patient is a teacher the growth was removed from the right vocal cord in August. The microscope showed it to be a papilloma.

Dr. FitzGerald Powell remembered having seen this case when it was shown to the Society at a previous meeting. There still appeared to be a small portion of growth remaining below the anterior commissure which might have to be removed.

Dr. Kelson thought there might be a small papilloma below the cord on the right side. The patient had recovered his voice, and had passed an examination in singing, and so he thought it better to leave it alone at present.

## Lupus of the Pharynx.

Shown by Mr. R. G. Johnson for Mr. Richard Lake. This patient states she has suffered from "ulcerated sore throat" with dysphagia since November, 1899. There is no history of phthisis or of syphilis, congenital or acquired.

In April, 1900, the tonsils were removed, immediately after which her voice became affected.

At the present time there are well-marked signs of phthisis at the left apex.

On examination the whole of the uvula, both posterior pillars of the fauces, the left tonsil, a small part of the soft palate to the left of the uvula, the surface of the lingual tonsil, what remains of the epiglottis, the ary-epiglottidean folds, with the arytænoids and ventricular bands, are seen to be involved in a lupoid process, which is, however, in a fairly stationary condition.

Dr. Davis had seen the case in the Middlesex Hospital; a piece was removed from the tonsil, examined, and pronounced to be lupus.

## Case of Bilateral Abductor Paralysis.

Shown by Dr. J. B. Ball. A young man, æt. 24, admitted recently to the West London Hospital for a hæmatocele of the testicle. Surgical interference being considered desirable, ether was administered. While under ether, and before the operation was begun, his breathing stopped, and he became cyanosed. Artificial respiration was performed, and air began to enter with loud stridor. Artificial respiration was kept up for about ten minutes, but the stridulous breathing continued for three quar-

ters of an hour. The next day Dr. Ball was asked to examine the larynx. The condition present is that of bilateral abductor paralysis. It is not quite typical, however. There is some obliquity of the line of the glottis, and some asymmetry of the cords. The history points to the condition having existed for a very long period, if, indeed, it was not congenital. The patient states that, as long as he can remember, his breathing is noisy and difficult on the least exertion. His mother states that as an infant his breathing was always troublesome and frequently crowing in character, and that when he was born he was not expected to live owing to his difficult breathing. The knee-jerks are present, and there is no sign of disease in the chest. Patient has not had syphilis.

Mr. SPENCER said it was a very curious-looking larynx. One cord was completely paralysed. The left cord, however, retained a good deal of movement. It might be congenital or syphilitic in origin. The question was, what would happen to the boy? Was it safe to allow it to go on as it was? There was not much room there, and with a little inflammation he might soon get into a dangerous condition.

Dr. WATSON WILLIAMS thought the right vocal cord appeared quite fixed, and there was certainly movement of the left cord. He suggested that some old inflammatory mischief caused fixation of the right cord, and that the present condition of the left, viz. abductor paralysis, was due to some more recently developed affection. The increased pulse rate, 96 a minute, suggested the existence of a bulbar lesion.

Sir FELIX SEMON said he had laid it down many years ago as a rule that in every case of bilateral abductor paralysis, if medical or surgical treatment did not succeed in actually restoring the activity of the abductors, it was the duty of the laryngologist to perform tracheotomy as a prophylactic measure, and rid the patient of the risk of suffocation. Since then, however, he had seen several cases in which fairly severe bilateral abductor paralysis had existed for many years with impunity. He reminded the Society that he himself had shown to it two such cases a few years ago, one of which he had already shown on the occasion of the International Medical Congress of 1881, *i. e.* fully twelve years before his last demonstration. This had made him somewhat doubtful as to whether his previous dogmatism was justified; although, on the other hand, several cases had been recorded in which the non-observance of his rule had led to sudden death by asphyxia. His course now was to tell patients plainly how matters stood, and leave them to decide. Certainly it did not increase the amenities of life to go about for years with a tracheotomy tube. On the other hand, an attack of simple laryngeal catarrh

might put the life of the patient in danger at any time, as actually happened in the case from which he had deducted his rule.

Dr. WATSON WILLIAMS mentioned a case *apropos* of Sir Felix Semon's remarks. The patient was brought to the Royal Infirmary at Bristol, and had marked inspiratory dyspnœa with stridor. On examining the larynx he found well-marked bilateral abductor paralysis. No reason for it could be discovered. Bearing in mind the dictum laid down by Sir Felix Semon, he was tracheotomised. He was able to breathe very comfortably, and in the course of a fortnight, owing to the left thyro-arytænoideus internus having become paralysed, he was able to do without the tube.

Dr. BRONNER recommended the use of large intubation tubes in cases of abductor paralysis with difficulty in breathing. The tube should be worn for a few hours daily, or constantly if possible, for a few weeks; this in many cases permanently relieved the dyspnœa.

The PRESIDENT: It was a very difficult question to decide what should be done. There was a well-known member of Parliament some ten or eleven years ago, with more or less mechanical fixation of the cords; adduction was good, but abduction very incomplete. He was able to speak in the House. The condition dating from small-pox had existed upwards of thirty years. He caught a slight cold, and died from laryngitis. Probably if something had been done his life would have been spared.

## SPECIMEN OF CYST. ? DERMOID.

Shown by Dr. FITZGERALD POWELL. The specimen shown was removed from the floor of the mouth of a girl æt. 16 years. The swelling which it caused was first noticed thirteen months ago, and had been gradually increasing in size.

When first seen I found, on examination, a considerable rounded swelling, extending from below the symphysis to just above the hyoid bone; it was moveable, soft, and fluctuating, and on looking into the mouth it was seen to push the floor upwards, and could be felt well back under the tongue; it had somewhat the appearance of a ranula, but was more regular in shape, and occupied both sides of the frænum linguæ.

I removed the cyst by a median incision through the skin, extending from just below the symphysis to just above the hyoid. The superficial structures were carefully divided, bleeding points secured, when the white glistening cyst wall was exposed, and by sweeping the finger round the growth it was easily enucleated and brought out. The wound healed by first intention, and little scar was left.

# PROCEEDINGS

OF THE

# LARYNGOLOGICAL SOCIETY OF LONDON.

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SIXTY-THIRD ORDINARY MEETING, *February* 1*st*, 1901.

E. CRESSWELL BABER, M.B., President, in the Chair.

ERNEST WAGGETT, M.B., CHARLES A. PARKER, F.R.C.S.(Ed.), } Secretaries.

Present—28 members and 4 visitors.

The minutes of the preceding meeting were read and confirmed.

The ballot was taken for the following gentlemen, who were elected members of the Society:

Eugene Steven Yonge, M.D., C.M.(Edin.), 3, St. Peter's Square, Manchester.
Arthur Ainslie Hudson, M.A., F.R.C.S.(Edin.), 3, Ellerdale Road, Hampstead, N.W.

It was proposed by the PRESIDENT, seconded by Sir FELIX SEMON, and carried unanimously, that the following be sent to the King's Most Excellent Majesty:

"The members of the Laryngological Society beg to offer to your Majesty their expression of sincere sympathy in the great sorrow that has befallen the Royal Family and the Empire, and to submit to your Gracious Majesty their respectful congratulations and allegiance upon your accession to the Throne."

The following cases and specimens were shown:

### A Case of Nasal Polypi with marked Deformity.

Shown by Dr. Donelan. The patient, a waiter æt. 23, had noticed increasing nasal obstruction since about 1892, which became complete in 1896, causing great spreading of nasal bones and the same marked deformity as now existed. A large number of polypi were then removed with the snare, but recurrence gradually took place.

In December, 1900, he came to the Italian Hospital, Queen Square, with complete obstruction due to the nose and post-nasal space being crowded with polypi.

The patient underwent a preliminary clearance of polypi, and the middle turbinals were removed, any polypi that escaped being subsequently snared, and finally, on January 9th, the nares and ethmoidal sinuses were thoroughly curetted. It was, however, to be feared that recurrence was again about to take place. Dr. Donelan requested the advice of members as to further measures.

The President said it was a case in which the polypi had come back after an operation of a radical nature had been done. It seemed to him that, before any further operation was undertaken on the ethmoid, the condition of the large sinuses ought to be investigated.

Dr. Herbert Tilley agreed with the President that the intra-nasal appearances afforded strong evidence of primary accessory sinus disease. He asked if the antra had been transilluminated.

Dr. Wm. Hill said a very interesting point was the cause of the enlargement of the maxillary bones, the nasal processes of which were enormously prominent and thickened. If polypi were really a sign of bone disease, one could understand disease extending in these advanced cases to other bones of the nose besides the ethmoids. Great enlargement of the "uncinate body," so evident in this case, was diagnostic of sinus disease, more especially of the antrum.

Dr. Dundas Grant said it was an interesting question as to how much deformity might be produced by a benign growth. Deformity of the face was classed among the signs of malignancy; the deformity in the case under discussion was frequently produced without there being anything of a malignant nature.

Dr. FitzGerald Powell said this was an exaggeration of a condition not infrequently seen as the result of the expanding pressure of polypi, accompanied by rarefying osteitis. The best results would be obtained by free curetting with a ring-knife, which would relieve the tension, remove diseased bones, and check suppuration. At the

same time attention should be directed to the maxillary sinuses, which should be drained if necessary.

Dr. BRONNER said that in the provinces cases of very great deformity frequently occurred. It generally disappeared even in adults in the course of a year or two after the removal of the polypi.

The PRESIDENT had seen these cases of deformity, and considered them due to dilatation from the pressure of the growths. He had not, like Dr. Bronner, seen the deformity disappear.

Dr. VINRACE wished to know whether Dr. Donelan attributed the deformity to anything except obstruction and the long time during which the condition had existed.

Dr. STCLAIR THOMSON supported Dr. Bronner in his remarks. Within the last three weeks he had had under his care a case in which marked deformity was present. He had operated on one side of the nose, and more or less completely cleared it of polypi, and left the other alone. In the former the condition subsided, and in the latter it remained unaltered. In his (Dr. Thomson's) case the nose was so distended that there was a separation between the nasal bone and the nasal process of the superior maxilla on each side. The difference between the two sides was remarkable even after a few days.

Dr. DONELAN thought from the first that the ethmoidal sinuses were certainly affected, and after the first curetting it became obvious that they were so on both sides. The left antrum was also affected, but he did not think the frontal sinuses were. The deformity was due, he thought, to the pressure of the mass of the growth. It was four years since the nose was completely cleared, and, as far as the patient could tell, there was no improvement in the deformity; there certainly was not any since it was cleared before Christmas last.

## A FATAL CASE OF EXOPHTHALMIC GOITRE.

Shown by Dr. DONELAN. The patient, an Italian girl æt. 16, was admitted into hospital on December 20th, 1900. There was no family history of goitre, and no history of any previous illness of importance. In September, 1899, the history begins with symptoms of palpitation, oppression, and dyspepsia, which were relieved by treatment and never caused much inconvenience. In September, 1900, during her father's absence she lived with some relatives who treated her cruelly, and on one occasion seized her by the throat and nearly strangled her. She had noticed no previous enlargement of the throat, but from that time the growth of the thyroid was rapid and continuous.

She first attended the hospital on December 14th, 1900, when she complained of the ordinary symptoms of exophthalmic goitre.

There was considerable thyroid enlargement, the neck measuring fifteen inches, moderate exophthalmos, a rapid pulse (140), and a mitral systolic murmur without apparent loss of compensation. She was advised to rest and to take a mixture containing ten minims Tr. Belladonnæ and five minims Tr. Digitalis. She rapidly became worse, and was therefore admitted into the hospital on December 20th. She had tremors affecting the head, neck, and thumbs, violent cramps of limbs and body lasting five to seven minutes, vertigo with a tendency to fall to the left, marked retinal pulsation, and traces of optic neuritis.

Von Graefe's sign was present, but Stellwag's absent. The pulse rate gradually increased from 140 to 160; nervous vomiting became persistent on the fourth day; finally she became comatose, and when with difficulty roused she complained of intense headache. She died, apparently of heart failure, on the sixth morning after admission.

The treatment consisted of belladonna and digitalis as before until vomiting became persistent. Citrate of potassium as recommended by Dreschfeld failed to check this, and rectal feeding was carried out, and ice applied to head and spine.

Extract from report of post-mortem made by Dr. Pareira:—"Brain intensely congested. Cerebellum very large and congested. Pineal gland much enlarged. Careful sections failed to show any other abnormality in these organs or in the medulla. Cervical sympathetic atrophied, thoracic normal. Thyroid gland much enlarged. Trachea much compressed though dyspnœa had not been present. A few small cysts in thyroid. Thymus gland persistent and much enlarged. Stomach atrophied. Uterus ill-developed and infantile. No corpora lutea in ovaries."

Dr. Donelan did not consider this disease was due to the fright caused by the assault, though doubtless the symptoms were thereby accelerated. There were evidently symptoms a year before, pointing to the commencement of the condition which, when thoroughly established, is called exophthalmic goitre. Without reviewing the various theories that had been put forward to account for this group of symptoms, the exhibitor desired to call attention to an important pathological feature, namely, the persistence and enlargement of the thymus gland. This persistence is found in practically every fatal case in

which it is carefully looked for, and enlargements may also occur as in the present instance. He would not presume to add another to the existing theories, but he thought the pathology of the disease had to be sought for in an earlier period of life. The thymus gland is a fœtal structure disappearing normally *pari passu* with the development of the thyroid. Its persistence is obviously evidence of an abnormal condition occurring in infant, if not in uterine, life. Evidence should be collected with a view to showing whether the failure of the thymus to undergo the normal retrogression reacts on the thyroid gland and nervous system through the medium of the blood in such a way as ultimately to produce these well-known symptoms.

Sir FELIX SEMON said it was new to him to learn that in cases of exophthalmic goitre one almost regularly found an enlarged thymus. He would like to ask Dr. Donelan to give more information on that interesting point.

Dr. DONELAN said, in reply, that he had just lately looked up the literature of the subject, and, as far as he was able to ascertain, it was generally mentioned that the thymus gland was persistent in the majority of cases. Some authors, amongst whom might be mentioned Osler, said it could be found in *all* cases if carefully looked for. Up to the present no pathological changes had been described as occurring in the gland. He thought the association of the enlarged thymus with subsequent increase in the thyroid was a point to be noted for further investigation. It might have something to do with the real cause of the disease. The thymus in this case was, he believed, unusually large.

## SPECIMEN OF MUCOUS PATCH ON THE TONSIL.

Shown by Dr. WYATT WINGRAVE. The section conforms to the classical descriptions of histological details, in that the stratified surface epithelium is considerably thickened, and exhibits all stages of necrosis, from simple cloudy swelling to complete vacuolation and disintegration. The nuclei are broken up into granules, while the protoplasm remains clear and liquefied, but the invading leucocytes are few and multinucleated.

The subjacent structures exhibit but slight activity beyond distension of the lymph spaces and multiplication of the mononucleated lymphocytes.

## Cutting Trephine for operating on Spurs and Deviations of the Nasal Septum.

Shown by Dr. Bronner. This trephine was used in conjunction with Spiesz's nasal speculum. The short blade of the speculum was placed in front of the spur, and the long blade over the lower turbinated bone. The trephine was worked by an electro-motor. The operation could be performed with cocaine or eucaine, and was practically painless. Spurs and deviations of the nasal septum were very common, and caused nasal obstruction, preventing the passage of the Eustachian catheter. The lumen of the trephine was about the same size as that of the largest intubation tube. Messrs. Down and Co. were the makers of the trephine.

The President thought Dr. Bronner's trephine was about the best form of such instruments to use, especially with the speculum shown, and the Society was indebted to the exhibitor for bringing it forward. Personally he always preferred a saw, and used a straight and not an angular one, because the latter "locked" so easily. After anæsthetising locally, a line was marked with the galvanic cautery where the sawing was to take place. This diminished the hæmorrhage, especially if a solution of supra-renal capsule were also used. He did not think that, theoretically, a circular trephine was the best instrument to remove a spur from a flat surface like the septum, although in practice it might answer perfectly.

Dr. StClair Thomson wished to elicit the opinion of members who had tried both the trephine and the saw. He himself had no experience of the trephine, but he had heard complaints of it "jamming," and of its liability to stop suddenly. Would those members who had tried both say whether they were in favour of the trephine?

Dr. William Hill had used the nasal trephine, with and without serrated edges, a great deal in times gone by. It, unfortunately, did not leave a really level surface, even when several pieces were removed. He therefore generally used a saw now, but he often felt that if he had a dental engine or motor ready at hand he would use a trephine, on account of its being more expeditious and less painful than the saw.

Dr. Herbert Tilley pointed out how very efficiently a nasal spur may be removed if a deep groove be first made with an intra-nasal saw, and the "spokeshave" then applied behind the groove and rapidly withdrawn. The cutting edge keeps accurately in the groove already made, and a flat surface is left upon the septum. This

method can be used for bony and cartilaginous spurs, but in the first case a deeper groove should be made with the saw. In a fairly tolerant patient the operation could be performed with cocaine alone.

Dr. BRONNER, in reply, said in using the trephine the "jamming" was not so great as with the saw if a sufficiently powerful motor were used. It was practically painless with cocaine or eucaine, and the quicker the instrument rotated, the less was the pain caused. In treating a deviated septum it was often necessary to apply the trephine twice, in order to remove a sufficiently large piece of cartilage. The cartilage in these cases was generally very thick.

## CONGENITAL SYMMETRICAL GAPS IN BOTH ANTERIOR PILLARS OF THE FAUCES, WITH COMPLETE ABSENCE OF TONSILS.

Shown by Sir FELIX SEMON. The patient was a girl æt. 11, who was seen by the reporter on September 28th, 1881. There was a tubercular family history, and the patient herself was very strumous-looking. She was brought to the hospital on account of naso-pharyngeal catarrh.

On examination of the throat two large ovoid gaps were seen to extend almost through the entire length of the anterior pillars of the fauces. They were perfectly symmetrical, and their edges were absolutely soft. Nowhere in the throat was there any evidence of scarring. A probe introduced through either of these gaps entered into the niche reserved for the tonsils. There was, however, not the least trace to be seen of any tonsillar tissue in these receptacles on either side. Neither mother nor child knew anything of the existence of the abnormality.

His reasons for considering the defect in the light of a congenital arrest of development were not merely the absolute symmetry of the gaps, and the absence of all scarring as well as of any history of ulcerative disease, but particularly the complete absence of the tonsils.

On looking through the literature at his disposal he has found that in three out of about twenty cases of an analogous kind, noted in the 'Internationales Centralblatt für Laryngologie' since 1884, a similar absence of the tonsils was expressly reported.

This fact seemed to him very striking, and considerably added

to the view that these gaps must be regarded as a result of arrested development, a view in which most of the observers who had seen similar cases agreed. Possibly they may represent the inner openings of incomplete branchiogenous clefts, a possibility which Chiari suggested when describing a case of this sort in 1884 ('Monatsschrift für Ohrenheilkunde,' August, 1884), although he then admitted, as the reporter does now, that a fully satisfactory explanation cannot yet be given. (The reporter is indebted for the drawing accompanying this description to Mr. E. Waggett, who has very kindly drawn it on an enlarged scale from a sketch made at the time.)

The PRESIDENT said it looked undoubtedly like a case of malformation.

Dr. STCLAIR THOMSON said that in calling the case "congenital," Sir Felix Semon had anticipated the decision of the question. In his opinion it was a doubtful point, and until a similar condition was detected in early infancy the question would remain open. It was new to him to hear of the absence of tonsils in this condition, and he briefly narrated the particulars of symmetrical gaps in a woman in whom the tonsils were still remaining. Since the last meeting he had seen two cases; one was bilateral and symmetrical, and had some slight scarring on the pharynx, though there was no previous history pointing to ulceration. The other case occurred in a medical man, who was willing to come to the Society. He had a gap on one side only, which had existed as long as he could remember. He has never had scarlet fever or syphilis.

## CASE OF SEROUS CYST OF INFERIOR TURBINATED AND FLOOR OF THE NOSE.

Shown by Dr. H. J. DAVIS. This patient, a woman æt. 25, has suffered from graduallv increasing nasal obstruction for some years. Ten days ago, when she came to the Middlesex Hospital, there appeared to be a marked hypertrophy of the anterior end of the right inferior turbinate, the floor of the nose being involved in the swelling, which was as large as a pigeon's egg, and was firm and resistent to the probe.

The tissues did not shrink under cocaine, and the swelling being mistaken for a growth an attempt was made to remove a piece for examination, which failed. An aural paracentesis

knife was then passed into the upper part of the swelling; a jet of greenish clear fluid spurted out of the nostril, and the swelling rapidly and entirely collapsed.

The cyst is slowly refilling, and can be seen as a fluctuating projection in the floor of the nostril. The patient has had no further treatment beyond the primary puncture.

Dr. MacBride thought the case must have been of great interest before the cyst was evacuated. He believed himself to have been the first to describe this form of cyst a number of years ago. To him the special point of interest was the origin of such cysts; it was difficult to imagine where they could originate. Had Dr. Davis formed any theory as to the causation? He might mention that Dr. Brown-Kelly, of Glasgow, had found glands with very long canals in this region of the nose, which he thinks may explain the occurrence of cysts. One of his (the speaker's) earlier cases kept on refilling, and had to be dissected out by raising the upper lip.

Dr. Davis, in reply, said he had considered the origin to be due probably to retention of secretions in one of the glands—a retention cyst, in fact. In this case the cyst was much more prominent two days ago, but the woman had had some sanious discharge from the nose that day, and it had again collapsed. If one looked carefully, one saw that the under surface of the inferior turbinate had been expanded, and the cyst was evidently of considerable depth beneath that bone.

## Case of Mucocele of the Frontal Sinuses.

Shown by Dr. Lambert Lack. This boy has already been shown at the Ophthalmological Society before operation. There is marked divergence of the eyes, and the bridge of the nose is widely distended, especially on the left side. When he first saw the case the mass of the growth seemed bony, but there was a fluctuating area at the upper and inner corner of both orbits. The history was four years' duration with steady increase. The diagnosis—mucocele of the frontal sinuses with dislocation downwards and outwards of both lachrymal bones—was confirmed by operation. The left frontal sinus was enormously distended, its anterior bony wall being practically absorbed, its cavity extending backwards and inwards behind the right frontal sinus, and downwards in the direction of the infundibulum. The mucoid contents were evacuated, and a large opening made through into the nose and maintained by a

plug which is still worn. This sinus is now secreting pus, but is becoming more dry, and as the opening into the nose is probably permanent it may be possible to shortly close the external wound. The right sinus was smaller, and an attempt was made to obliterate it without making a communication with the nose, but it has not yet healed. The infundibulum on the left side was probably first obstructed, and the right infundibulum obliterated by the pressure of the expanding left sinus. These cases are rare, and I should be glad to receive any suggestions to hasten the cure.

Dr. HERBERT TILLEY thought, considering the long duration of the treatment, and the nature of the operation already performed, that nothing short of a further radical operation offered any prospect of cure. He therefore suggested that, as the patient was a growing lad, and as much of the present deformity would be permanent, a more extensive removal of bone was indicated.

Dr. MACBRIDE asked Dr. Tilley to explain exactly how he proposed to proceed. The left frontal sinus was of very great depth. This case was just one of those where the frontal sinus was so deep that it seemed to him that the method proposed by Dr. Tilley practically amounted to performing Kuhnt's operation, but then the upper wall of the orbit would have to be removed; if the soft parts were allowed to fall in on the sinus, there would still be a considerable space which could not be filled up or covered. He thought there must be a cavity left owing to the depth of the sinus. He had operated on a good many frontal sinuses, and he found those described in the text-books were perfectly easy to deal with; but in a large proportion of cases one had cavities containing pus behind the orbit, and one could not let the soft parts fall in in such cases

In answer to Dr. MacBride, Dr. TILLEY said he would propose a horizontal incision over the lower central part of the forehead, which should join the incisions already present and partially healed. The soft tissue covering the lower part of the forehead could then be drawn upwards, and a complete removal of the anterior bony walls of both sinuses carried out. The septum could simultaneously be removed, and so allow the soft parts to fall on to the posterior walls of the sinuses, and bring about their obliteration. The receding angle between the roof of the orbit and the lower part of the posterior wall would, he thought, fill up with granulation tissue, which would eventually organise; and even if a small cavity eventually remained in this position, it would probably be harmless if free drainage into the nose was secured. In such a growing lad the deformity, he thought, would not be greater than at present, and it was obvious that something must be done to ameliorate the present condition of things.

The PRESIDENT said that it seemed to him that the only way of obliterating the sinus was by Kuhnt's operation, which consisted in the removal of the whole of the anterior wall except about an

eighth of an inch along the supra-orbital ridge. The periosteum and skin should be carefully stitched down, a rubber tube, projecting at the inner angle, being kept in the wound. Granulation tissue would form and obliterate the sinus. This must leave a certain amount of depression. The case he had done and shown to the Society was satisfactory as far as the result was concerned. The case was one of a large mucocele, and if the same procedure were carried out in the case under discussion he thought the patient would get equally well.

Dr. VINRACE inquired what were the urgent symptoms demanding operation, and suggested it might have been better to leave the case longer before proceeding to such grave surgical measures.

CASE OF PERSISTENTLY RECURRING NASAL POLYPUS WITH SUPPURATION IN FRONTAL AND ETHMOIDAL SINUSES; OPERATION; RESULT.

Shown by Dr. LAMBERT LACK. This patient is shown as a contrast to the case exhibited by Mr. de Santi at the last meeting of the Society, which I take it was intended as a direct challenge to me. The two cases are very similar. This patient had had polypi for many years, commencing when she was about fifteen, accompanied by profuse sinus suppuration, and for three years had had them removed as often as every fortnight, but in all that time had been unable to breathe through her nose. Two years ago when I first saw the patient I scraped out the nose under gas. The operation had to be done as an out-patient, and therefore was not so thorough as I could have wished, but in spite of this the patient has had free nasal respiration ever since. On three occasions small pieces have subsequently been removed with a snare, but now for more than two years there has been no return of the polypi. After the operation the discharge from the nose also greatly lessened, but did not completely cease until the frontal sinuses had been obliterated. This operation, which I always recommend where practicable, as I believe it to be the only sure curative measure, entails the complete removal of both the anterior and inferior walls of the sinus, but in spite of this the deformity may be scarcely noticeable, as this case shows. My experience of this operation makes me think that a deformity such as occurred in the case Dr. Tilley showed at the last meeting is quite exceptional.

Dr. StClair Thomson thought the case showed the necessity for care in specifying beforehand the amount of relief we might secure, and how we should be slow to claim a complete cure in these cases. There was a distinct fœtid odour from the nose of this patient; although she had washed out her nose twice already that day there was pus in each middle meatus; and she informed him that although the operation had been done nearly two years ago, she still had to syringe her nose three times a day. Now both Dr. Tilley and he had shown completed cases of operation for frontal sinusitis at the last meeting, but candour compelled him to say that neither of them was then completely cured. In Dr. Tilley's case there was some pus in the middle meatus. His own patient had washed out his nose in the morning before coming to the meeting, and by 5 o'clock the secretion had not accumulated in such quantity as to be distinctly evident. This secretion could not possibly come from the frontal sinus, as he (Dr. Thomson) had seen that the fronto-nasal duct was quite obliterated before allowing the operation wound under the eyebrow to heal up. It must, therefore, have come from the ethmoidal cells, and these had, since last meeting, been well curetted; a slight crust of dried mucus still formed over them, but the patient did not require to syringe his nose more than once a week. In Dr. Lack's case there was distinct pus, though doubtless the patient's sufferings had been greatly relieved.

Dr. Herbert Tilley was surprised to hear (for the first time) that the case he showed at the last meeting was not a complete cure, and he ventured to think that Dr. Thomson had some other case in his mind. Dr. Lack had spoken of his case as a cure, and in spite of dissenting opinions the speaker was inclined to agree with him if the word was not too rigidly applied. In the case referred to, no pus came from the sinuses, but one or two ethmoidal cells were not clear from disease, and they would probably cause little trouble. This led to the question asked by one member, "When is a surgeon justified in advising an external radical operation upon a chronic frontal sinus empyema?" Dr. Tilley thought the answer mainly turned upon the patient's views on the subject, and cited a case under his care for the last two years of a young engineer, who was just beginning to get on in his profession. This patient had applied to him on account of nasal obstruction, purulent discharge, a chronic headache, and inability to concentrate his mind on his work. The nostrils were full of polypi, and pus flowed freely from both frontal sinuses. On irrigation by the right fronto-nasal canal the fluid returned from the left nostril, demonstrating a septal perforation allowing free communication between the sinuses. In due course all the polypi were removed, also the middle turbinals on both sides, and a quantity of the ethmoidal cells. The patient (who was seen six weeks ago) says he is "cured" because his headaches have gone, he feels quite well, the discharge has "practically ceased," and he only uses one handkerchief a day. Examination of the nasal cavities reveals a drop of pus at the lower end of each fronto-nasal canal, and the speaker thought that he was not justified in advising a radical operation under such circumstances, for the patient was really in very little danger,

and not inconvenienced by his condition. The speaker thought that in such cases the nose should be merely cleansed once or twice daily, and nothing else done. Contrariwise, if the individual was of a nervous disposition, and could not tolerate the occasional appearance of a streak of pus from the nose, he then explained the nature of the operation, its chances of success, the possibility of a small scar, etc., and left the patient himself to settle which course he would pursue.

Sir FELIX SEMON said Dr. Tilley had raised a very grave and important question, which he was very glad had been brought forward. The question was, when ought one to perform a radical operation in these cases? Belonging to the seniors, he did not wish to be considered as opposing the progress of the times. It was a great achievement that they could diagnose these cases better, and so treat them more successfully than in the past by these big radical operations; but, on the other hand, he looked back over a period of twenty-five years, which had been devoted to special practice, and within that period he had seen plenty of these cases, and, so far as he knew, very few of them had come to grief prior to the discovery of these modern forms of treatment. No doubt there were a *few* cases in which threatening symptoms, such as severe headache, coma, meningeal troubles, and other complications, had arisen from a misunderstanding of their original cause, and from want of radical treatment; but how few were and are such cases! Looking at the question from another point of view, he asked whether a really complete and lasting cure could be promised in every one of these cases after a so-called radical operation? He had seen a good many of Dr. Tilley's cases, and most heartily congratulated him on the results, but he had also seen other cases—and he was not the only one who had—in which after the performance of a radical operation suppuration still continued; further operations had become necessary, and the patient finally was not much better off than before. This fact had been brought forward before in the Society. He was particularly anxious not to be thought incapable of seeing anything good in things new, but really, in his opinion, it was a matter deserving very great consideration as to whether the discovery of a little pus coming from the frontal sinus demanded radical operation in every case. He thought the surgeon was bound to tell the patient that the big operation occasionally left some deformity.

Dr. FITZGERALD POWELL had been much interested in this discussion, which to a certain extent had somewhat relieved his mind, as it appeared to him that the tendency of late was to rush to the performance of this rather serious operation as soon as pus was seen in the nose. He had at the present time a case in his hands, in which it had occurred to him that the radical operation should be done. The patient was a young woman who had suffered from all the signs of "frontal sinusitus" in a marked degree. He suggested to her the radical operation, also putting before her the possibility of deformity. As she was about to be married, she decided not to undergo the operation. At several sittings he removed as much as possible of the middle turbinate and freed the infundibulum, afterwards washing out the sinus. The patient was now perfectly free from pain and

frontal headache. She used a nasal douche, and was quite comfortable. Every now and then a small quantity of pus appeared in the nose, which caused little or no inconvenience. This case fully illustrated the safety and propriety of leaving the radical operation alone.

Dr. DONELAN asked Dr. Lack what proportion of these cases underwent spontaneous cure. He had a case under his care about a year ago, in which a young man aged twenty-four had distinct suppuration of the right frontal sinus, and arrangements were made to operate. Before it could take place the discharge came away. He washed out the nose, and the patient had remained perfectly well since.

Dr. VINRACE wished to know how long would Dr. Lack wait, after freeing the nostrils from polypi, before proceeding to undertake one of these terrible operations.

Dr. LACK, in reply, said he thought Dr. Thomson a little hypercritical. He saw no reason for continuing treatment, as the patient was practically well and had ceased attending him for nearly a year. The indications for external operation on the frontal sinus were rather indefinite. He recommended operation whenever the disease caused symptoms producing serious inconvenience. When the only symptom was slight purulent discharge he thought the cases best left alone. He always in the first instance adopted intra-nasal methods to the extent of removing the middle turbinate, opening the anterior ethmoidal cells, etc., and thoroughly clearing the approach to the infundibulum, so as to allow the sinus to drain freely into the nose. If this failed to give relief he operated externally, and always endeavoured to obliterate the sinus, as he believed it the only certain method of obtaining a cure. Personally he did not believe in the possibility of making a definite diagnosis except by opening the sinus, and thought many of the cases cured by intra-nasal operations, such as opening up the anterior ethmoidal cells, were really cases of ethmoidal cell disease, but this was only an additional argument for carrying out thorough intra-nasal methods before adopting external operation.

## PAPILLOMATA REMOVED FROM LARYNX BY ENDOLARYNGEAL METHOD.

Shown by Dr. HERBERT TILLEY. The patient was a lad æt. 4½ years, who was brought on account of difficulty of respiration and hoarseness. The former was so marked that the night previous to operation the patient was nearly asphyxiated. It was deemed advisable on account of the dyspnœa to perform a preliminary tracheotomy. Four days after this the endolaryngeal operation was carried out. The patient was chloroformed by Dr. Hewitt, and held in a sitting attitude; it was then quite

easy to remove a few growths before the returning laryngeal reflex and acts of swallowing rendered a further deepening of the anæsthesia necessary.

By this means the growths were removed, and the voice returned for six months, when increasing hoarseness necessitated a second operation. On this occasion only a few growths were present, and were easily removed.

The speaker emphasised the ease with which the operation could be performed when the anæsthetic was skilfully given in the sitting position.

### Case of Epithelioma of Tonsil with Extensive Glandular Involvement in a Middle-aged Man.

Shown by Dr. Dundas Grant. The typical epitheliomatous ulcer extended over from the tonsil on to the soft palate and anterior pillars, involving also the adjacent portion of the base of the tongue. There is also a large hard mass of glands in the neck. Dr. Grant presumed that the members of the Society would agree that the case was beyond operation. A coloured drawing by Dr. Mackintosh showed the characters and extent of the ulcer most perfectly when first seen. Since then a mass out of the centre of the growth had sloughed away, giving the patient very great relief.

Sir Felix Semon remarked that, in his opinion, it was not a case for operative interference.

### Microscopical Portion of Vocal Cord removed by Means of Jurasz's Punch Forceps from the Vocal Cord of a Gentleman æt. 61.

Shown by Dr. Dundas Grant. The patient was the subject of huskiness of the voice which commenced with influenza between seven and eight months before he was seen, gradually increasing in severity. On laryngoscopical examination there was seen in the middle third of the left vocal cord a granular outgrowth of a reddish-pink colour, internal to which was an excavation, the floor of

which was moist and of a yellowish colour. The larynx was otherwise normal, and there was no impairment of mobility of the vocal cord. There was a history of primary specific inoculation in youth, and of a consolidation of the apex of the right lung in early middle age, the pulmonary trouble having apparently completely subsided. An examination of the morning sputum was made by a skilled bacteriologist, who in the first film found two bacilli which stained like those of tubercle; numerous subsequent examinations of the sputum were in that respect entirely negative, and the bacteriologist came to the conclusion that there was not sufficient evidence on which to found a diagnosis of tubercle. Mercurial inunction and iodide of potassium were without the slightest effect, and the great probability was, therefore, that the disease was epitheliomatous, although the appearance was not absolutely typical. A highly skilled *confrère* considered that the evidence pointed also in this direction, and that the removal of a portion by endolaryngeal methods or the opening of the larynx was called for. Dr. Grant removed a large portion by means of Jurasz's forceps, but in none of the sections removed was there any appearance in the least suggestive of epithelioma. The growth seems, therefore, to have been entirely composed of inflammatory tissue, and the patient at present suffers only from the interference with his voice, which is due as much to the use of the forceps as to the disease itself. He is rapidly improving.

### Case of Glottic Spasm in a Young Woman æt. 24.

Shown by Dr. Dundas Grant and Mr. Mackintosh. Mr. Mackintosh was called to see the patient on account of a suffocative attack, the onset of which had been quite sudden; there was no previous hoarseness, but the patient had experienced uncomfortable choking sensations in the throat; there was a harsh brassy cough, the voice was husky, and there was occasionally stridulous inspiration. The suffocative attack rapidly and completely subsided, but the slight huskiness of the voice persisted. On laryngoscopic examination there was no œdema of the framework of the larynx; the vocal cords were slightly

congested; the most marked feature was swelling of the lingual tonsil, in which there were numerous patches of exudation; there was also a distinct enlargement of the thyroid gland. Next day Drs. Grant and Mackintosh examined the patient together at the Central London Throat and Ear Hospital. The larynx was then free from any sign of inflammation; the swelling of the lingual tonsil had considerably subsided, and there were elicited such stigmata of hysteria as comparative hemianæsthesia of the right side, and diminution of pharyngeal and nasal reflex. The treatment ordered was bromide of potassium. The case was, therefore, considered one of hysterical glottic spasm, the acute lingual tonsillitis being a factor in the exciting causation.

Mr. Mackintosh called attention to the defective condition of the teeth, the whole of the upper set being represented by a row of foul blackened stumps which, in view of recent investigations, he thought might act as a producing factor.

Sir Felix Semon was not convinced that the local cause excited the spasm. He asked whether the lingual tonsil could be responsible for hemianæsthesia and paralysis. From the symptoms he personally would have great doubts as to the local cause.

Dr. Herbert Tilley related a case of glottic spasm in a particularly healthy-looking man (a butcher) aged forty-two. During the speaker's examination of the patient's throat a sudden suffocative attack ensued, the patient fell from his chair, and seemed in imminent peril of asphyxiation. A long-drawn inspiration terminated the attack, and the patient was quite well again. It seemed probable that the great irritability of the pharynx and larynx was due to excessive cigar smoking, because while avoiding tobacco for two months he had no attack. At the end of this period he had a similar attack ten minutes after smoking his first cigar.

### Case of Innocent Growth on the Right Vocal Cord.

Shown by Dr. Wm. Hill. The patient was a woman æt. 48, with a small red, innocent growth, springing from the upper surface of the right vocal cord near its anterior extremity, and slightly projecting into the glottic space, thereby causing hoarseness; this symptom had lasted about one year. The larynx at present was extremely intolerant to intra-laryngeal instrumentation. Unfortunately the patient was from the country, and occupying a bed in hospital which should be placed

at the disposal of a more serious case; under the circumstances, he wished to know the opinion of members as to whether he could, with any confidence, send the patient back to her doctor in the country (who was a skilled laryngoscopist), with the suggestion that the growth should and could be eradicated by applications of salicylic acid (5 per cent. in alcohol). He had no personal experience of the treatment, and hearsay evidence as to its value had been conflicting.

Dr. DUNDAS GRANT thought it a pediculated growth which habitually lay underneath the vocal cord. During the action of phonation it was forced up between the cords by the expiratory blast, and it seemed to him that as soon as the patient drew a breath it entirely disappeared. He thought that to apply salicylic acid or any other chemical would be a waste of time. The growth could be most easily removed by operation.

Dr. LACK said he had never seen any good result from the use of salicylic acid.

Dr. BRONNER thought formalin much more efficacious than salicylic acid, but in the present case the forceps should be used.

Dr. FITZGERALD POWELL said, in view of the intolerance of this patient's larynx to operative measures, he would recommend swabbing the larynx with a solution of perchloride of iron as likely to cause the disappearance of the growth, which was a very small one, and appeared to him to grow from the upper surface of the cord, and not from below. He had not infrequently seen these small growths disappear under the systematic employment of this treatment.

Dr. VINRACE asked Dr. Hill if he thought it would be advisable to nip the growth off.

Dr. HILL, in reply, was glad to get an expression of opinion on the salicylic treatment. When the larynx had been educated to tolerance the growth could be removed easily enough with forceps, but that would take a long time, he feared, in this instance.

## A LARYNGEAL CASE FOR DIAGNOSIS.

Shown by Mr. ATWOOD THORNE. The patient, a man æt. 43, came to St. Mary's Hospital, on January 19th, in a very excited condition, complaining that while drinking a cup of cocoa he felt great pain in the throat, and he thought he must have swallowed some broken china or something.

Owing to the patient's excitement the house surgeon was unable to get a good view of the larynx, but finding a slight wound on the tip of the epiglottis was inclined to believe that

some sharp substance had been swallowed, or had entered the larynx.

When seen on the 21st the cricoid cartilage was found to be swollen, the left ventricular band much crumpled, and in the arytænoid space was found a collection of muco-pus, and on removing this a gaping scar, as of a burst abscess, was visible.

There is no indication of tuberculosis in the lungs, but there is a history of syphilis dating back twenty-two years.

The wound of the epiglottis may have been due to an over-enthusiastic dresser passing a probang.

Dr. DUNDAS GRANT said the man had occasional loss of voice. Both vocal cords moved perfectly well, but there was an extraordinary swelling of the left ventricular band. It was one of those cases in which at times the swelling either acts as a damper by pressing on the vocal cord, or interferes with the production of tone by getting between the cords. If the trouble was sufficiently serious to justify the introduction into the larynx of a cautery, he would recommend cauterisation of the ventricular band.

Mr. ATWOOD THORNE said, in reply, that the ventricular band was certainly much swollen. The interest of the case, however, lay in the fact that the man had a pain in the throat directly after drinking a cup of cocoa, and thought he had swallowed a piece of china, and on examination two days after a recent scar was seen in the inter-arytænoid space.

## CASE OF SUPPOSED EPITHELIOMA OF THE LARYNX.

Shown by Drs. DUNDAS GRANT and WYATT WINGRAVE. J. C—, male æt. 53, a piano-maker, was first seen on December 11th, 1900, complaining of loss of voice of twelve months' duration, commencing with slight huskiness and gradually becoming more marked; there had been no pain except on vocal effort; deglutition was normal; there was no cough, but lately occasional dyspnœa, especially on exertion, accompanied by inspiratory stridor. He had lost two stone within twelve months. There was no personal history of syphilis or tuberculosis. His wife is tubercular, and he has lost two children with phthisis. The sputum is scanty, and no tubercle bacilli could be found, the chest, beyond a slight emphysema, appearing to be normal. In the larynx there was seen a granular fringe along the whole length of the right vocal cord, and to a slighter extent below

the most anterior portion of the left cord. The right half of the larynx was completely fixed, and some thickening was felt over the right ala of the thyroid. The opinion of the exhibitors was that it was a case of epithelioma, and they were desirous of having opinions as to whether a portion of the growth should be removed for examination, or the exploration effected by thyrotomy; they hesitated about removing a portion without receiving the patient's consent to a partial or complete extirpation of the larynx, should the diagnosis be confirmed.

Sir FELIX SEMON was not firmly convinced of its malignancy. Exactly the same appearance might be produced by either syphilitic or tuberculous infiltration. He certainly had seen malignant cases where there was very little more evidence than in this case, but he did not think the appearance absolutely typical. He would not feel justified in removing the larynx, but he thought an exploratory thyrotomy quite justifiable.

Dr. DUNDAS GRANT said there was no evidence of tuberculosis in the chest and sputum. The man had not been put upon iodide of potassium, but there was no history of syphilis. Was it a case in which one should remove a piece for examination, or do an exploratory thyrotomy? If it was malignant, and any operation was to be done, the sooner the better. That was the position of the case.

# PROCEEDINGS

OF THE

# LARYNGOLOGICAL SOCIETY OF LONDON.

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SIXTY-FOURTH ORDINARY MEETING, *March 8th*, 1901.

E. CRESSWELL BABER, M.B., President, in the Chair.

ERNEST WAGGETT, M.B.,
CHARLES A. PARKER, F.R.C.S.(Ed.), } Secretaries.

Present—30 members and 4 visitors.

The minutes of the preceding meeting were read and confirmed.

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

Wilfred Glegg, M.D., M.R.C.P.(Edin.), Throat Hospital, Golden Square, W.

The following cases and specimens were shown:

## A CASE OF MALIGNANT DISEASE OF THE LARYNX IN A MAN ÆT. 47, TREATED BY THYROTOMY AND REMOVAL OF THE DISEASED AREA, SHOWN SEVEN MONTHS AFTER OPERATION.

Shown by Sir FELIX SEMON. Mr. F. J. B—, æt. 47, was sent to me on July 4th, 1900, by Dr. Maguire, of Stoney Stratford. He had been suffering from hoarseness for several months past. This was the only symptom.

On examination the right vocal cord was found to be much tumefied in the middle part and ulcerated in front, the ulceration extended into the subglottic cavity, and the mobility of the cord was much affected; the left side was quite free. Iodide of potassium failed to exercise any effect, and thyrotomy was performed on July 16th, 1900. When the larynx had been opened, it was found that the new growth was a good deal more extensive than it had appeared from laryngoscopic examination. It not only occupied the whole right half of the larynx, completely destroying the right vocal cord, but also extended below the anterior commissure to the front part of the subglottic cavity, and attacked the front part of the lower surface of the left vocal cord. On the other hand, it was well circumscribed. When the growth was removed it was found that it deeply infiltrated the thyroid cartilage, both on the right side of the subglottic cavity and on the left side of the anterior commissure. It was removed together with an area of apparently healthy tissue, and the parts were very energetically scraped, so that everywhere healthy cartilage was visible. Considering the condition just described, the chances with regard to recurrence appeared rather doubtful. The parts removed were examined by Mr. Shattock, who reported that the growth was a typical squamous-celled carcinoma. The patient made an uninterrupted recovery, and returned home on July 26th, ten days after operation.

Four months later Mr. Cecil Powell, of Stoney Stratford, reported for Dr. Maguire that the patient was getting on very satisfactorily, his general health had much improved, he had gained in weight, and the voice, which had been quite aphonic, had slightly increased in strength.

When I saw him on February 11th, *i. e.* seven months after operation, he was, as he is now, in excellent health, there being not the least trace of recurrence, and the voice, although still hoarse, had gained a good deal in strength since the operation. On phonation the remnant of the left vocal cord somewhat crossed the middle line, but only in front reached the cicatricial ridge which replaces the removed right vocal cord.

The PRESIDENT, on behalf of the Society, congratulated Sir Felix

Semon on the success of his case; the result was most satisfactory, and the patient had a wonderfully good voice.

Mr. P. DE SANTI asked Sir Felix Semon the percentage of absolute recoveries in the cases on which he had operated. He knew the general percentage, but it would be interesting to hear what were his individual figures.

Sir FELIX SEMON hoped the voice would continue to improve. His experience was that the improvement continued up to the end of the first year, and even after that in some cases. In reply to Mr. de Santi, he said his last cases, namely those of the past eighteen months, had not been tabulated, but excluding these his permanent cures were 83·3 per cent.

## SPECIMEN OF RETENTION CYSTS OF THE LYMPHOID FOLLICLES OF THE VALLECULA.

Shown by Mr. H. BETHAM ROBINSON. This specimen was removed from a healthy man æt. 25, who complained of a lump in his throat and occasional pain in the neck.

On examination, both by means of the tongue depressor and the laryngeal mirror, some whitish *lumps* were seen at the base of the tongue, standing out above the level of the mucous membrane, and situated about the outer margin of the vallecula; on the right side was a single large one, the size of a sixpence, and on the left side were three smaller ones.

Under cocaine they were removed with scissors and forceps.

The histological examination of these growths corroborates the clinical diagnosis. They consist of tonsillar tissue with retained products in the follicles.

The specimen seemed to him worth bringing to the notice of the Society, as he could not find any record of this condition.

## CASE OF CHRONIC LARYNGITIS WITH THICKENING OVER THE CRICOID POSTERIORLY.

Shown by Mr. H. BETHAM ROBINSON. The patient, a man æt. 44, complained of aching pain at the back of the neck and some pain on swallowing. There was no history of tubercle or syphilis; no cough, and no loss of flesh. His voice was husky and weak. There was general chronic laryngeal catarrh, with

marked thickening of soft parts in the middle line posteriorly, and also definite subglottic thickening of the true cords.

Under the application of chloride of zinc all the symptoms and signs of catarrh had disappeared, with the exception of the posterior thickening.

## Two Cases of Recent Perforations of the Septal Cartilage.

Shown by Mr. H. Betham Robinson. The first case was of tuberculous origin, and occurred in a lad æt. 20, who first noticed both his nostrils blocked in January, 1899. After a little while there was discharge from the right nostril, and later from the left. There was no pain except when the nostrils were completely blocked by crusts.

At the beginning of February, 1901, he was found to have a circular perforation in the septal cartilage, with thickened margins covered by grey watery exuberant granulations. These were curetted away, and lactic acid, 20 per cent., rubbed in, after which iodoform ointment was applied. He had very much improved under this treatment.

The second case occurred in an engine-driver, æt. 43, who complained of discharge from right nostril.

When first seen there were black crusts on either side of the cartilaginous septum, but no evidence of a perforation could be discovered by means of a probe. On the left side there was a small angular spur.

Over the right temple was a small indurated spot, and there was enlargement of the pre-auricular and cervical glands, probably secondary to the spot.

There was no history of tubercle, but a definite one of syphilis eighteen years before.

When next seen, sixteen days later, there was an oval perforation in the cartilage only, without any thickening of the edges, and the glands in the neck were breaking down.

The question here was whether the perforation, limited as it was to the cartilage, was induced by the trauma (picking), or whether syphilis played any part in its production.

The PRESIDENT said that the first case was undoubtedly tubercular, and that the other might be either a syphilitic lesion or a simple perforation. The bone was not exposed, and the perforation was entirely in the cartilage, which was in favour of its being of a simple character.

Dr. DUNDAS GRANT asked if Mr. Robinson had seen the case at the stage of the gumma.

Mr. BETHAM ROBINSON said the patient referred to when first seen had simply a black mass where the perforation was now situated, which looked very much like necrosed cartilage. There was no hole then, but when he next saw the case he found the perforation in its present position. The septum broke down very rapidly. The softening glands in the neck might possibly be of syphilitic origin.

## A CASE OF (?) SARCOMA OF TONGUE AND FAUCES.

Shown by Mr. H. BETHAM ROBINSON. The patient, a married woman æt. 49, was first seen on February 20th last, and then gave the following history. She had noticed no symptoms before a month ago. Her throat then felt ulcerated, and something seemed to burst; there was slight bleeding, but no matter. The bleeding had not been repeated, and there was no pain or dyspnœa, but with the increase in size of the tumour eating and drinking had become difficult. Her appearance corresponded with her acknowledged good health. There was no history of syphilis or tubercle.

On examination over the left posterior half of the tongue there was a somewhat circular swelling, the edge of which was raised fully one eighth of an inch above the surface of the tongue. It extended backwards and downwards, involving the left tonsillar region by the side of the epiglottis. The tongue movements were remarkably free, and the growth, though extensive superficially, evidently did not penetrate to any depth into the substance of the tongue. The surface of the swelling did not seem ulcerated, and (on February 20th) there was only one slightly enlarged gland at the angle of the jaw.

Since the patient was first seen the glands on the left side have become considerably enlarged and matted; this might be explained by an attack of influenza during the past few days.

The pathologist considered the tumour to be a mixed sarcoma, but Mr. Robinson thought that syphiloma was by no means improbable. This view was to some extent borne out by the

following points:—the age of patient, her good health, the rapid growth, the absence of pain, and the tardy involvement of glands. On this supposition, iodide of potash had been given for the past week with some improvement.

The PRESIDENT remarked on the interesting nature of the case. Its character was doubtful. Antisyphilitic treatment ought to be tried.

Mr. SPENCER thought from the clinical appearance and from the microscopical specimen that the case was one of gumma.

Sir FELIX SEMON asked if the painlessness was not in favour of syphilis as against malignancy.

Mr. BETHAM ROBINSON, in reply, said the growth was called "sarcoma" because this was the opinion expressed in the pathologist's report. He favoured syphilis himself.

## CASE OF A MALE ÆT. 26 WITH THE LEFT VOCAL CORD IN THE CADAVERIC POSITION, RIGHT FACIAL PALSY, AND PARALYSIS OF THE RIGHT GENIO-HYOGLOSSUS AND THE LEFT HALF OF THE SOFT PALATE.

Shown by Dr. HAVILLAND HALL. T. I—, æt. 26, corporal 6th Lancers. Has had five and a half years' service in India. Has since been in South Africa. Has not had fever. Acute rheumatism in July, 1900. Admits gonorrhœa but no history of syphilis.

Patient was on active service in the recent South African campaign. Two days after embarking for England from Cape Town patient first noticed a difficulty in swallowing. This steadily increased, and reached its maximum in fifteen days. Two days after landing at Southampton he first noticed a difficulty in speech, which is now so pronounced. This also gradually increased, and became stationary in about nine days. This period was also marked by the first appearance of the hacking, brassy cough, which was very distressing on admission into hospital. Patient had not noticed the right facial paralysis or the weakness on the right side until they were pointed out to him in the hospital.

There is no history of headache, fits, or vesical or rectal trouble during the development of the present illness, and it is remarkable that the patient has never had to lie up, or been in

any way incapacitated from going about while the symptoms have been manifesting themselves.

*Condition on Admission.*—No headache, vomiting, or optic neuritis; intellect clear; no aphasia; speech markedly affected. Difficulty with labials and linguals to some extent, but great hoarseness also.

Eyes react to light and accommodation; no ophthalmoplegia of any kind; no nystagmus; paralysis of whole of right seventh, and deafness of right ear. Paralysis of right genio-hyoglossus. Tongue cannot be deflected to left side. Palsy of left side of soft palate; left vocal cord in cadaveric position.

Both sterno-mastoids and trapezii act equally well. Marked weakness on right side of body (both limbs). Both knee-jerks abolished; no ankle-clonus; plantar reflexes normal.

No sensory disturbance of any kind in body or limbs; some blunting of sensation in fauces, palate, and posterior pharyngeal wall.

A disseminated subacute polio-encephalitis is suggested as the probable cause of the condition.

The patient has had iodide and mercury in full doses, but without any apparent amelioration of his symptoms.

### Case of Extreme Deflection of Septum to Right Side, causing almost Complete Unilateral Obstruction, in a Male æt. 20.

Shown by Dr. Pegler. In this case there was considerable deviation of the right nasal bone with discoloration and thickening. The patient sought advice more for the disfigurement than for the obstruction to breathing or deadness of his voice. There was a history of a fall at age of three. The case was shown to elicit from members whether in such an extreme case as this there seemed a prospect of a good result from a sawing operation, or whether one of the methods of fracturing and forcible straightening of the septum appeared preferable.

Dr. Herbert Tilley thought the best treatment would be to saw off the projection in the right nostril. It was not a suitable case for Asch's operation, because the space in the left nasal cavity was already none too large for breathing purposes, and the result of Asch's

operation would be to still further occlude the left side without making much difference on the right. The great thickening of the nasal bone on the right side was interesting. According to the patient this had been present since the fall which caused the septal deflection. It would seem to be one of those cases of traumatic periostitis of the bone, examples of which had already been shown to the Society at previous meetings.

Dr. PEGLER, in reply, thanked the members for their suggestions. He should try the saw as suggested in the first instance, as he had had on the whole better successes in these cases by that means than by performing an Asch or one of its modifications. The careful use of splints or adhesion preventers would be an important part of the after treatment.

## CASE OF MALIGNANT DISEASE (EXTRINSIC) OF THE LEFT SIDE OF THE LARYNX IN A MALE ÆT. 56.

Shown by Dr. PEGLER. In this case there was also a malignant involvement of some glands on the same side of the neck. The case was shown to ascertain the feeling of members as to question of performing complete extirpation, the patient being willing to submit to any operation proposed for his relief. The history only extended back four months; voice not affected.

Mr. P. DE SANTI was strongly of opinion that the case should be left severely alone. The man had a large mass of glands on the left side, which were very hard and fixed. There were sure to be other glands deeper down, and it would be impossible to remove these, and therefore impossible to remove the whole disease.

## CASE OF MALIGNANT DISEASE OF THE TONSIL.

Shown by Dr. JOBSON HORNE. The patient, a man æt. 60, states that the symptoms of the throat affection from which he is suffering are of not more than five months' duration. At first he experienced a soreness on the right side, more painful on swallowing; this steadily increased, and now deglutition is most difficult and painful.

There is considerable glandular enlargement on the right and also on the left side, and obvious swelling about the angle of the jaw, and under the chin there is a discharging sinus.

The jaw can be only partially opened, and the tongue cannot

be protruded. The right tonsil is enlarged, extending across middle line, on the surface of which is an ulcer with thickened edges. The ulceration is extending on to the soft palate.

Recently he has experienced pain in the region of the left tonsil. There is no history of syphilis obtainable. He abstains from spirits, and only smokes half an ounce of tobacco a week in a clean pipe. Since February 26th he has taken thirty grains of Pot. Iod. a day, and has experienced relief.

The case is shown in the hope of eliciting suggestions as to ætiology, and for affording relief by either medicinal or operative measures.

## Case of Total Extirpation of the Larynx.

Shown by Dr. Glegg for Mr. Harvey. When admitted to hospital this patient, a man æt. 48, was not in good general condition.

On examination a sessile growth the size of a large bean was seen situated on an infiltrated base just below the right arytæno-epiglottidean fold, and running obliquely down over ventricular band and hiding the anterior two thirds of vocal cord. The right side of larynx was fixed, and the posterior third of the vocal cord, which was alone visible, was seen to be motionless and white. The left side of the larynx and the vocal cord moved freely. There was an indefinite thickening on right side of neck opposite the level of thyroid cartilage (enlarged gland ?). The respiration was comfortable although there did not seem to be very much room. The voice was hoarse. The patient could only take fluids owing to obstruction to passage of solids, but had no pain.

*History.*—Until six months before operation the patient never had any trouble with the throat. About that time he had a little difficulty in swallowing and a feeling of gurgling in the throat. About two months before operation had pneumonia, temperature reaching 105°, and suffered from great dyspnœa, so much so that tracheotomy was contemplated. During the next two months he was hoarse on and off, gradually getting worse; there was increased difficulty in swallowing, the cough was often

severe, and there was much phlegm in throat, and occasional slight earache. He could swallow solids until two days before admission. Had been a heavy smoker and also drank freely. He had suffered from winter cough, and lately some wasting. There was a history of syphilis twenty-five years ago; he had been taking iodide of potassium without any benefit. A piece of the growth was removed and examined microscopically, and the diagnosis of epithelioma was confirmed.

On July 25th, 1900, the operation of total extirpation of the larynx was performed by Mr. Harvey, and it was then found that on the right side, at the level of the inferior cornu of thyroid, the growth had perforated into the neck through the posterior part of the crico-thyroid membrane.

The patient's health remained good, and the local condition satisfactory up to December, 1900, when he presented himself for examination, and a large, hard, irregular gland was found and removed from the sheath of the jugular above the level of the great cornu of the hyoid on the right side. He has now a Gluck's artificial larynx, whereby a loud whisper can be produced and conversation can readily be carried on, and his health appears to be quite satisfactory.

## Case of Extreme Elongation of Uvula.

Shown by Dr. H. J. Davis. This patient, a male æt. 52, is the subject of left hemiplegia and old nasal and laryngeal trouble. He sought relief for stridor and dyspnœa associated with complete abductor paralysis of right cord.

The cords now move well, and there is no stridor, and I am simply showing him as a curiosity for another reason. He has the longest uvula I have ever seen. It hangs like a pigtail from his fauces, and when he protrudes his tongue—which organ is also of unusual length—you can see without the help of a spatula the uvula lolling on to the epiglottis.

Dr. Davis, in answer to a question, said the man had a slight cough, but the physical signs in the chest accounted for it. The patient did not wish to be operated upon; there was slight anæsthesia of the pharynx.

Sir FELIX SEMON said he thought the scarring would account for the anæsthesia of the pharynx.

## SPECIMENS OF POST-NASAL GROWTHS REMOVED "EN MASSE" WITH A CURETTE.

Shown by Dr. H. J. DAVIS. These specimens, besides demonstrating the size to which such growths may develop, show—

(1) Two lateral masses attached to median raphe.

(2) Another specimen of the same in which the growth is studded with white specks, similar to that observed in follicular tonsillitis.

(3) A mass at free border of which is an ulcerated area containing pus and calcareous matter. This was removed from a child æt. 7, with enlarged cervical glands and probably tubercular.

(4) A central mass with a largish vessel entering upper surface.

They have been preserved in spirit since last June, and are therefore much shrunken, but the sulci and convolutions are very well marked.

## A CASE OF SUBMUCOUS HÆMORRHAGE OF SOFT PALATE.

Shown by Mr. DE SANTI. This occurred in a man and was the size of a walnut. It had appeared suddenly whilst eating some crusts of bread, and was in all probability due to bruising therefrom. He had had two similar attacks, once on the back of the tongue and once underneath the tongue in the floor of the mouth.

When first seen by Mr. de Santi there was an ulcer in the right glosso-epiglottic fossa, on both sides of which there were enlarged veins. The hæmorrhage from the back of the tongue had probably come from the right glosso-epiglottic fossa.

The man was not a "bleeder."

Unfortunately all traces of the hæmatoma had by now disappeared, and also the ulcer already referred to.

### Drawing of Congenital Fenestration of the Faucial Pillars.

Shown by Dr. Watson Williams. This was shown in reference to the cases and drawings brought forward at the previous meetings of the Society. It depicted another case of probable congenital malformation.

### Case of Fixation of the Left Vocal Cord and Empyema of Right Maxillary Antrum.

Shown by Dr. Dundas Grant. Frances T—, æt. 44, married, came under my observation on February 14th, 1901, complaining of hoarseness and dyspnœa on exertion, and a frequent catch in the breathing. The hoarseness had been present to a slight degree for from eighteen to twenty years, and had been gradually getting worse. On examination the left vocal cord was found to be absolutely fixed in the median position, its edge being markedly concave. Both cords had lost their lustre, and were distinctly congested. There appeared to be an abnormal degree of fulness round the base of the arytænoid cartilage in the left hyoid fossa. There was slight movement of the left cornicula. The movement of the right vocal cord was not quite complete. There appeared to be a rounded fulness under the left vocal cord, but this proved to be due to a shadow cast by a very dark greenish pellet of inspissated muco-pus adhering to the lower surface of the right vocal cord. On inspection of the naso-pharynx there was found to be a small collection of muco-pus in the neighbourhood of the right middle turbinated body, and on anterior inspection there was found a polypoid enlargement of the middle turbinated body. On transillumination the right antrum showed comparative opacity, and when it was punctured a considerable amount of fœtid muco-pus was washed out. The frontal sinuses were perfectly translucent. There is a slight flattening of the bridge of the nose, attributed to compression at birth.

She is the twelfth of a family of fourteen, of whom only two others survive. The brother, two years older than herself, died

at fourteen of scarlet fever. Her father lived to very old age; her mother died at forty-four of dropsy, probably from heart disease. There are believed to have been several miscarriages. The patient has had seven children, of whom two have died; no miscarriages. She is somewhat anæmic, the palate is paretic, the pupils contract to light, and the knee-jerks are normal. The expulsion of the inspissated muco-purulent crusts in the larynx has been greatly facilitated by the inhalation of turpentine in warm water, and by the occasisnal injection of 10 per cent. menthol in olive oil into the trachea, the voice having become much clearer and the breathing much freer. She has been washing out the nasal passages, and it is proposed to puncture the antrum without delay. There is no evidence of abnormality in the thorax, and the laryngeal affection is probably maintained by the nasal suppuration.

Dr. DE HAVILLAND HALL thought it was an affection of the joint rather than a paralytic one. There certainly seemed to be on comparison with the right cord a difference in the shape, the left arytænoid being more round and full.

Dr. DUNDAS GRANT was glad to hear Dr. Hall's confirmation of his own opinion. The swelling was extremely small, and consequently left room for a considerable difference of opinion.

### CASE OF TUMOUR OF THE VOCAL CORD IN A BOY.

Shown by W. G. SPENCER. This boy, æt. 12, has a tumour obscuring the right vocal cord, also a swelling in the right leg groin.

Huskiness in speech was first noticed a year ago, which has increased, until now he is very hoarse.

The swelling in the right leg began five years ago, after a blow from a stone. It disappeared, to return six months ago. The patient presents no other evidences of inherited syphilis. In the larynx there is nothing abnormal except a tumour, which obscures the right vocal cord. The swelling is red in colour, has a smooth glistening surface, and shows no sign of ulceration or hæmorrhage. When the glottis closes it seems to come in contact with, and then to pass somewhat over, the left vocal cord. But the right vocal cord vibrates freely during vocalisa-

tion, as shown by the fact that the vocal fremitus to be felt in the crico-thyroid space seems to be equal on the two sides.

The swelling in the leg involves the upper and inner surface of the tibia; the skin is discoloured; two apparently periosteal nodes are to be felt on the tibia, from which extend backwards to the popliteal space an induration of the skin and subcutaneous tissue. The swelling is tender, and there is pain, especially at night. The femoral glands below and the iliac glands above Poupart's ligament are a little enlarged, but soft and discrete.

Dr. DE HAVILLAND HALL asked if any one would have suggested that the laryngeal condition was of syphilitic origin from the local appearances without reference to the tumour in the leg. To his mind the cord gave no suggestion of a specific lesion. He thought that it was a tumefaction rather than a distinct tumour, and he should have had no idea of suspecting syphilis unless he had seen the leg.

Dr. LAMBERT LACK thought that some members might remember a similar case shown to the Society by Dr. W. H. Kelson. In this case also there were no definite signs of inherited syphilis. The indefinite outline of the swelling on the ventricular band and the fixation of the cord pointed to its being of an inflammatory origin.

Dr. STCLAIR THOMSON said there was nothing in the appearance of the laryngeal condition indicative of a specific lesion. It agreed with what was commonly described as prolapse of the ventricle, but which was really inflammatory hypertrophy of the ventricle of Morgagni. Perhaps the case might be treated first with antispecific remedies to see what the result would be before resorting to surgical or other treatment.

Dr. BOND did not think it was specific, and he doubted whether the leg was, for there was a distinct history of injury at the beginning.

Mr. SPENCER, in reply, said the cord was not fixed; vocal fremitus was obtained equally on both sides. He thanked Dr. Lack for recalling the case of Dr. Kelson to his mind. This might be a gummatous infiltration. With regard to Dr. Bond's remarks to the effect that the tumour in the leg might be due to the stone which injured the boy five years ago, it was rather a long time for a traumatic osteitis to be gradually going on. The injury might have localised the gumma in that particular position. He would treat the case with Pot. Iod., and show it again in a month's time.

## A LARYNGEAL CASE FOR DIAGNOSIS.

Shown by Dr. PERMEWAN. The patient, a man æt. 55, was sent to him four weeks ago suffering from dysphagia.

On examination a small circular white tumour about the size

of a sixpence, low down on the back of the pharynx, could be seen on depression of the tongue. Laryngoscopically there was swelling of both arytæno-epiglottic folds, and behind the right arytænoid cartilage there was a whitish, granular-looking polypoid swelling. The left side of the larynx and left vocal cord were quite immobile, there being apparently fixation of the cord very near the median line.

The small growth was removed with a snare, and on examination was pronounced by a pathologist to be "inflammatory." The patient was ordered iodide of potassium. Three weeks afterwards the patient was seen again, and there was some apparent recurrence of the pharyngeal growth, but otherwise the appearances were unchanged. Dr. Permewan desired the opinions of the Society on the nature, prognosis and treatment of this case.

Sir Felix Semon would not commit himself definitely, but he was inclined to think that the various projections in the pharynx on the left and right side originated from one and the same general infiltration, which also caused the fixation of the left half of the larynx. He thought the whole thing was malignant.

Mr. Spencer thought that it might be syphilitic, but if not that it was most likely malignant. He had shown a large number of cases to Dr. de Havilland Hall at the Westminster Hospital, in which malignant disease of the lower part of the pharynx had gone unnoticed for a long time. The primary growth in that situation was exceedingly small. In this connection he instanced the case of a man who had a growth for a long time not quite as large as a threepenny piece, and indurated glands on each side of the neck. He had seen six cases in two years of malignant growth of the lower portion of the pharynx, and in one or two there were indurated glands in the neck, these latter having been sent to him with the request to take away the glands; in none could he see any chance of doing good by surgery.

Dr. Dundas Grant brought before the Society about a year ago a man with an extremely small growth in the wall of the pharynx, similar to that seen on the left side in Dr. Permewan's patient. His case was made easier in diagnosis by the involvement of the glands. There was room for some doubt as to whether or not it was malignant so far as its appearance was concerned, but the extreme hardness on palpation made it pretty evident what the real nature of the case was. Eventually the man died in the Cancer Hospital of malignant disease. He was disposed to think the present case one of malignant disease. It was certainly singular to have a large growth on one side and the cord fixed on the other.

Dr. Bond was disposed to think it malignant, though one might be

led astray by the pathological report on the piece removed, which was reported to be of an inflammatory nature. Evidently there was extensive mischief. It was very uncommon to see two separate patches of apparently malignant growth, but the intervening tissue was no doubt quite infiltrated. Commonly, when one examined masses of this nature with the fingers, one made out very evident hardness and induration of the growth and surrounding parts. In this case the growth was quite soft. He showed such a case some three years ago. He thought this case a similar one, and that it was malignant.

Dr. FITZGERALD POWELL remarked that, with all due deference to the distinguished opinions which had been given, he could not help having a strong suspicion that the case might prove to be specific in character; he had elicited the fact that the man's wife had had three miscarriages, and he certainly thought that he should be treated by antispecific remedies.

Dr. PERMEWAN, in reply, agreed on the probable malignant character of the case. He would, however, give iodide of potassium freely, and report the result to the Society. He thanked Dr. Bond for the suggestion as to palpating these growths as well as examining them laryngoscopically.

## A LARYNGEAL CASE FOR DIAGNOSIS.

Shown by Dr. BENNETT. P—, male æt. 31, a teacher, was first seen in September, 1900, on account of hoarseness of one month's duration. Examination of the larynx revealed the presence of what appeared to be a small granulating surface immediately below the anterior commissure of the cords, and involving to a very slight degree the anterior inner margin of the left vocal cord. On two or three occasions this surface was curetted and a small amount of granulation tissue removed. Nothing had been done to it for the last three months. The voice is now better, though not clear. There is still a small swelling visible, and the opinion of members of the Society is invited as to the nature of the condition.

Dr. STCLAIR THOMSON had perhaps not listened attentively to Dr. Bennett's description of his case, but he had obtained a very complete view of the whole length of the cords, and on phonation no thickening was visible in the anterior commissure. On phonation a slight thickening was seen in the anterior subglottic region. This was not an uncommon condition; it did not interfere with the action of the cords, and he therefore thought that the cause of any impairment of voice must be sought for elsewhere.

# PROCEEDINGS

OF THE

# LARYNGOLOGICAL SOCIETY OF LONDON.

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SIXTY-FIFTH ORDINARY MEETING, *April 12th*, 1901.

E. CRESSWELL BABER, M.B., President, in the Chair.

ERNEST WAGGETT, M.B.,
CHARLES A. PARKER, F.R.C.S.(Ed.), } Secretaries.

Present—31 members and 4 visitors.

The minutes of the preceding meeting were read and confirmed.

The ballot was taken for the following gentleman, who was elected a member of the Society:

Wilfrid Glegg, M.D., M.R.C.P.(Edin.), Throat Hospital, Golden Square, W.

The following cases and specimens were shown:

## CASE OF TUMOUR OF RIGHT VOCAL CORD WITH A SWELLING ON THE LEG IN A BOY.

Shown by Mr. SPENCER. This case was shown at the last meeting. Since then the patient had taken 15 grs. of iodide of potassium daily, and Ung. Hydrargyri had been applied to the leg every night.

Both swellings had largely subsided, tending to show that both had origin from the same cause, namely, inherited syphilis.

Mr. Spencer proposed to increase the dose of iodide of potassium, in order to obtain their entire disappearance.

## Man æt. 33 with Chronic Laryngitis and an Ulcer on one Vocal Cord.

Shown by Dr. StClair Thomson. The patient presented himself for hoarseness, and a constant desire to clear the throat, which had commenced about six months ago. When he was first examined there was general subacute laryngitis, the cords were congested, irregularly thickened and rounded. On the anterior third of the left vocal cord there was an oval, boat-shaped ulcer, covered with a greyish slough. A thickening on the opposite cord appeared to fit into this ulcerated depression on phonation.

His temperature was 98·8°, pulse 86; there were no symptoms suggestive of tuberculosis, and nothing was found in his chest. There was no definite history of lues, but he was put on 10 grs of iodide of potassium three times a day. On a subsequent occasion I examined his nose, and found each middle meatus covered with dirty greenish crusts. He was given a cleansing lotion, and at his last visit no crusts were visible; his left nose was clear, but there was some pus in the right middle meatus and in the right choana. In spite of the improvement in his nose the hoarseness was worse. This was a fortnight ago, and I have not seen him since, but show him to-day, before further treatment is carried out, to see if members agree that the chronic laryngitis and ulcer are both due to infection from the nose.

Sir Felix Semon thought it was a simple case of chronic laryngitis, and was not tubercular or specific.

The President said he was not sure of the presence of ulceration in this case.

Dr. StClair Thomson, in reply, said that at first the idea of tubercle had occurred to his mind whilst diagnosing the case; but the temperature was normal, the pulse not hurried, and though repeated examinations of the chest were made, no signs of pulmonary tuber-

culosis were detected. There was no history of syphilis. Iodide of potassium was given, but this did not improve the patient, in fact the drug made him much worse. There was nothing definite about the nose, but there was a good deal of catarrh. He decided in favour of chronic laryngitis, possibly of nasal infection.

### Case of Infiltration of Right Cord of Three Months' Duration in a Man æt. 40.

Shown by Dr. StClair Thomson. This man has been hoarse since early in January. It will be seen that the posterior two thirds of the right cord is represented by an even, red infiltration. The cord moves freely. There is some general hypertrophic laryngitis. The cavum is clear; some polypi have been removed from each nostril. He has had some treatment with iodide of potassium, although there is no history of lues. Rest to the voice and abstinence from tobacco and spirits do not appear to have improved him.

Dr. Jobson Horne considered that the changes to be seen in the larynx suggested *pachydermia diffusa*.

Dr. StClair Thomson, in reply, agreed with the remarks put forward by Dr. Jobson Horne, and thought the case more like one of pachydermia diffusa. The patient had been watched for some time. He was suspected of being addicted to alcohol.

### Case of Infiltration of the Right Vocal Cord of Six Months' Duration in a Man æt. 56.

Shown by Dr. StClair Thomson. This patient has been hoarse since September, 1900. The central portion of the right cord is rounded, red, and infiltrated. As to the movement of the affected cord I have been considerably puzzled. At times it has appeared to move freely, but on other occasions I have felt convinced that it was slow and partially tethered in its excursions. The rest of the larynx is normal. He presents no changes in nose, pharynx, or chest. There is no history or suspicion of lues, but he has been given iodide of potassium up to 15 grs., three times a day, without any result. His weight is 12 st. 9½ lbs., and does not vary. Feeling that the appearances were uncertain and suspicious, I asked Sir Felix Semon to see the patient, which he kindly did about four

months ago, and his conclusion was that there was not then sufficient evidence to justify a diagnosis of malignancy. Two months ago the patient was seen by Mr. Butlin, who wrote to me as follows:—"I do not think it is a new growth. It is too smooth, and there is too free movement of the cord. Also, his voice is not so badly affected as I should expect it to be with a malignant tumour of that size and character. On the other hand, I do not think that so definite and limited a swelling of the cord is likely to be due to any ordinary chronic inflammation. It is not like tubercle, not quite like syphilis, not like any of the 'infective' group of tumours. I have twice opened the larynx for somewhat similar tumours, under the impression that, if the disease was not malignant, it was too suspicious to be left. In one case I found in the centre of the rounded swelling a little mass of what appeared to be coagulated blood, in the other something of the same kind, but not so dark-coloured. One of the patients was a clergyman, the other a commercial traveller, therefore they both used their cords a good deal. I cannot help suspecting that this may be a case of a similar kind, in an agent who talks a good deal. In both my cases there was the same redness of the affected cord. I do not know whether you can get rid of the tumour without incising it or carefully cutting it away, taking the greatest care not to injure the cord itself in doing so. To do this may necessitate the opening of the larynx from the neck."

Both my patients are voice users; this one is a commercial traveller, while the former one is a shop assistant.

One of Mr. Butlin's cases is described by Sir Felix Semon in an article on "Blood-clots simulating Neoplasms in the Larynx,"* and the description there given certainly suggests a similarity to the present case.

### Case of Laryngeal Neoplasm occurring on the Posterior Wall, and accompanied by Paresis of Left Vocal Cord in a Man æt. 49. For Diagnosis.

Shown by Dr. Scanes Spicer. The only symptom had been hoarseness of gradual onset, commencing over four years ago.

* 'Annales des maladies de l'Oreille,' etc., xxv, 1899, No. 8.

The growth was sessile, and attached to the posterior wall. A portion was curetted off, and reported by a pathological expert to be tubercular. Six weeks later a further portion was removed, and was deemed, after examination by the same expert, to be malignant. There had been no pain, hæmorrhage, or emaciation, and there are no enlarged glands; no purulent infection from sinuses or nasal stenosis. There are no history or signs of syphilis or tuberculosis, and nothing to suggest excessive or perverted use of voice, or special exposure to dust in occupation. The patient had been on potassium iodide (gr. v, t. d. s.) for two months with no effect on his condition. Dr. Spicer inquired whether the Society considered that the clinical appearances were so suggestive of malignancy as to demand laryngo-fissure.

Sir FELIX SEMON feared the growth was malignant. Seeing that it was so very small, he advised an exploratory thyrotomy to aid the diagnosis, which was certainly difficult.

In reply, Dr. SCANES SPICER said that, as there was a conflict between the evidence of the histologist and that of the history of the case, and as the clinical appearances were equivocal, he welcomed the remarks that had fallen from Sir Felix Semon. He had not seen the section himself, but clinically he doubted the malignant theory.

A CASE OF LARYNGITIS WITH MARKED SUBGLOTTIC HYPERPLASIA OCCURRING BELOW THE ANTERIOR COMMISSURE IN A MAN ÆT. 36. FOR DIAGNOSIS.

Shown by Dr. SCANES SPICER. The illness commenced with hoarseness four months ago. The patient is anæmic, but there is no evidence of tuberculosis, there being no emaciation, night sweats, hæmoptysis, or cough, and there is no history of any other disease. The treatment for the last month had been a spray of chloride of zinc and small doses of iodide of potassium. Dr. Spicer thought the case was not at all plain, and seeing that the patient was a corn dealer, he inquired whether it was possible that a husk had become imbedded in the larynx. Occasionally the epiglottis and aryepiglottic folds became œdematous.

Dr. DUNDAS GRANT thought it was a case of tuberculosis.

Dr. PEGLER said, had not the evidence against tubercular disease of the lungs been confirmed, he would have regarded the laryngeal

disease as tuberculous, to judge from a casual inspection. In testimony of how deceptive appearances sometimes were, he would mention a case very recently under his care, which was brought to his mind by a remark of Dr. Spicer's, that the œdema in this case might have been caused by the irritation of a husk swallowed by the patient. A middle-aged woman came to the hospital stating that she had swallowed a fish bone a week previously, and still felt it sticking in her throat. Examination of the larynx failed to reveal the bone, but a very marked œdematous swelling was seen occupying the left arytenoid region, and obscuring the glottis and both vocal cords, except quite the anterior portion of the right one. As this œdema might be due to one of several sources of irritation, a portion of tissue was removed for examination by Mr. Lake, who saw the case with the speaker. No bone was found, but the swelling began to subside, and a week later the patient brought a comparatively large plaice bone to the hospital, which she had hawked up. After this the œdema rapidly disappeared.

Mr. Lake felt very much inclined to recommend the use of mercury in some form.

## A Specimen of a Larynx from a Case of Primary Laryngeal Diphtheria.

Shown by Dr. Logan Turner. The case was of interest from the fact that the disease was confined entirely to the larynx, that it occurred in a strong vigorous adult, and that it ran a rapidly fatal course. Frequent attacks of severe dyspnœa necessitated tracheotomy. *Post-mortem* examination showed the mucous membrane of the larynx to be covered with diphtheritic membrane, which extended from the apex of the epiglottis to the cricoid cartilage. Bacteriological examination demonstrated the presence of the Klebs-Löffler bacillus and streptococci.

## A Specimen of a Larynx for Diagnosis.

Shown by Dr. Logan Turner. The larynx was removed from a boy æt. 8 years, who had died suddenly during the night from asphyxia, resulting from the drawing of vomited matter into the larynx and bronchi. All the organs of the body were healthy.

The mucous membrane of the larynx and upper part of the trachea was studded with a number of small white points, varying in size from a half to one millimetre or more in diameter.

and resembling small miliary tubercles. The posterior surface of the epiglottis was almost completely covered by a large white patch of a similar kind. There was no evidence of ulceration or swelling.

The microscope showed that each patch appeared to consist of a small area of lymphoid tissue, lying beneath the epithelial layer, and infiltrating between the glands of the submucous layer. There was a small communication with the surface. There were no giant-cells or other evidence of a tuberculous condition.

Dr. JOBSON HORNE said he had examined the larynx, and also the microscopic section; he did not consider the minute nodules to which attention had been directed had any pathological significance. By the epithelium having been destroyed, the underlying structure had become more obvious.

### A CASE OF DESTRUCTION OF THE NOSE CAUSED BY A FERRET.

Shown by Mr. WALSHAM. The patient is now 24 years of age. At the age of three months a ferret was found gnawing her face. The whole of the nose, part of the skin of the forehead, and a large part of the middle of the upper lip were destroyed. She has had eighteen plastic operations, the most successful being done by Sir Thomas Smith in 1887, when the skin was taken from the arm, the arm then bound to the face for three weeks to fashion the nostrils, and the lip was repaired. The lip was very successful, and the left nostril fairly so. She has had the Indian operation done also, but it was a failure.

Right nostril was open, but closed up after last operation in 1899.

The PRESIDENT said that he agreed with Mr. Walsham that nothing further should be done. He added that he understood from Mr. Walsham that the introduction of cartilage in this case had been tried without success.

### A CASE OF EPITHELIOMA OF THE LARYNX.

Shown by Dr. JOBSON HORNE. The patient, a man æt. 69, stated that in August, 1899, he had "influenza" which was followed by some impairment of voice, and which had gradually

increased; he had experienced no pain or discomfort, and had not troubled about medical advice. Excepting an occasional cold, he considered his general health had been good.

The growth occupied the anterior two thirds of the right vocal cord, and appeared to be confined to this region. The greater part of the growth was a papillomatous mass filling the anterior third of the glottis. Being partly concealed under the ventricular band of the opposite side it could only be fully brought into view on deep inspiration. The right vocal cord was motionless. The left was not affected. There was some general congestion of the larynx, but this was not more marked on the right than left. No glandular enlargement had been made out.

Thirty grains of iodide of potassium had been taken daily during the previous fortnight without any material change being noted. The case was shown to ascertain opinions as to diagnosis.

The PRESIDENT said it looked like malignant disease. There was want of action on the right side of the larynx.

Sir FELIX SEMON was of opinion that there could hardly be any doubt as to the malignancy. There should be no hesitation in performing thyrotomy and removing the growth.

Dr. FITZGERALD POWELL said he had seen the patient in January last, and had advised operation, thinking there was no doubt as to the malignancy of the growth. The patient had declined operation, and he had not seen him again until now. Though still thinking it malignant, he was struck by the fact that the tumour had not grown or altered very much since January.

Dr. JOBSON HORNE, in reply, expressed his thanks for the opinions that had been given, which he also shared.

### CASE OF TUBERCLE OF THE LARYNX IN A MAN ÆT. 18.

Shown by Dr. FITZGERALD POWELL. The patient states that he has suffered from gradually increasing hoarseness and difficulty of breathing for the last four years, accompanied by cough and attacks of suffocation at night. Five years ago he had erysipelas of the face and head, and twelve months ago the eruption, now apparent, on his nose and face appeared. He complains of pain in swallowing.

On examination the epiglottis, arytænoids, ventricular bands and as much of the larynx as can be seen are found to be pale

and much swollen, and there appears to be very little room for respiration. The swelling in parts is covered by superficial erosions.

He had applied a 5 per cent. ointment of salicylic acid to the nose and face, which had caused some improvement, and he proposed curetting the larynx and applying lactic acid.

### Specimens from Recent Cases illustrating the Two Chief Classes of Intra-nasal Papillomata.

Shown by Dr. Wyatt Wingrave. 1. The squamous variety regionally belonging to the vestibule, and histologically identical with an ordinary cutaneous wart. 2. The columnar or cylindrical variety only growing on mucous membrane, and therefore never found in front of the lumen vestibuli.

This latter may grow from the septum, floor, or turbinals, and is often referred to as a "moriform growth." Histologically it presents digitations of myxœdematous tissue covered with columnar or "palisade" epithelium, ciliated and smooth, resting upon a hyaloid basal border.

Warts on the mucous membrane may, however, be covered with squamous epithelium, a heterologous feature which is due to irritation causing retrograde changes, as seen in atrophic rhinitis, and often in slowly growing polypi.

One specimen is that of a "bleeding tumour." It is a squamous papilloma, which grew from the septum about half an inch behind the lumen vestibuli and above the floor. The "core" consists of numerous blood-vessels with very thin walls, which run into the digitations. Nests are found, but not of the "horny" variety so characteristic of the vestibular and cutaneous variety. The surface epithelial laminæ are also thinner.

Bleeding tumours other than malignant and granulomatous most frequently are of one of these two types of papillomata.

### Drawings of (1) Cyst in the Floor of the Nose; (2) Pachydermia Laryngis (Tubercular).

Shown by Mr. Richard Lake.

The President congratulated Mr. Lake on the excellent drawings he had shown to the Society.

## A Case of Pharyngo-mycosis in a Female.

Shown by Mr. Attwood Thorne.

Dr. Scanes Spicer said the question to be considered was whether these cases should be actively treated or not. When the patients were worried by symptoms such as a sensation of a foreign body, scraping, discomfort, sourness of breath, unpleasant taste, and flatulent dyspepsia, he would recommend active treatment, such as the free and regular use of alkaline antiseptic washes, the application of perchloride of mercury solution to the crypts, or the insertion of the galvano-caustic point into three, or four, or six of these at a time. He usually found that these cases were very obstinate, and that even long holidays, alternating with periods of active treatment, by no means guaranteed freedom from recurrence. Patients suffering from mycosis were not as a rule content to be left alone.

Dr. Pegler inquired whether a bad taste in the mouth was complained of, as in a case of his own at present under treatment this was the principal symptom, and it was one to which some text-books gave prominence.

Dr. FitzGerald Powell advised scraping with a sharp curette once or twice a week, and the application of a solution of nitrate of silver, twenty to thirty grains to the ounce.

Dr. Wyatt Wingrave emphasised the importance of differential diagnosis between true leptothricia and keratosis of the tonsils. The latter appeared as hard papillary projections from the lacunæ, not easily removable, and showing under the microscope typical horny epithelium with few or no leptothrices. He had found a saturated solution of salicylic acid (well rubbed in) the best treatment for keratosis, while true pharyngo-mycosis yielded to sulphurous acid and antiseptics.

Mr. Parker thought that the most important point to be remembered in the treatment of cases of mycosis was that in the early stages of the trouble the fungus was very firmly adherent and very difficult to remove or destroy, but that if it was left alone for a few months—some placebo being given to the patient in the meanwhile—the fungus growth generally became quite loose, and it could then be easily wiped away. He therefore recommended that such cases should be left until the growth became loose.

Sir Felix Semon said that in discussing the treatment of pharyngo-mycosis, the Society was going over old ground, as the same subject had only recently been discussed by the members. At the former discussion every one who spoke recommended this or that remedy as giving excellent results, and there was, altogether, a great variance of opinions. Personally, he found that these cases, whether of the leptothricial type, or a true keratosis, always occurred in people very much below par, and if they were ordered change of air, tonics,

rest, open-air exercise, etc., they would, in his opinion, get well without any other treatment, medicinal or operative. In his experience a bad taste was not at all usually present in the mouth.

Mr. ATTWOOD THORNE, in reply, said that the patient complained of no bad taste in the mouth. Personally, he was inclined to avoid any active treatment.

## CASE OF ANTRAL SUPPURATION WITH MARKED DISTENSION OF THE INNER ANTRAL WALL.

Shown by Dr. HERBERT TILLEY. The patient is a boy æt. 16, who came under treatment for inability to breathe through the right nostril and a purulent nasal discharge, associated with feelings of languor and general depression.

Examination of the right nasal cavity showed a large swelling of the inner antral wall, which touched the septum opposite. On pressing it outwards with a probe a crackling sensation and noise were produced. A ridge of bone traversed the swelling from above downwards, and at first sight the appearance closely resembled that of a swollen middle turbinal, but the latter bone could be seen in its normal position above.

The bony ridge referred to was undoubtedly the uncinate process of the ethmoid, and immediately in front of this the soft bulging could be easily penetrated by an ordinary surgical probe.

The right second upper bicuspid, which was carious, was removed, and for three months the patient had been irrigating the antrum twice daily with various antiseptic washes. As long as these were continued the discharge practically ceased, but if the irrigation was interrupted for two or three days, then the discharge reappeared. The question arose as to whether any radical operation, such as removal of the bulging inner wall, or even a more radical procedure, should be adopted. The patient's father was very averse to any operation unless it was absolutely necessary for the cure of the case.

The PRESIDENT said that Dr. Tilley's motive in showing the case was to receive suggestions for treatment. It seemed as if the inner wall of the antrum was very much bulged, but, to make certain of this, examination of the parts with a fine probe was necessary. He would not advise a radical operation being done at present. The

opening had only been made in January last, and the discharge, according to the patient, was slight in quantity, therefore he thought syringing should be continued for a time.

Dr. FitzGerald Powell said that if it was a fact, as he understood was the case, that there was no discharge at all, he did not think it was necessary to do a radical operation on the chance of discovering polypi.

Dr. Scanes Spicer saw no objection to waiting a little longer before resorting to further operative measures, but in his opinion something more radical would have to be done, either through the nose or through the canine fossa, for the reason that the discharge through the ostium maxillæ was an irritating one, and was keeping up ethmoiditis and inflammation of the uncinate body, producing the appearance which had been described as "cleavage."

## Case of Cyst of the Thyroid.

Shown by Dr. Pegler. The patient was an elderly woman under the care of Dr. Frederick Spicer, for whom the exhibitor had offered to show her to the Society. An operation was contemplated next day, and Dr. Spicer would be glad of suggestions.

The swelling was the size of an orange, tense, fluctuating, and having a history of about eighteen months' duration. There were pressure symptoms, which had increased latterly, and the larynx was considerably displaced.

The President said that he was always doubtful as regards the cystic nature of these growths. He had had a large experience of them, and he was of opinion that without puncturing it was not possible to say whether they were cystic or not. This, he believed, had not been done in this case; probably not one, but several cysts would be found. With regard to treatment, the shelling out of these cysts could usually be accomplished without much difficulty; but in those cases where it could not be done, he had adopted the plan of opening the cysts and sewing the wall to the edge of the skin, allowing the cavity to granulate up. It took a longer time, but gave good results. He had been in the habit of puncturing goitres for exploratory purposes for many years, but had had an unusual experience lately. Immediately after puncturing a moderate sized goitre in a woman aged 25, and evacuating only a few drops of blood, the gland swelled up slightly, and a few days afterwards he heard from the medical man that an extensive ecchymosis had come out, extending down to the nipples. This soon subsided, and the gland returned to its previous size. Some tachycardia was present in this case, but no exophthalmos.

Dr. Dundas Grant asked if other members of the Society had had

good results from tapping and then injecting perchloride of iron, as formulated by Sir Morell Mackenzie. He had several cases in which this procedure answered well. He was guided beforehand by the degree of collapse that the cyst underwent after tapping, and previous to injecting with iron.

Sir FELIX SEMON could answer Dr. Grant's question. Some fifteen or twenty years ago he had a very lively controversy in the 'British Medical Journal' on the injection treatment of goitres. He then quoted a number of cases showing that the injection of iodine occasionally was very dangerous. Since then he knew of another case in which injection of iron after puncturing a cyst had been followed by inflammation of the gland, sepsis, and death. In former years he himself had used injections a good deal in his cases, and had never personally had any bad result, but he had now completely given up this method of treatment. The surgery of the thyroid gland had made such advance that one ought not to have recourse to such expedients as injections now, when one could remove the whole thing more simply and surgically.

The PRESIDENT agreed with Sir Felix Semon that the injection of iron was not satisfactory. It might produce an abscess, and give rise to a great deal of trouble.

Dr. STCLAIR THOMSON thought that in modern surgery the method of tapping and injecting cysts had gone out of practice. It was simply done in the pre-antiseptic days from fear of opening these cavities, but now they might be opened perfectly harmlessly.

Dr. FITZGERALD POWELL said he thought the best treatment was removal of the tumour. He considered that there was a good deal more danger in tapping and injecting these cysts than in shelling them out. He referred to a case in which he witnessed a well-known surgeon introduce needles for treatment by electrolysis. The patient died within half an hour.

## CASE OF RHINOLITH ? IN A CHILD.

Shown by Mr. R. CHARSLEY.

Mr. ATTWOOD THORNE considered that the case was one of foreign body, and expressed a wish that a further report of the case be made at the next meeting.

The PRESIDENT would prefer to call it a case of foreign body rather than rhinolith; he had used a probe, but could feel no solid body. There was either a growth or a foreign body obstructing the nostril.

Dr. CHARSLEY could obtain no information of any foreign body having been put in the nostril. The body was white, hard, and very moveable, but he was puzzled to know exactly what it was. He saw the patient for the first time on the previous day.

N.B.—The day after the meeting the boy was anæsthetised, and a block of white india-rubber, one inch long by half an inch broad, was removed from the nostril.

## Case of Unusual Tumour on the Posterior Wall of the Larynx.

Shown by Dr. Lambert Lack. The patient is a female, married, æt. 39, who for fifteen years has had occasional difficulty in swallowing. This has been worse for the last three months, and the voice has been weak. The patient is thin, but not wasting, and there are no enlarged glands in the neck. On laryngoscopic examination a large, nodular, pale tumour is seen projecting from the posterior surface of the arytænoids on the right side. It is soft to touch, and grows apparently from the posterior surface of the cricoid cartilage. The growth is almost certainly not epithelioma, and appears to be either simple or possibly sarcomatous. Suggestions as to diagnosis and treatment are asked for, since as far as the exhibitor's experience goes the case is quite unique.

Sir Felix Semon considered it a very interesting and rare case. Of one thing he felt sure, and that was that it was not carcinomatous, and he was very strongly of opinion that it was not a sarcoma. If it were a malignant growth, there would be by now secondary infection of the lymphatics, and there would also be deficiency of movement of the vocal cord on the affected side, from myopathic disability of the posterior crico-arytænoid muscle. Both these signs being absent here, he was convinced of the innocent nature of the growth. He advised that the growth should be removed by the snare internally, and should be submitted to microscopical examination, and he would be guided in the future treatment of the case by the result of that examination.

Dr. StClair Thomson thought it should be described as an œsophageal growth. It seemed to him to be a simple growth, and he agreed with Sir Felix Semon's remarks. Sir Felix and he had seen a similar case in consultation together. The patient was a lady from the Cape, who had a suspicious-looking growth behind the larynx, and they had come to the conclusion that there was an abscess in connection with it, which of course there was not in Dr. Lack's case; but the tumour was like the one in the present case. His own patient returned to the Cape two or three years ago, and he had since heard that she had remained perfectly well. She was an elderly woman; the glands were not enlarged. No operative treatment was carried out.

Dr. Jobson Horne, referring to the remarks made by the previous speaker, said he thought the growth sprang primarily and mainly from the arytænoid region, and he regarded t as a laryngeal and not as an œsophageal growth.

### Cases of Lupus of the Septum and Widening of the Dorsum of the Nose in a Young Girl.

**Shown by Dr. Dundas Grant.**

### Case of Pachydermia of the Vocal Processes in a Middle-aged Man.

Shown by Dr. Dundas Grant. The patient, whose employment necessitated the use of his voice in directing the work at a large railway station, had for one year been becoming gradually more and more hoarse. On the vocal processes there were found extremely typical pachydermic swellings. He was being treated by means of weekly applications of salicylic acid, and was improved as regards voice, although no change in the pachydermic swellings was obvious.

### Case of Specific Perforation of the Palate and Ulceration of the Larynx of Tuberculous Appearance in a Middle-aged Woman.

Shown by Dr. Dundas Grant. The perforation of the palate was typical of tertiary syphilis, and there was indirect evidence (miscarriages, etc.) of specific infection. In the larynx the epiglottis was thickened and ulcerated all over in a manner resembling tuberculosis, but without any increase of secretion. Dr. Grant asked whether this appearance had been met with by other members in pure cases of syphilis; he was himself of the opinion that the process in the larynx was of tuberculous nature, and that, in fact, the case was one of mixed tuberculosis and syphilis. (Coloured drawings of the appearances in the pharynx and larynx by Dr. Mackintosh were exhibited.)

Dr. Scanes Spicer said that this case had been under his care some time ago. He regarded the present condition of the epiglottis as a tubercular one, for the appearances differed from all the syphilitic ulcerations he had seen. The epiglottis was really very similar to that in Dr. FitzGerald Powell's case. When he had the case there was no laryngeal involvement at all, but the palate presented the typical perforation and distortion of tertiary syphilis—just as seen now.

# PROCEEDINGS

OF THE

# LARYNGOLOGICAL SOCIETY OF LONDON.

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SIXTY-SIXTH ORDINARY MEETING, *May 3rd*, 1901.

E. CRESSWELL BABER, M.B., President, in the Chair.

ERNEST WAGGETT, M.B.,
CHARLES A. PARKER, F.R.C.S.(Ed.), } Secretaries.

Present—30 members.

The minutes of the preceding meeting were read and confirmed.

The following cases and specimens were shown:

## CASE OF LARGE LARYNGEAL GROWTH SHOWN AT A PREVIOUS MEETING.

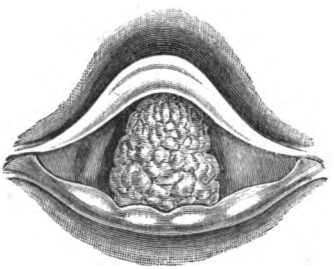
Shown by Dr. BARCLAY BARON. There was, on the previous occasion, some difference of opinion as to the nature of the growth, but it was generally agreed that it was attached by some sort of pedicle, and that its removal through the mouth would be easy. At the operation it was found quite impossible to remove it in this way, as the growth was a widely infiltrating epithelioma with no pedicle at all, the epiglottis and other structures of the larynx being implicated.

The patient is still living, the glandular infection being very considerable; he has declined to submit to a total extirpation of the larynx, which would be necessary to eradicate the tumour.

A Man æt. 61, from whose Left Vocal Cord a Large Epithelioma was removed by Endo-laryngeal Operation in 1886 and again in 1887, since which there has been no Recurrence.

Shown by Mr. Mark Hovell. R. P—, æt. 46, a stoker at some gas-works, came to the Throat Hospital, Golden Square, on March 17th, 1886, suffering from severe dyspnœa, caused by a large growth of a whitish colour, which almost filled the larynx. He looked pale and anxious, and perspired freely on the least exertion.

On March 20th, after a solution of cocaine had been sprayed into the larynx, nearly the whole of the growth was removed



The growth as seen before operation.

through the mouth with cutting forceps. Free hæmorrhage occurred, but it quickly subsided. The growth came away easily, and after its removal was found to have been attached to the inner border and under surface of the left vocal cord for almost its whole length. Subsequently two or three small pieces were removed as before with cutting forceps, and when the patient left the hospital, on April 5th, not a trace of the growth remained.

After the operation the patient gave the following history:

In the summer of 1884, whilst making up the fire, he suddenly experienced, for the first time, difficulty in breathing. The subsequent attacks of dyspnœa, which as time went on became

more severe, used to come on suddenly and last for a few minutes. They came at irregular intervals, sometimes two or more in a day, and at other times only one or two during the week. In consequence of the attacks increasing in frequency and severity, he went to the Westminster Hospital at the beginning of 1885, and there saw Dr. de Havilland Hall, who wished him to become an in-patient; but he refused to do so, and did not consent to this proposal until April, by which time the difficulty in breathing had considerably increased. He remained in the hospital three months, during which time some pieces of growth were removed by Dr. Hall. He was taken by Dr. de Havilland Hall to see Dr. Felix Semon at St. Thomas's Hospital, who attempted to remove the remaining portion of the growth. He left the hospital, but was subsequently taken by Dr. Hall to see Dr. Semon again, who then recommended the removal of the portion of the larynx to which the growth was attached. To this treatment the patient refused to submit.

He returned home and resumed work, and remained at it for three weeks or a month. The difficulty of breathing then became so great that he was obliged to seek further advice, and he went to St. George's Hospital, with the hope that relief could be obtained there without an operation being performed. He saw Dr. Whipham, and was made an in-patient. When he had been in the hospital about a week, he learnt that it was proposed to perform tracheotomy before an attempt was made to remove the growth through the mouth. He declined to have tracheotomy performed, and left the hospital. He then again returned to work, and remained at it until the end of 1885, when his breath was too short to enable him to continue at it any longer.

On March 17th, 1886, he came to the Throat Hospital as before mentioned.

After leaving the Throat Hospital the patient was not seen again until May 2nd, 1887, on which date he returned, and was found to be in a condition similar to that which existed when admitted the previous year. On examining his larynx a growth was visible almost identical in appearance, as regards size, colour, and macroscopic texture, to that previously removed. Subsequent to the second operation he told me that on leaving the hospital on April 5th, 1886, he resumed work, and felt no

discomfort until about January, 1887, when his breathing became a little short. The dyspnœa steadily increased, and about the middle of April he was obliged to discontinue work.

As the patient still refused to allow any extra-laryngeal operation, it was decided to again remove the growth with forceps. A solution of cocaine having been sprayed into the larynx, the growth was removed as before with cutting forceps. It was tougher than that of the previous year, and had a much larger base, being attached not only to the under surface and inner edge of the left vocal cord, but also to its upper surface and to the left ventricular band. At the first operation, on May 9th, although the hæmorrhage was greater than it had been on the former occasions, sufficient growth was removed to enable the patient to breathe with comfort. Another piece was removed on May 17th, and the patient left the hospital on May 20th. The last piece was removed on June 15th, after which no trace of the growth was visible, and the surfaces from which it had been removed soon healed. The long intervals between the operations were made to suit Mr. Hovell's convenience, and were not caused by any unfavourable symptoms having occurred. On June 30th slight congestion of the larynx still remained; the left vocal cord moved but little, but the movement of the right cord was normal. His voice was strong and distinct, but slightly husky in consequence of the congestion.

The patient was examined on August 13th, 1887, and there was no trace of the growth. The movement of the left vocal cord was impaired, but with the exception of slight general congestion of the larynx, and slight thickening of the interarytænoid fold, the result of chronic laryngitis, no abnormal condition was visible. The patient's voice was clear and strong, and there was no dyspnœa. The patient had been employed at the gas works for twenty-one years, and the dusty work during this period would account for the chronic laryngitis.

The following microscopical report of the growth removed in 1886 was kindly made by my colleague, Mr. Frederic Eve:

"The growth removed in 1886 was an epithelioma with a markedly papillary surface. The papillæ were very long and filiform. The base of the growth, under the microscope, showed prolongations downwards of the surface epithelium. These were

cylindrical, and terminated in a well-defined rounded or subdivided end. In some parts the growth of epithelium was more confused, and composed of tortuous columns or cylinders, which here contained numerous cell-nests; but these also existed in smaller numbers in other parts of the growth. The submucous tissue was nowhere present in the parts removed, but the epithelial columns forming the growth were so well defined that I do not suppose there was any diffuse infiltration of the mucosa with young epithelial cells.

"The growth removed in 1887 differed from that of the previous year in that it contained very few cell-nests, and these of small size. The epithelial columns were more confused, and their margins less well defined. Some shreds of mucosa were attached to its base. These were composed of small spindle-cells and fibrous tissue, containing elongated nuclei, and many small round or 'indifferent' cells. Looking at the matter solely from a histological point of view, I have no hesitation in expressing my opinion that the growth was an epithelioma. This is based on the extensive and characteristic ingrowth of epithelium, the presence of cell-nests, and the general appearances of the neoplasm.

"*P.S.*—I have formed an impression that epitheliomata are less highly malignant if distinctly warty or papillary on the surface; whilst, when the opposite condition exists and the surface is flat or ulcerated, the infiltration below is wider and more diffused, and the growth more malignant. As examples of comparatively lowly malignant warty epitheliomata, I may mention chimney-sweep's cancer of the scrotum, and the epithelioma following ichthyosis of the tongue. This may account in some measure for the successful issue of your case."

Mr. Hovell, in conclusion, said that, although the attempt to remove an epithelioma from the larynx by means of forceps was not a procedure which in an ordinary case would be entertained, or, if undertaken, would in the large majority of cases have any chance of success, yet exceptional cases must be dealt with in an unusual manner.

In the present case the man was fortunate to have got rid of the disease by the measures adopted; but, although in his case a cure had been effected, it was to be hoped that other patients

would not persistently refuse to have the affected region exposed and efficiently dealt with, or decline to have even a preliminary tracheotomy.

Mr. DE SANTI said that he was extremely interested in the history, the line of treatment, and the result of this case. What one had to consider in the matter was, firstly, the microscopic appearances of the sections submitted to the meeting; and secondly, the clinical features presented by the history given. Mr. de Santi had very carefully examined the microscopic sections, and must state that he could not find in their appearance anything whatever pointing to epithelioma. The drawing shown was a very artistic one of a perfect epithelial cell-nest, but in no part of the sections could he find anything even like an imperfect cell-nest. Moreover, cell-nests might occur in growths that were not epitheliomatous. He felt certain that as regards the microscopic appearances the diagnosis of epithelioma must be considered non-proven. Again, looking to the clinical aspect of the case, the time over which it had extended, together with the great size of the growth, as shown by the drawing, was quite unlike any epithelioma he had ever seen or heard of. If the growth had been malignant and had existed as long as stated, there must have been extensive infiltration at its base, and no endo-laryngeal operation could possibly have eradicated the disease as the disease had been eradicated in this instance. Neither, therefore, did the clinical features or the microscopic appearances warrant the diagnosis of epithelioma, and in Mr. de Santi's opinion this conclusion was more than supported by the result obtained by the removal of the growth by endo-laryngeal forceps. In his opinion the growth had been of an innocent nature throughout.

Sir FELIX SEMON declared his entire agreement with the remarks of Mr. de Santi. It would not be expected of him, after the lapse of fifteen years, that he should recollect the case, and indeed he frankly confessed that he had no recollection whatever of it. What he was going to say would be based only on the drawing which Mr. Hovell had shown to the Society, on the microscopical appearances, on the clinical features of the case, and finally on the present appearance of the patient's larynx. From all these points of view he could not help confessing that the case was a mystery to him. To begin with, he could not reconcile the idea of malignancy with the clinical appearance as now presented. We were taught—and his own experience corroborated it,—that the difference between a benign growth and a malignant growth was that a non-malignant growth sprouted from the *surface*, while the malignant infiltrated the *tissues*. How then could an infiltrating growth be removed so thoroughly that no recurrence had taken place, whilst the larynx, as at present seen, showed not the least trace of any operation having ever been performed? He did not wish to be misunderstood, and he wished to say distinctly that he did not deny the *possibility* of removing a malignant growth from the larynx by endo-laryngeal operation. Quite a number of cases of that sort were now on record. Perhaps some of the older

members of the Society might remember a letter which he had written to the 'British Medical Journal' on June 4th, 1887, in reference to the case of the then German Crown Prince, for the purpose of warning laryngologists against subordinating clinical apprehensions to the report of the microscopical examination. But in that letter he himself had described a case on which involuntarily he had performed a radical intra-laryngeal operation. It was the case of an old gentleman, aged seventy-five, who had a suspicious-looking wart on one vocal cord. He had only wished to remove a piece for microscopical examination. However, as every laryngologist of experience knew, intra-laryngeal operations were after all more or less of a fortuitous character, and by an exceptional piece of luck he found he had removed the *whole* growth. Mr. Shattock made transverse sections through the whole growth and its base, and it in part bore the characters of a typical cornifying epithelioma. The patient in question was now alive, although more than ninety years of age, and about six weeks ago he actually preached at a wedding! It was well known to the Society that his friend, Professor Fraenkel, of Berlin, had made himself the champion of the intra-laryngeal method of removing a malignant growth in suitable cases, and there were now, as he had said before, a number of well-authenticated cases on record in which the proceeding had been successful. But he could not understand, in spite of this, how after removing an infiltrating growth from the larynx, particularly of the size of the one shown in Mr. Hovell's drawing, it came about that one could not detect the slightest evidence of its former presence and of its removal. Now there was no sign whatever in the larynx of Mr. Hovell's patient to show that a large epithelioma had been removed. If he were asked at the present moment in a court of law to state on oath from which vocal cord the growth had been removed, he would have to confess his inability to tell, and he would have to say it looked as if nothing had been removed. So clinically he must confess the case beat him altogether. Further, he had seen a good many cases in which there was for some time a considerable arrest in the progress of a malignant growth, but for this to happen for *several years*, during which there was practically no progress observed in the size of the growth, surely was most unusual. He was not one who did not believe in things for the mere reason that he himself had not seen them; but he found it difficult to understand an arrest of this kind. Again, from a careful examination of Mr. Hovell's own drawing of the growth, it looked to him much more like a large papilloma springing from the anterior commissure of the vocal cords than like a growth, benign or otherwise, springing from one of the vocal cords. If this surmise of his should be correct, then they would have a perfectly natural explanation of the present appearance of the case. He had once himself removed a very large papilloma looking exactly like the growth shown in Mr. Hovell's drawing from the anterior commissure of the vocal cords of a lady aged forty-eight. The specimen was at present in the museum of St. Thomas's Hospital. With regard to the microscopical appearance, he had looked very carefully, but could not see anything in the specimen typical of epithelioma. He willingly admitted that it was an old

specimen, and therefore it might not be so characteristic as it originally had been. He had asked Mr. Hovell if he would consent to more pieces being examined by the Morbid Growths Committee. He hoped it would be the general opinion of the Society that such an unusual case should be submitted to this examination. In conclusion, he wished to say that nothing had pleased him more than Mr. Hovell's final observations to the effect that this was an unusual case, and therefore had to be dealt with in an unusual manner. If the man absolutely refused to have the growth removed in the way which was in accord with the progress of modern scientific surgery, *i. e.* by external operation, then under such circumstances an intra-laryngeal operation was permissible; but he strongly hoped that a case of this sort would not be made the starting-point for further intra-laryngeal operations in cases of suspected or proved malignancy. These remarks were analogous to those he had made at the last meeting in the discussion of the value of injections of iodine or iron in cases of goitre. At a time when one had not a better, such methods were both valuable and permissible, but the operator should keep pace with the progress of surgery; and so he was particularly delighted to hear Mr. Hovell say that under normal circumstances he would recommend the extra-aryngeal operation. With this sentiment he entirely agreed.

The PRESIDENT, in commenting upon this interesting case, thought Sir Felix Semon's proposal of re-examination of the tumour by the Morbid Growths Committee was a valuable one, and ascertained from the meeting that it would be its wish to adopt it. He said the larynx at the present moment showed so little change that it was difficult to imagine that any malignant growth had been removed.

Mr. VINRACE wished to asked Mr. Hovell whether from first to last he had observed any lymphatic enlargement in connection with this growth?

Mr. MARK HOVELL, in reply, said he had not troubled the Society with the full notes of the case, and therefore had not mentioned the attachments of the growth at the time of the first and second operations. At the first operation the growth was attached to the inner border and under surface of the left vocal cord along its whole length. At the second operation the growth was much tougher, and it had a much larger base, being attached to the whole length of the under and upper surface, and inner edge of the left vocal cord, and to the left ventricular band. As regards the portions of the growth which he exhibited, he should be very happy for the Morbid Growths Committee to have a portion of each for further examination. He reminded the meeting that Mr. Eve, who had made his own sections, had definitely stated that the growth was an epithelioma. With regard to the mobility of the left vocal cord, the movement was impaired after the first operation, and had remained so since. In reply to Mr. Vinrace, he did not recollect any lymphatics being enlarged.

## Female æt. 15, with Absorption of the Cartilaginous Septum due to Pressure from Nasal Polypi.

Shown by Dr. Frederick Spicer. The patient came under observation some months ago with both nostrils completely obstructed with polypi, on the removal of which the cartilaginous septum was found to have been absorbed, and the nose disfigured, but there was no perforation.

The case was shown in order to obtain the opinion of others as to its causation; but Mr. Spicer ventured to describe it as above, firstly, because he believed the usually recognised sources from which this trouble arises have been eliminated; secondly, on account of the history; and thirdly, because of the totally blocked condition of the nose when first seen.

There was no family history of syphilis, and none of scrofula; nor was there a history of any injury.

The first indication of anything wrong was the appearance four years ago of what she called "a pimple" upon the bridge of the nose, from which matter came; this was accompanied by a discharge of pus from the nostrils, and was of sufficient import to require the assistance of a doctor. It only lasted a few days.

The President understood that this case had been brought forward with a view to eliciting an opinion as to whether the absorption was really due to pressure from the nasal polypi. It was evidently a case of nasal polypus with disease of the ethmoidal, and possibly of other, sinuses. He should hardly say that absorption of the cartilaginous septum was due to pressure, but more likely to some abscess in the septum, and he would like to ask Dr. Spicer whether he had observed at any time in this case an abscess in this position.

Dr. FitzGerald Powell had seen a case under treatment very similar to Dr. Spicer's, in which there had been an abscess of the septum, which pointed, and was opened at the anterior margin of the septum. The cartilage had entirely fallen away from the nasal bone. There was considerable thickening or broadening of the latter, the result of ethmoiditis. The exciting cause was said to be traumatism. The case was improving, and if possible, and agreeable, he would show the patient at a future meeting as an interesting comparison with the present case.

Mr. Nourse thought that an interesting point in this case was the actual cause of the falling in of the nose; was it due to the absorption of the septal cartilage or to some further injury? He recollected a case he saw at the hospital a short time ago, where the only remain-

ing vestige of the division between the two nostrils was the little columella; the septum, bony and cartilaginous, having entirely disappeared, and yet the nose was perfectly straight and without deformity externally. It struck him in this case that possibly, although there had been disappearance of the triangular cartilage, the falling in was due to the absorption of the lateral cartilages, with consequent breaking of the cartilaginous arch.

Dr. Scanes Spicer thought that this was a case of old septal abscess in which the upper lateral cartilages had been destroyed by the suppuration, and that the deformity was characteristic of that condition. In his experience, traumatism and syphilis were the commonest forerunners of these septal abscesses.

Dr. StClair Thomson thought that Mr. Nourse's explanation might read entirely the other way. He agreed with the President that the broadening was due to starting ethmoiditis, and that the most likely explanation was that the patient had had an abscess of the septum. He had made reference on a previous occasion to a case in which an abscess in the septum—not traumatic—occurred in the course of suppurative disease of the antrum. Of course they all knew of cases like that mentioned by Mr. Nourse, where the whole cartilage might be absent, and yet there was no falling in. But if the cartilage was absent through an abscess, the consequent contraction of the cicatricial tissue explained the dragging down of the bridge and the deformity of the nose. In this patient, if the nose was grasped from side to side and compared with one's own nose, it became very evident that there was a large defect of the quadrilateral cartilage of the nose.

The President thought Dr. Thomson's explanation the correct one, *i. e.* the occurrence of contraction of the cicatrix after absorption of the cartilage.

Dr. F. Spicer thanked the various speakers for their remarks. He had nothing more to add. He thought he must agree that the absorption was due to abscess, and considered the abscess was secondary to polypi and ethmoidal trouble.

## Case of Unusual Laryngo-pharyngeal Tumour in a Woman, with Microscopic Specimen of Growth removed.

Shown by Dr. Lambert Lack. This patient was shown at the last meeting of the Society (see page 116). The advice given on that occasion had been very carefully considered, but after some hesitation the exhibitor had preferred to perform an external operation, so as to thoroughly examine the growth and its attachments, and to see exactly what steps were necessary to completely extirpate it. An incision some four inches long was accordingly made in the anterior triangle of the neck, the sterno-mastoid muscle and the large vessels drawn outwards, and the

lateral pharyngeal wall exposed. A linear incision was then made into the pharynx, and the larynx hooked forward so as to thoroughly expose its posterior wall. The growth was soft and nodular, about the size of a pigeon's egg, and attached by a broad base to the mucous membrane over the cricoid cartilage. The mucous membrane was divided all round the growth, and it was then dissected off the larynx. The wound in the mucous membrane of the larynx was closed with a few catgut sutures. The wound in the pharynx was then closed by a row of closely placed fine sutures uniting the edges of the mucous membrane, and the pharyngeal aponeurosis was also carefully stitched up. A large drainage-tube was inserted into the wound in the neck, and the skin wound closed by silk-worm gut sutures. Just before opening the pharynx, a laryngotomy was performed as a precautionary measure, but it was really not needed, and the tube was removed next day. The after history was uneventful. The patient swallowed easily the day after the operation, and five days later could take solids more easily than before operation. The wounds, except where the drainage-tube had been, healed by first attention, and the patient is now able to attend the meeting, on the sixteenth day after the operation. Examination with the laryngoscope shows nothing abnormal.

Dr. Jobson Horne has made sections of the growth, which he reports to be a mixed-cell sarcoma.

Sir Felix Semon suggested that this specimen should be submitted to the Morbid Growths Committee. He did not pretend to be a great histologist, but to him the section of the tumour looked more like a fibroma than a sarcoma, and he would like to have the opinion of the Morbid Growths Committee. Under all circumstances, Dr. Lack must be congratulated on his most successful operation.

Dr. StClair Thomson asked if Dr. Lack intended publishing the case in full in the 'Proceedings;' if not he would like to have a few particulars as to whether it was necessary to put temporary ligatures round any of the arteries; as to whether he had experienced any difficulty with bleeding or breathing, and as to what steps were necessary in turning round the larynx.

Dr. Lambert Lack said there was no difficulty with bleeding, as the large wound exposed the whole field of operation to view. Consequently there was no necessity to put temporary ligatures round any of the large vessels. Such a proceeding was only necessary when operating in the pharynx through the mouth, where it would be impossible to pick up any large vessel which might be cut.

The PRESIDENT having obtained from the Society an expression of its desire that a specimen of the growth should be submitted to the Morbid Growths Committee, Dr. Lack said he should be very pleased to supply a portion of the growth for examination.

### SPECIMEN OF BONY OCCLUSION OF ONE NOSTRIL.

Shown by Dr. LAMBERT LACK. The specimen showed a complete occlusion of one nostril at about its centre by a bony septum. The nose was otherwise normal. The specimen was obtained whilst dissecting, and no history was obtainable.

### SPECIMEN OF MULTIPLE PAPILLOMA OF LARYNX.

Shown by Mr. H. W. CARSON. The specimen was removed post mortem from a female child æt. 2½ years, who had died suddenly of asphyxia. There was a history of orthopnœa and dysphonia from birth. The specimen showed well-marked papillomatous growths in the region of the vocal cords, and a subglottic extension on the anterior wall. There was some œdema in the arytænoid region.

Mr. Carson wished to ascertain the views of members of the Society on the question of prognosis, more especially as regards recurrence after thyrotomy.

The PRESIDENT said this subject had been under discussion at the Society on previous occasions. They knew that recurrence often did take place. There was the celebrated case in which thyrotomy was performed seventeen times.

### CASE OF PACHYDERMIA LARYNGIS.

Shown by Mr. CHARLES A. PARKER. This patient had been shown to the Society about two years ago, when it was thought by some to be of a tuberculous nature. Since then the chest had been frequently auscultated, and the sputum examined from time to time, but no evidences of tubercle had been discovered. The local condition was practically unchanged, in spite of various

methods of treatment, both at Mr. Parker's hands and at the hands of others, for the patient had sought relief at other hospitals. Mr. Parker would be glad to know if anything further could be done for the patient.

The PRESIDENT said he understood that the condition had existed for three or four years without much improvement.

Dr. JOBSON HORNE considered the condition was typical of pachydermia laryngis verrucosa, and agreed with Mr Parker that tuberculosis was not a factor in its causation. Dr. Horne was not in favour of any local treatment of a surgical nature.

Mr. DE SANTI was of opinion that in this case the line of treatment now should be to leave the man quite alone.

Mr. PARKER, in reply, said he showed the case chiefly because on the former occasion it was thought by some members to be tubercular, and he was then asked to bring it forward again. He did not think there had ever been any evidence of tubercular disease. For the last nine months no treatment had been attempted.

## A CASE OF TUMOUR OF THE BASE OF THE TONGUE IN A YOUNG FEMALE.

Shown by Dr. DUNDAS GRANT. This case was shown with the object of gaining from the members of the Society opinions as regards both diagnosis and treatment.

Mr. DE SANTI considered this case to be one of extensive sarcoma of the base of the tongue. The feel of the tumour, its irregular surface, the absence of ulceration, the age of the patient, and the history, all pointed strongly to its malignant nature. Moreover, a large piece of the growth had been removed a year ago (unfortunately he understood this piece had been lost, and therefore not submitted to microscopic examination), and had been followed by a rapid and considerable extension of the tumour. The patient he noticed had enlargement of the submaxillary glands, and this was far from uncommon in sarcomata of this neighbourhood. A piece of the growth should be removed and submitted to a skilled pathologist for microscopic examination, and the case dealt with surgically.

Dr. LAMBERT LACK had under his care at the present time, a young girl æt. 19, presenting some features very much like this case. The tumour was a smooth one with large vessels coursing over it, and he was under the impression that the growth was a thyroid tumour. He would not, however, like to give that diagnosis in the present case, unless some of the ulceration seen was due to the removal of pieces by Dr. Grant.

The PRESIDENT said with regard to thyroid tumours at the base of

the tongue, he had had one case which he had shown to the Society, but this case presented a different appearance. It was more irregular and more like a malignant growth.

Dr. FitzGerald Powell said that the tumour looked like a carcinoma to him, though the woman's age was against its being so; anyhow a portion should be removed and examined microscopically before anything further was done.

## A Case of Ulceration of the Tip of the Tongue in a Man æt. 52. For Diagnosis.

Shown by Mr. Attwood Thorne. The patient had complained of some pain for the last year. Mr. Thorne only saw the patient ten days ago, and he then at once put him on iodide of potassium, grs. 10 three times a day. There was, if anything, a slight improvement. Hs asked whether it was epithelioma, syphilis, or tubercle? The tongue was slightly fixed.

The President advised that the iodide of potassium be pushed.

Mr. Mark Hovell suggested that a piece should be removed and submitted to the microscope.

Dr. StClair Thomson said syphilitic disease was certain, and malignant possible. In all cases where there was any doubt it was the rule to treat the case on anti-syphilitic lines. He had once had a patient who was condemned to have his tongue removed by a leading authority on syphilis. That patient was afterwards shown as having been cured of cancer by Mattei's remedies. Mr. Thorne would be well advised to take no further measures until inunctions of mercury had been given a good month's trial.

Mr. de Santi considered this case to be epitheliomatous rather than syphilitic. There was marked induration at the base of the ulcer; the ulcer itself was raised and warty, not depressed and punched out, and it rubbed distinctly over the lower incisor teeth. There was a little limitation of movement, and some slight fulness in the submaxillary region. It was an uncommon situation for a gumma, but not so uncommon for epithelioma.

Dr. Lambert Lack said that Dr. Thomson had exactly stated his views when he said it was certainly syphilis and quite likely epithelioma, but he disagreed entirely with his suggestions as to the course to be pursued. Dr. Lack thought it was very wrong to put a case of suspected epithelioma in such an accessible region on a course of iodide of potassium, and more especially to give him a month's course of treatment by mercurial inunction, when the diagnosis could be immediately made by removing a small piece of growth for microscopical examination. Should the case be malignant, the danger of such a long delay was obvious.

Mr. VINRACE wished to ask whether Mr. Thorne had noticed any fixation in the tongue. He thought the patient had considerable difficulty in putting it out, and its movement was impaired. He asked if there were any infiltrations, other than those of a malignant nature, which impaired the movements of the tongue.

Mr. THORNE, in reply, said that he would remove a small portion for examination, and would order mercurial inunctions, and hoped to report on the case at a future meeting.

# PROCEEDINGS

OF THE

# LARYNGOLOGICAL SOCIETY OF LONDON.

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SIXTY-SEVENTH ORDINARY MEETING, *June 7th*, 1901.

E. CRESSWELL BABER, M.B., President, in the Chair.

ERNEST WAGGETT, M.B.,
CHARLES A. PARKER, F.R.C.S.(Ed.), } Secretaries.

Present—32 members and 3 visitors.

The minutes of the preceding meeting were read and confirmed.

The following cases, specimens, and instruments were shown:

## CASE OF ULCERATION OF THE LARYNX (? TUBERCULOUS) IN A MALE ÆT. 48.

Shown by Dr. DE HAVILLAND HALL. The patient was first seen on April 30th, 1901, when he complained of hoarseness. He was in the army thirteen years, and has been in India, Canada, Egypt, and South Africa. The only previous illness he has had was enteric fever in 1882. No history of any venereal disease can be obtained. The patient lost his voice twelve months ago, but he had no treatment until last April. He has had a cough and some expectoration, but no hæmoptysis. He has lost weight.

There has been thickening and ulceration of both vocal cords and interarytenoid commissure. There has also been some ulceration on the laryngeal aspect of the epiglottis. There are physical signs of consolidation with râles at both apices, and a few tubercle bacilli have been found in the sputum.

Under the inunction of blue ointment and the administration of potassium iodide—20 grains three times a day—there has been considerable subjective improvement, but very little objective alteration in the larynx.

Dr. StClair Thomson was of opinion, from an inspection only of the larynx, that it was a case of tuberculous ulceration in a syphilitic subject, who had probably had pachydermia, and had now contracted tuberculosis of the larynx.

Dr. de Havilland Hall said this was precisely the view he took of the case when it was in hospital, though he was unable to obtain any history of syphilis. In spite of inunctions of mercury and iodide of potassium internally, there had been very little alteration in the appearance of the larynx as seen by the laryngoscope. At the present time, however, the patient breathed much more comfortably than he did when first seen.

## Case of Malignant Laryngeal Growth in a Man æt. 52.

Shown by Dr. StClair Thomson. This patient complains of hoarseness coming on slowly for the last two and a half months. He attributes it to repeated colds since January, so that we may take it that the laryngeal affection dates from at least five months ago.

His voice is now reduced to a hoarse whisper. The anterior four-fifths of the right cord is occupied by an oblong growth with an irregular mammillated surface; the tips of some of these excrescences present the white snow-like surface which has been referred to at previous meetings of the Society in connection with the question of malignant disease. The anterior third of the left cord is also infiltrated, and shows one or two of these white-tipped mammillæ. The posterior part of the same cord appears as if indented by the larger growth on the right cord. Both cords move, but while the left moves freely, the right is decidedly limited in its excursions.

There is nothing in the patient's history to arouse a suspicion

of lues. He has no cough, expectoration, or hæmoptysis. The temperature is normal, the pulse is not hurried, and the chest sounds are normal. He has taken 5 grains of Iodide of Potassium with some Liquor Hydrargyri Perchloridi since May 25th without any apparent effect.

Dr. Thomson inquired whether the condition was due to malignant disease, whether the diagnosis could be made with sufficient certainty without recourse to removing a portion for microscopic examination, and whether the case was suitable for operation by laryngo-fissure?

Mr. SPENCER thought it was malignant and now bilateral owing to infection from the opposite side. In his opinion it required early and extensive operation.

Mr. WAGGETT asked Dr. StClair Thomson if he contemplated performing thyrotomy, and if so, would he bring the case before the Society when he had done so. He presumed thyrotomy should be undertaken as an exploratory measure.

Dr. STCLAIR THOMSON said he thought of performing a thyrotomy, and he wished to know whether members present thought the diagnosis could be positively made without recourse to the excision of a piece of the growth. He himself thought removal of a portion was unnecessary, for if the examination was negative it would not alter their present opinion. Before proceeding to a thyrotomy he should like to know how freely one might remove the parts when both cords were affected? Of course, one might scoop out very freely the whole of one side of the interior of the larynx. Could one be as free on the other side without fear of stenosis? He had had one case in which the whole of one of the cords right up to the arytenoid was removed, and the anterior fourth of the opposite cord as well, but in the present case it seemed to him that not only the whole cord originally affected, but two thirds of the opposite cord required removal; if at the exploratory operation he found this was so, would it be safe to carry it out?

Sir FELIX SEMON said that he had several times found it necessary to excise both vocal cords, and that no subsequent stenosis had resulted. He did not think that such an event was to be feared. He quite agreed with Mr. Spencer that in all probability there was secondary disease of the left vocal cord, owing to auto-infection. Probably, however, it would be found sufficient to simply excise the left vocal cord, if this suspicion should turn out to be justified, with curved scissors.

## A Case of Frontal-Sinus Suppuration Fourteen Months after External Operation,

Shown by Dr. StClair Thomson,

and

## Three Cases Demonstrating the Results of External Operation on the Frontal Sinus,

Shown by Dr. Herbert Tilley.

Dr. Thomson's Case. This case was shown to illustrate the completeness and permanence of the cure of nasal suppuration, due to frontal sinusitis, and also to demonstrate that the external scar was trifling and had not increased with time.

The ordinary external operation was performed on April 10th, 1900. A photograph was shown of the scar three months later, and by comparison with the patient's actual condition, it would be seen that this had not increased.

The patient still has suppuration in the antrum, which is drained through a tooth socket. She had, however, been instructed not to syringe this out for forty-eight hours, and as she had not had occasion to wash her nose out since the date of operation on the frontal sinus it would be allowed that the freedom of the nose from all trace of pus was both genuine and complete. She now never requires more than one handkerchief a day, and states, that were it not for æsthetic reasons, two a week would suffice.

Dr. Herbert Tilley's Cases. These cases were shown to demonstrate that if the radical operation was effectually carried out, there was no reason why a recurrence of the discharge should take place with lapse of time, as he understood Dr. McBride to have suggested at one of the recent meetings of the Society, and that there was nothing terrible about the operation. These cases had been operated on fourteen months, nine months, and six months ago respectively, and there was still no trace of purulent discharge into the nostrils. Two of the cases also illustrated how slight a deformity is caused by a somewhat radical operation.

Dr. Vinrace confessed to having used the word *terrible* in connection with these operations, as he considered them both formidable and

of a serious nature. He laid stress on the importance of freeing the inferior meatus or breathing channel of the nose from all obstruction, and of giving that a fair trial before proceeding to the radical operation. He gathered from the patients that this had not been done in the cases before them. He also considered that it seemed more rational to enlarge *per nares* the natural communication between the frontal sinus and the nose, namely the infundibulum, than to perform an external operation.

Dr. FITZGERALD POWELL asked the exhibitors to give the Society some detailed information as to the methods adopted in the operative treatment of these cases. He would like to know firstly what amount of bone was removed, whether the whole of the anterior wall of the sinus or only a portion of it. Also, if the opening from the nose to the sinus was enlarged and kept open by a tube, either solid or hollow, for purposes of drainage; and secondly, as to the method of packing, and general treatment. They seemed to him to be very excellent results, upon which the operators should be congratulated.

Mr. SPENCER asked Dr. Tilley to give some information with regard to the comparative frequency of unilateral and bilateral affection of the frontal sinuses. Dr. Tilley seemed to meet with unilateral cases chiefly; was it that these cases were more frequent? At one time, very nearly fifty per cent. of cases of frontal-sinus empyema were found to be bilateral, but he had noticed Dr. Tilley showed fewer bilateral than unilateral cases. Was this due to the fact that by doing the radical operation on one side early he prevented the empyema from becoming bilateral?

Dr. MCKENZIE JOHNSTON said that, generally speaking, he thought the antrum of Highmore a much simpler thing to treat than a frontal sinus. In several of these cases, however, the antrum had been opened, and from the fact of the patients still wearing a tube, he presumed that in these cases, as far as the antrum was concerned, the termination of the case was not yet reached. He would like to know when it was proposed to remove the tubes, and whether the "cure" was considered complete before the antrum was in a satisfactory condition.

Dr. FURNISS POTTER asked Dr. Tilley what symptoms he considered necessitated the operation. Would he do the operation in every case in which he had reason to suppose that pus came from the frontal sinuses?

Dr. PEGLER said it was just worth remarking with regard to Mr. Vinrace's remarks that there was much difference of opinion as to which really was the "breathing channel" of the nose.

The PRESIDENT said the main point of interest was what should be the exact radical operation undertaken. The treatment should be as short as possible, and leave as little scar as possible. On these two points the Society would be glad to hear the remarks of Dr. StClair Thomson and Dr. Tilley. He thought it was clearly settled, as had been mentioned by Dr. Tilley, that before operating on the frontal sinus it should if possible be washed out from the nasal cavity. It was usually also necessary to first remove the anterior end of the middle turbinated body.

Dr. StClair Thomson said that with regard to the severity of the operation, the temperature chart showed this not to be the case. His patient was out of bed on the fourth day after the operation, and on the seventh was up for the whole day, and in about a fortnight left the hospital. So at any rate it was not such a "terrible" operation as regards the time the patient had to remain in bed. This woman had the operation done because the discharge was such that she averaged six to eight handkerchiefs a day, and sometimes in the twenty-four hours she might require eighteen. The symptoms were pain over the left eye and neuralgia. She had had discharge for ten months. The disease was evidently brought to a head by an attack of influenza, which made her frontal-sinus condition much worse. There was plenty of room in her nose to admit of proper breathing when it was not obstructed by pus. When the frontal sinus was opened it was found full of pus, and entirely lined with degenerated polypoid mucous membrane. The anterior end of the middle turbinate was removed sixteen days before the operation, which evidently had given sufficient room for drainage, since for some two months after the operation the patient was able to blow air from the hole in the forehead. Even now, if one put the hand on the forehead when the patient distended her nose, one could feel the scar bulge. Several members had noticed this. With reference to the suggestion of treating the frontal sinuses from within the nose, the matter had been considered by the Society on a previous occasion. In this patient, knowing that unsatisfactory results had been obtained, and that fatal cases had been put on record, he determined to keep the wound open for a long time. He operated on April 10th, and did not allow it to close till June 30th. This was one of the factors in the treatment of his case. Another was that he cleared out the fronto-nasal duct, but left no drain into the nose. His patient had, as Dr. Johnston mentioned, still empyema of the antrum. He had thought it might simply be a reservoir for the frontal sinus, and so he left it alone, hoping it would spontaneously heal when it ceased to be filled from above. But the antrum was still secreting pus, though in very small amount. At some future time he intended operating on the maxillary sinus.

Dr. Tilley, in answer to Dr. Vinrace, observed that removal of nasa polypi was a purely temporary measure, and did not relieve the headaches for which the operation had been performed in the cases exhibited. One of his patients had been having his polypi periodically removed for seventeen years at different hospitals. He also pointed out that other questions raised by Dr. Vinrace and Dr. Potter would be found answered in the Proceedings of the Society for February, 1901, p. 78. In reply to Mr. Spencer, Dr. Tilley said that in twenty-three cases of frontal-sinus empyema with which he had had to deal, ten cases had been bilateral.

## Two Cases of Thyrotomy for Malignant Disease of Vocal Cords.

Shown by Dr. Herbert Tilley. In these two cases the operation had been performed five and three and a half years ago respectively. The patients had enjoyed perfect health since, and in the second case the voice was quite good. In the first case the left vocal cord and arytænoid cartilage had been removed, and a few weeks after the operation a large granulation appeared in the anterior commissure, which was still present in a cicatrised form. Had this not been carefully watched it might have been regarded as a recurrence. Sir Felix Semon had confirmed the opinion of the nature of the case before it was operated on. Full details of both cases may be found in the 'British Medical Journal,' October 22nd, 1898.

Mr. Waggett had seen Dr. Tilley do the operation in one case. He remembered that a fortnight after the operation they found some large suspicious-looking granulations in the anterior commissure. These, however, disappeared without treatment.

## Case of Infiltration on Left Cord in a Man æt. 28.

Shown by Dr. Furniss Potter. This patient, a railway porter, whose duties entailed very considerable use of the voice, had recently come under observation complaining of huskiness and a feeling of irritation in the throat, which had troubled him for the last six months.

On examination the uvula appeared to be somewhat elongated, and the left cord was seen to be reddened and infiltrated in its whole length, and it presented an uneven granular appearance. Its mobility was not impaired. The arytenoid region was unduly red, but otherwise the larynx was in normal condition.

The chest had been carefully examined, but no sign of pulmonary mischief had been detected. There was no cough or expectoration, and no loss of flesh or strength, the patient stating that he felt perfectly well, and able to do his work. There was no history of syphilis, and the family history was free from evidence of tuberculous taint.

THE PRESIDENT thought the case might be tubercular, but he understood there was no evidence of tubercle in the lungs. There was no want of movement of the cords.

Dr. FURNISS POTTER thought it was tubercular.

## SPECIMEN FROM A CASE OF SARCOMA OF THE TONSIL, WITH MICROSCOPIC SLIDE.

Shown by Dr. McKENZIE JOHNSTON (Edinburgh). L—, male, æt. 28 years, a farm servant from Shetland, was sent to me at the Royal Infirmary about the beginning of December, 1900, on account of a tumour in his throat. He stated that he had only been aware of its presence for about six weeks, but on inquiry it was found that his friends had noticed for about three months that his speech was thicker than usual. He had no pain or discomfort, and had nothing to complain of except the fact that he felt a lump in his throat, although, latterly, he noticed that when swallowing liquids they were occasionally regurgitated through the nose.

On inspecting the throat, the left tonsil was seen to be enormously enlarged, extending inwards for some half inch beyond the middle line, and also well down into the pharynx. In colour and appearance it appeared much like an hypertrophied tonsil, only somewhat softer and more vascular. Nothing else abnormal could be seen. Several friends to whom I showed it were inclined to think that the condition was a simple inflammatory swelling. I ordered a course of iodide of potassium, but it was soon evident that in spite of this the growth was rapidly increasing, and that glands underlying it were also enlarging. I then removed the greater part of the projecting mass with the electro-cautery, and Dr. Gulland, who kindly examined it for me, pronounced it to be a rapidly-growing round-celled sarcoma. It was therefore evident that if it was to be removed the operation should be undertaken as soon as possible.

On January 3rd, 1901, my friend Mr. David Wallace operated, and I am further indebted to him for the following notes of the steps of the operation. The remains of the tonsil and tissue between the pillars of the fauces and the pillars themselves

were removed, together with two enlarged glands situated posteriorly and below the angle of the lower jaw. An incision corresponding to the posterior part of Kocker's normal incision was made behind and below the angle of the jaw, the enlarged glands removed, and a ligature placed on the external carotid artery. The jaw was exposed in front of the masseter muscle and divided obliquely, in a line from above downwards and forwards, and the two portions widely separated. This, after opening the mouth, exposed the region of the tonsil very freely, and allowed excision of the diseased tissues to be readily carried out. There was practically no bleeding. The jaw was united by silver suture, a drainage-tube inserted through the opening into the mouth, and the posterior part of the wound completely closed. The patient made an excellent recovery, and at the present date remains perfectly well.

THE PRESIDENT said this was a very interesting case, and the Society was much indebted to Dr. MCKENZIE JOHNSTON for coming so great a distance to show this specimen.

## SPECIMEN OF A CHEESY MASS FOUND IN AN ADENOID GROWTH AFTER REMOVAL.

Shown by Dr. MCKENZIE JOHNSTON. The cyst appeared to be about size of half an almond, and was filled with a cheesy material.

Dr. STCLAIR THOMSON did not think these cases were very rare. One often saw them in acute adenitis of Luschka's tonsil, but in the chronic cases they were more rarely visible in the mirror. He had had a case sent to him at the Throat Hospital for recurrent attacks of laryngitis, tracheitis, and bronchitis. The patient had adenoid remains, which were removed, and all present were struck by the sickening smell of the caseous matter in the adenoid growths. It was quite possible that from time to time it gave rise to infection, spreading downwards. He did not think Dr. Johnston looked upon this condition as being of rare occurrence, but showed his specimen as being a good example of these cases. They occurred more often than was suspected.

Dr. JOHNSTON agreed with Dr. Thomson's remarks. He did not think the case extremely rare, but he had not met with such a good specimen before, nor one in which the secretion was so deeply situated;

the specimen, of course, did not exemplify the condition so well as when it was at first removed. Small, somewhat seedlike, masses were often seen, but such a cyst he did not remember to have seen before in this situation.

### Sketch of an Aneurism of the Aorta in which Paralysis of the Left Vocal Cord was the only Physical Sign during Life.

Shown by Dr. Donelan. This patient, an Italian man æt. 39, was admitted into the Italian Hospital on February 14th, complaining of loss of voice, slight dyspnœa, and some numbness and pain in the left arm. He had become slightly hoarse two months before, and had complete aphonia for fifteen days before admission.

There was no history of syphilis. No physical signs could be elicited by the stethoscope. On the 15th, at the request of Cavaliere Naumann, under whose care he was, I made a laryngoscopic examination, and found the usual evidences of paralysis of the left recurrent nerve.

The diagnosis made was paralysis of left recurrent from intrathoracic tumour, probably an aneurism.

On the following morning the patient was suddenly seized with symptoms resembling those seen in angina pectoris, became rapidly collapsed, and died within two hours of the seizure.

The post mortem showed a healthy state of all the organs with the important exception of the aortic arch, where a small oval aneurism was situated on the postero-superior aspect, and immediately outside the origin of the left subclavian. The tumour overlapped and compressed the left recurrent nerve in the manner shown in the rough sketch exhibited.

### Case of Separation of the Upper Lateral Cartilage of the Nose in a Male æt. 25.

Shown by Dr. Fitzgerald Powell. On May 1st of this year this patient consulted me, complaining of considerable nasal obstruction, discharge, and deformity of his nose. He stated

that on June 15th, 1900, he received a blow on the nose, which was followed by bleeding.

In November, 1900, he had an attack of influenza, which left him with much nasal obstruction, and in December he consulted a specialist, who did not find much the matter in his nose.

In January, 1901, a swelling suddenly appeared on his septum, which was opened, and contained pus; a drainage-tube was put in. From this time his nose began to sink and broaden.

When I saw him last May his nose had sunk in at the junction of the cartilages and the bones. The nasal bones were thickened, and the nose widened. The septum was deflected to the left, was swollen, and had an opening of a sinus, which was discharging. The upper lateral cartilages had become separated from the nasal bones.

At the present date he has much improved, the nose is more natural in shape, not so thick and wide, though the depression remains. The sinus is closed; there is no discharge, but he says he sometimes has attacks of epistaxis.

The PRESIDENT understood that portions of cartilage had come away, the result being that the cartilaginous arch had fallen in.

Dr. FITZGERALD POWELL said he showed this case as he thought it would be of interest as a comparison with a somewhat similar case shown by Dr. Frederick Spicer at the last meeting of the Society. Dr. Spicer thought that the condition in his case arose from the pressure of polypi, but the general opinion of the members was that it was due to abscess of septum, probably arising from traumatism. In the case now before them the man had received a blow on his nose on June 15th, and as late as seven months afterwards an abscess formed in his septum, which was opened and drained, and from that time the falling in of the nose took place from the separation of the cartilages. The sinus was discharging up to a month ago, but was now healed, some necrosed cartilage came away, but no bone was observed. The shape of the nose appeared to be improving.

## A CASE OF CHRONIC ULCER OF THE SEPTUM (? TUBERCULOUS).

Shown by Mr. WALTER SPENCER. This occurred in a girl æt. 18, who worked with dusty woollen goods. The ulcer was situated on the left side of the septum, and had been present for a year, during which time there had been some healing at its

lower part, but some extension upwards. There is now an ulcer about ½ cm. in diameter covered by granulations, which easily bleed. The cartilage is not exposed. She has a ringing cough, but there is no evidence of lung or laryngeal disease, nor have tubercle bacilli been found with sputa. The treatment applied has been simple, only alkaline douches and ointments.

Dr. McKenzie Johnston said from the view which he had obtained there seemed nothing to favour the idea of tuberculosis. He considered it of a simple nature, and recommended the application of chromic acid, and at the same time of some simple ointment to prevent the secretions from becoming too hard. He had no doubt it would heal in a short time.

Mr. Parker looked upon the case as one due to dry rhinitis. The ulcer was situated just at the spot where excoriation occurred from dust, etc., impinging on the septum. He did not think there was any evidence of tubercle.

The President thought there was an absence of evidence of tuberculosis in this case.

Mr. Spencer would apply some chromic acid, and recommend to the patient the use of a douche.

## An Apparatus for Vibratory Massage.

Shown by Dr. A. Hudson. Dr. Hudson considered that this instrument afforded a useful method of applying vibratory massage by means of an electromotor. It could be so regulated that any kind of massage could be employed from the faintest stroking to the coarsest hammering. Many thousand vibrations could be obtained a minute, and consequently there was great power of penetration, as the exhibitor had proved by experiments with water enclosed in an india-rubber bag. He had obtained markedly beneficial results in diseases of the eye and ear, and suggested that it was equally suitable for nose and throat troubles, especially for bringing about absorption of inflammatory thickening, and for the stimulation of muscles in cases of paralysis. He had also found it useful for relieving pain and inducing sleep.

Dr. Vinrace asked if any motor power could be used to work the instrument.

Dr. Hudson replied that a continuous current was necessary.

## Three Cases of Bilateral Abductor Paralysis in Tabes Dorsalis.

Shown by Sir Felix Semon. (The notes of these cases were very kindly prepared for the demonstration by Dr. M. Douglas Singer, Senior House Physician to the National Hospital for Paralysis and Epilepsy, Queen Square, Bloomsbury, of which the three patients were then inmates.)

Case I.—G. B—, toy-maker, æt. 51 (under Sir William Gowers). Syphilis twenty-five years ago. No secondary symptoms.

*Present illness* began three or four years ago with pains and pins-and-needles in legs and feet, and some difficulty in walking. Quite from the beginning he had "choking attacks" at night. Stridor at night first noticed about three years ago, and during last three months has been present also in the daytime if he exerts himself at all. Has also had transient diplopia and a girdle sensation. Hesitant micturition for two years. No incontinence.

*Status*, April 26th, 1901.—Pupils R. > L., Argyll-Robertson type. Partial bilateral ptosis. All deep reflexes absent. Superficial reflexes brisk. Marked ataxia of legs. Well-marked Rombergism. Well-marked analgesia of trunk, ulnar borders of arms and legs.

*Larynx*, May 3rd.—Marked double abductor paralysis, almost complete. The left cord is a little better abducted than the right, but even then the maximum width of the glottis in inspiration is only $1\frac{1}{2}$ to 2 mm. Subjective and objective dyspnœa is considerable.

4th.—Tracheotomy performed by Mr. Ballance.

31st.—The glottis is a little wider than it was four weeks ago during inspiration.

In remarking on this case, Sir Felix Semon said he wished to draw particular attention to the fact that since the performance of tracheotomy, the inspiratory inward movement of the vocal cords had ceased. This fact was held to be important in connection with the question whether such inspiratory inward movements were due to a purely mechanical cause, viz. to the

rarefication of the air below the stenosis during inspiration—a view held by the older laryngologists, and by the speaker,—or whether it represented an active inward movement of the vocal cords due to the fact that during respiration both abductors and adductors were simultaneously innervated, and that the abductors having been paralysed, the innervation of the adductors alone prevailed. This view had been advocated by Rosenbach, Burger, and others. If it were correct, one would naturally expect the inspiratory movement to continue even after the performance of tracheotomy. The disappearance of the movement in the present case was held to point strongly in favour of the mechanical theory.

Case II.—C. L—, barman, æt. 32 (under Dr. Bastian). Syphilis fourteen years ago. Temperate in alcohol, non-smoker.

*Present illness* began three years ago with a heavy feeling in his feet and sudden giving way at the knees. Soon after he began to have lightning pains. Two years ago he was told that he snored very much at nights, a thing which previously he did not do; this snoring has continued ever since. Sixteen months ago began to have difficulty in walking, which has steadily increased. About five months ago first had choking attacks at night, and on one occasion lost consciousness in one of these attacks. No bladder trouble.

*Status*, May 13th.—Pupils small, R. > L., Argyll-Robertson type. Knee and Achilles jerks absent. Elbow and wrist jerks diminished. Superficial reflexes brisk. Marked ataxia of legs, with extreme Rombergism. Some analgesia of legs.

*Larynx*, May 31st.—The larynx shows abductor paralysis on both sides with paresis of the internal thyro-arytenoid and the inter-arytenoid muscles. The glottis in front on deep inspiration forms a small ellipse, the vocal processes of the arytenoid cartilages almost touch one another; behind them a comparatively large triangular gap remains.

Case III.—T. W—, smith's labourer, æt. 30 (under Dr. Bastian). Father of patient died of "religious mania." Syphilis fourteen years ago. No secondary symptoms.

*Present illness* began with gastric and rectal crises two and a

half years ago, and have recurred at intervals ever since. Ten months ago began to have also difficulty in walking and lightning pains. About the same time first had choking attacks at night, and soon after noticed a change in his voice. Has had also girdle sensation and precipitate micturition.

*Status*, March 1st.—Pupils L. > R., Argyll-Robertson type. Double ptosis. Knee jerks absent. Slight ataxy and Rombergism. Analgesia of ulnar borders of arms and of lower part of trunk.

*Larynx*, March 8th.—Considerable bilateral and asymmetrical abductor paralysis with slight paresis of the internal tensors. On phonation the cords come promptly together, and only a very small elliptic gap remains in the middle part of the glottis. On deep quiet inspiration the cords are never separated more than about 2½ mm. in the broadest part of the glottis; their inner borders are slightly excavated, and a small triangular gap remains in the cartilaginous part of the glottis. The speaking voice has a slightly forced mournful character. Patient states that he has lost several notes in the upper register.

The PRESIDENT remarked on the great interest of these cases, but at such a late hour of the meeting he thought it would be impossible to enter upon a full discussion of the subject. The case in which tracheotomy had been performed was, he thought, of especial interest.

Dr. FITZGERALD POWELL asked Sir Felix Semon when in his opinion it was necessary to perform tracheotomy in such cases.

Mr. WAGGETT asked what Sir Felix thought of the plan of early tracheotomy in such cases as these, the ordinary cannula being replaced by a solid plug. This measure would relieve the patient of danger from sudden and fatal dyspnœa, while at the same time avoiding the disadvantages of permanent respiration through a cannula.

Sir FELIX SEMON said that at this late hour it was impossible to fully enter upon the discussion of the points which had been raised by the various speakers. With regard to Dr. Fitzgerald Powell's question, he wished to say that this subject had been discussed quite recently in the Society, when he had stated the principles which now guided his action as to the performance of tracheotomy in cases of bilateral abductor paralysis in tabes. It was a very difficult question indeed, and the decision must be made dependent upon the degree of stenosis, and the question of serious choking fits supervening, whilst a full explanation of the situation ought to be given to the patient, and the decision in doubtful cases be left to him. The occurrence of paralysis of the interarytenoid muscle, which as a rule followed the original abductor paralysis somewhat later than the paralysis of the internal tensors, was a blessing in disguise to the patient, as the greater

opening of the glottis resulting from this paralysis greatly diminished the danger of suffocation. As to the permanent wearing of a tube, he thought that the dangers and discomforts it was said to entail were more theoretical than real. He had a patient, a stockbroker, on whom he had performed tracheotomy twenty-one years ago for bilateral abductor paralysis, who was fully able, whilst still wearing his tube, to follow his occupation, and he had never suffered from bronchial or pulmonary affections.

# INDEX.

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