that point will then be seen to acquire minimum vibrations during the application of the pump. These vibrations could be measured only with the aid of the most accurate mathematical instruments.

A vibratory movement may be discerned also in the liquid of the semicircular canals, if, with a file, a very tiny hole be bored in correspondence with each of them, and the eye be fixed on a luminous point produced by the endolabyrinthic liquid reflecting the light of the frontal mirror.

By making a suitable cut in the hard wall of the middle ear, so as to expose the round window, one could also see the vibration communicated to the membrane of this window by the endolabyrinthic liquid. The pneumatic treatment made in the way described gave a regular vibrating movement to all the parts forming the middle and internal ear. Their diagnostic means did not allow them to judge absolutely the clinical results, and in which cases the treatment might be advisable. On some patients it would have a useful effect—on others no effect at all. They could draw the conclusion that the treatment would be useful in chronic, but not in suppurative, diseases of the middle ear.

SOCIETIES' MEETINGS.

PROCEEDINGS OF THE LARYNGOLOGICAL SOCIETY OF LONDON.

Fifty-third Ordinary Meeting, December 1, 1899.

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

A Diagnostic Mistake. By SIR FELIX SEMON.

On October 18, 1898, I was consulted by Mr. A. W——, aged thirty-nine, on account of soreness of the throat on the right side, about the level of the larynx, limited to one definite spot. He also stated that his voice had become gruff, and that swallowing, particularly of his saliva, was somewhat inconvenient. He had not brought up any blood, and stated that he had not lost flesh.

On examination the pharynx was healthy, but the right vocal cord was fixed in about the cadaveric position, and the mucous membrane over the right arytænoid cartilage and the adjoining portion of the plate of the cricoid was considerably tumefied. There was no definite evidence of new growth and no ulceration. On phonation the left cord crossed the median line.

Externally there was general fulness of the glands below the anterior belly of the sterno-mastoid muscle, and this region was more tender on pressure than the corresponding part on the left side. There was a somewhat indefinite history of a chancre many years ago, apparently not followed by any secondary symptoms, although the patient had never been properly treated for it.

I gave him iodide of potassium in 10-grain doses for a fortnight, after which time I wished to see him again.

On the occasion of his second visit no improvement was noticed; on the contrary, the laryngeal tumefaction had increased, and the glands on the right side of the neck were distinctly larger and harder than they had been before. The patient also complained about increased pain in swallowing, sometimes shooting into the right ear. The iodide of potassium was increased to 20 grains three times daily, and the patient was told to come again in a fortnight's time.

When he saw me for the third time, on November 18, matters were again worse than before. Still no ulceration was visible in the larynx, but the tumefaction had increased, and he was now very hoarse. The pain in swallowing had also become worse, and there was more swelling of the glands in the anterior triangle than before.

It seemed practically certain that one had to do with infiltrating malignant disease of the larynx. The removal of a fragment for microscopic examination was impossible owing to there being no distinct projection, but only general tumefaction.

As the question of operative interference became urgent, I sent the patient to Mr. Butlin for an independent opinion. Mr. Butlin shared my conviction that the disease was malignant, as also, I understand, did Dr. StClair Thomson, whose independent opinion the patient sought.

Although, on account of the extensive glandular swelling in the neck, I did not think the case a very suitable one for radical operation, still, I felt it my duty to lay the alternatives of letting matters go on or attempting a radical cure before the patient, who decided in favour of operation.

I had a consultation with Mr. Watson Cheyne, who also did not consider the case a favourable one, but felt sure that, if any radical operation were attempted at all, it ought to be complete laryngectomy. The patient consented to this.

On November 26, in the presence of Dr. Lambert Lack and of myself, Mr. Watson Cheyne commenced the operation. In making the initial incision for tracheotomy, he came at once across an

enlarged and apparently infected gland, in the middle line, quite distant from the region in which one would have previously anticipated that infection might have taken place. Other enlarged glands were detected immediately afterwards, which seemed to come through the crico-thyroid membrane. Tracheotomy having been performed, and a cut joining the tracheotomy incision having been made parallel to the border of the lower jaw, a number of small glands, apparently infected, became visible immediately, almost along the entire line of the incision.

Under these circumstances, I urged that it was hardly worth while going on with the more serious operation originally contemplated, and Mr. Cheyne agreed with this view. The operation was therefore abandoned, but the tracheotomy tube left in position. So far as one could judge with the naked eye, the glands appeared epitheliomatous; unfortunately, no microscopic examination was made.

The patient quickly recovered from the tracheotomy, and returned home a fortnight after the operation.

On October 24, 1899, Mr. W——, whom both Mr. Cheyne and I had supposed to have long since succumbed to his illness, suddenly called on Mr. Cheyne, looking very well, and saying that he had been gaining flesh and strength. He told him that the glands in the neck had continued to enlarge after the operation, but had gone down a month or two afterwards. He had been taking "Clay's mixture" (a preparation of Chian turpentine). His voice was still somewhat hoarse, but strong. He was still wearing his tube, but wanted to have it removed if possible, this being the reason he had gone to see Mr. Cheyne. There was no difficulty in breathing without the tube, and the difficulty in swallowing had entirely disappeared. Nothing in the shape of glands was to be felt in the neck.

Mr. Cheyne wished me to see the patient with him, and a consultation took place on October 27, 1899.

The patient looked better than I had ever seen him before, and stated that he had gained 13 pounds in weight since last year. His voice was good and strong; he wore the tube with De Santi's speaking apparatus. No glands could be felt externally, the right vocal cord was still fixed as before, but the tumefaction on the right side of the larynx had quite disappeared.

I put this case on record because it seems to me to teach the important lesson that, even under circumstances such as I have described, and which practically seemed to leave no doubt as to the nature of the disease, a number of experienced observers may

be mistaken, unless, indeed, it be assumed that the disease had after all been epithelioma, and that it had been cured by Chian turpentine.

What the real nature of the disease was can, even now, I think, hardly be stated with absolute certainty. What seems most probable, however, is that, after all, there had been a syphilitic perichondritis of the larynx, in the course of which an extensive but purely inflammatory swelling of the cervical glands occurred, and that whilst the laryngeal affection, for some unknown reason, had not yielded to the iodide, later on it had spontaneously subsided, followed by reduction of the glands to their normal size. Other causes, such as a so-called "idiopathic" or tubercular perichondritis, do not seem to come into question here.

There can, of course, be no objection to the patient's tube being now removed if, after preliminary corking, it is found that his laryngeal respiration suffices.

The PRESIDENT expressed the opinion, which he was sure was unanimous, that Sir Felix Semon had done a very kind thing in bringing this case before the Society, an example which they might all follow with advantage, for they certainly learnt more from mistakes than from anything else. As regards the cause of the great improvement, the man himself was firmly convinced that it was due to his mixture. Chian turpentine had a reputation at one time, and there might, after all, be something in it. It reminded him of a similar diagnostic mistake in a different part of the body. He had a clergyman with chronic jaundice in the Hostel of St. Luke. His colleague, Mr. William Rose, and he proposed to the patient that he should be examined surgically, to see if the obstruction could be removed. Mr. Rose accordingly opened the abdomen, and found a hard mass which he regarded as malignant disease of the liver. He (the President) was present at the operation, and agreed with him. The patient was sewn up, and left the hostel in two or three weeks. Six months later he wrote to say he was completely well, and had remained so since the operation. There is another example in which an incision is followed not immediately by improvement, but improvement some time later. He referred to tubercular peritonitis. He would therefore suggest that possibly the incision in the neck had something to do with the improvement.

Mr. BUTLIN said: I saw this patient in consultation with Sir Felix Semon, and came to the conclusion that the disease was probably malignant, not so much on account of the appearance of the larynx as because of the enlarged gland at the angle of the jaw.

It is a very unfortunate circumstance that the glands which were taken out were mislaid, so that no microscopic examination of them was made; for we very much need more knowledge of the real nature of these diseases which disappear spontaneously, and which yet have many of the characters of malignant disease. It is, of course, almost certain, but it is not actually proved, that the disease in this case was not malignant, and that the diagnosis was erroneous. As to the mere error in mistaking an innocent affection for malignant disease, I have seen that mistake made so frequently by the best surgeons that I have long ceased to think seriously of it. And in many of the cases the disease has been so situated that it could be easily handled and closely examined. What wonder, then, if errors of diagnosis are made now and again in regard to tumours of the larynx which cannot be reached with the fingers, and which are only seen in the distance in a looking-glass? The wonder is, not that mistakes of diagnosis are occasionally made, but that the diagnosis is so frequently correct. I suppose no disease is so frequently mistaken for malignant disease as syphilis; and I have often said that iodide of potassium has cured more reputed cancers than all the quack medicine in the world.

Dr. StClair Thomson said it might interest the members if he read his notes of this case, as the patient consulted him a little over a year ago, and as he did not mention that he had been under the care of any colleague, the notes had the value of being uninfluenced by any suggestion. He found on November 19, 1898, that the patient was slightly hoarse, had slight dysphagia, and no cough, but some irritation in the throat. There was an enlarged hard gland below the right maxillary angle. The laryngeal mirror revealed a tumour of the right arytænoid, irregular, not ulcerating, concealing the greater part of the glottis, but the right cord on phonation was evidently fixed. The left cord moved easily. There was no loss of weight; no history of lues. The heart and lung sounds were normal. The patient was advised to take iodide and mercury for a week, when the question of operation would have to be considered. The patient then withdrew from Dr. Thomson's study, and the patient's brother proceeded to show such an intimate acquaintance with thyrotomy, iodide of potassium, extirpation of the larynx, etc., that he was charged with having seen other medical men about his brother. He confessed that the patient had been under Sir Felix Semon's care for the past five weeks, and that he had also seen Mr. Butlin. He was thereupon advised to return to their care, and be guided by their advice.

Dr. StClair Thomson had not seen the patient again until he

was shown at the meeting. In connection with this curious case, Dr. StClair Thomson said he would venture to refer to another, as it was not probable that he would be able to bring it before the Society. It was that of a poor professional man, aged forty-eight, who was sent to him for loss of flesh, and dysphagia of three or four weeks. The left arytænoid region was occupied by an irregular, dull red growth, with white necrotic-looking patches on it, something like the snow-drifts in the hollows of high mountains. The speaker believed that Sir Felix Semon had referred to unusual snow-white appearance of tumours as pointing strongly to malignancy. Gleitsmann had also referred to the very white appearance in a laryngeal growth of unusual character. In Dr. Thomson's case there was much pain and discomfort from the constant tendency to swallow mucus. The cord on the same side was partially hidden, but was seen to move, while the right cord was normal. A gland was felt to be slightly enlarged on the affected side. There was no specific history. Under these circumstances a very gloomy prognosis was given, and, indeed, the patient's attendant in the provincial town where he lived was written to to be prepared for tracheotomy.

Happening to be in the same town a month later, Dr. Thomson had asked to see the patient, and found his voice clear, his swallowing easy, and the growth entirely disappeared, with the exception of a slight thickening of the left aryepiglottic fold. The cords were clear and moved freely. This improvement had taken place without the administration of any antispecific, or any particular line of treatment.

Mr. Spencer asked, respecting the two enlarged glands seen on the crico-thyroid membrane, one on each side of the middle line, were these glands frequently seen? He had seen the two glands enlarged in an undoubtedly syphilitic patient, who had first been treated by iodide of potassium and mercury, but who had afterwards to be submitted to thyrotomy in order to clear out the interior of the larynx. These glands might have been considered malignant to the naked eye had not the diagnosis of syphilis been certain.

Sir Felix Semon, in replying, said, with regard to the remarks of the President, that he also had seen cases of tubercular peritonitis get infinitely better, although not entirely cured, after opening the abdomen. He hardly thought, however, that such an explanation would apply to the present case, the less so as only a very small number of enlarged glands had been exposed to the air in the course of the operation. He certainly was not a believer in

the efficiency of Chian turpentine in cancer. With regard to Dr. StClair Thomson's observation, he begged to disclaim all responsibility for the description of certain forms of laryngeal cancer as similar to a 'snow-drift.' What he had said in reality was, that if one met with a growth of particularly snow-white colour, which at first sight looked like a papilloma, but the eminences of which were not nearly so bulbous and rounded as in papilloma, but *sharply pointed* like grasses, that such an appearance was extremely suggestive of malignant disease. With regard to Dr. Spencer's remark, he thought glands existed near the crico-thyroid membrane on both sides of the trachea.

Case of (?) Myxofibroma of the Post-nasal Space. Shown by Dr. FitzGerald Powell.

The patient, a boy aged seventeen, states that he always had good health until four years ago, when he began to sleep badly at night, and as soon as he went off to sleep he was awakened by a feeling of suffocation. He had also at this time attacks of free bleeding from the nose and mouth, which occurred about twice a week. This got gradually worse. Two years ago he went to St. Bartholomew's Hospital, and was an in-patient for six weeks. He states he had a swelling in his throat, which was lanced, but not otherwise dealt with. For over two years he has been unable to breathe through his nose. The growth grew pretty quickly about two years ago, but the patient does not think it has grown of late. Since the nose has been completely blocked he has not had any bleeding, but has suffered from great drowsiness, and has had incontinence of urine for two years.

On examination, the naso-pharynx is seen to be full of a somewhat soft reddish-white growth, resting on the soft palate and pushing it forward, but not extending below the free edge of the palate. It is lobulated, movable, and is free posteriorly and at each side.

On pushing the finger along the front of the growth it appears as if its point of origin can be felt. It seems to be firmly attached to, and to be continuous with, the posterior end of the septum, which appears to be pushed to the left.

The right choana is roomy and filled with a prolongation of the growth, which can be seen from the front.

Dr. Herbert Tilley thought the growth was of a sarcomatous nature. It was soft, very vascular, with an extensive attachment, points which he had been enabled to determine satisfactorily by examining the growth with the finger in the post-nasal space. He

advised removal, and in view of the difficulties which might be encountered at the time, especially free hæmorrhage, a preliminary laryngotomy or tracheotomy would be advisable. The soft palate should then be divided, and the growth fully exposed to view, so that there could be no difficulty in dealing efficiently with its attachments, and the whole treatment would be rendered easier.

Mr. Spencer did not think this case malignant, but some of these growths tended to burrow extensively outward into the neighbouring sinuses and fossæ. In a recent case he had found such a growth extending outwards behind the upper jaw into the temporo-malar region and cheek. It had been successfully removed from the face by cutting away the outer wall of the nose and antrum without disturbing the orbital plate or the alveolar border and hard palate. He did not see the necessity of tracheotomy if the parts were well exposed, a sponge drawn upwards into the naso-pharynx, and the patient well propped up.

Dr. Scanes Spicer said, as far as one could see from a cursory examination, this was not likely to be a malignant tumour. He had seen many similar cases, which were like modified polypi. A more careful examination was necessary, and, in his opinion, the growth should be removed by means of a snare. He called attention to the large space between the soft palate and the spine, which would render possible almost any manipulation without dividing the palate in this case. He agreed with the name the exhibitor had given to the case—myxofibroma.

Mr. Butlin said: The tumour in this case, from its large size and red surface, appears to me to be probably a fibroma, and may probably be removed with safety. I have had a considerable experience in the removal of these post-nasal tumours, and have long since come to the conclusion that by far the safest and most certain method is to divide the soft palate and the soft parts of the hard palate in the middle line, and cut away the bone of the hard palate until the tumour is thoroughly exposed. I am very much opposed to temporary resection of the upper jaw and other methods practised through the nose. Nor do I find it necessary to perform tracheotomy. The patient should be laid on his side, with the head forwards and low, the mouth well opened with a gag, and the light reflected from a head lamp or mirror. When the surface of the tumour has been thoroughly exposed, and its attachments have been ascertained, it can be freely cut out with scissors, chisel, and bone forceps. The hæmorrhage is often very severe in such cases, but it can be arrested by plugging with gauze if it does not

cease spontaneously. The removal of the tumour in this manner is not likely to be followed by recurrence of the disease.

Mr. Symonds said he thought that in a great many of these cases it was unnecessary to perform so large an operation as that proposed. He thought in the great majority of young people these fibromata could easily be removed from the mouth, while the smaller ones could be extracted through the nose. He had on several occasions dissected them from their adhesions by the finger introduced from the naso-pharynx, and sometimes from the nose at the same time. While the hæmorrhage was for the moment smart, he had never encountered any difficulty in arresting it immediately by a plug in the naso-pharynx, this plug being removed before the patient left the table. He thought the hæmorrhage in this case did not indicate any special vascularity. He had noted that there was not uncommonly an adhesion between the tumour and the pharyngeal wall, which bled freely on being torn. In a recent instance this hæmorrhage led a surgeon of distinction to abandon a case which was successfully dealt with in the manner described. He would therefore reserve the larger operation for those cases where the tumour grew into the neighbouring fossæ. He would call attention also, on the point of recurrence, to the fact that the mass removed on the second occasion might be a growth from a considerable mass left behind, and yet be of a simple nature. In one such instance he had at a second operation removed a process from the sphenoidal sinus.

Dr. Bond recommended that the growth be attacked through the mouth, which would not be difficult. The soft palate should be split, and thick pieces of silk should be passed through the sides of the palate and used as retractors, so as to afford a good view of the whole thing before chiselling away part of the hard palate, if that should be necessary. He was a strong believer in laryngotomy in operations on fibroids and sarcomata in the naso-pharynx, and recommended that a small sponge, fixed on the middle of a piece of tape, should be pulled down into the top of the larynx. Thus ample room was afforded the operator in the mouth and pharynx; he was not incommoded by sponges or chloroforming impedimenta; the chloroformist could do his work at ease, and any severe hæmorrhage could be readily treated. The laryngotomy wound was a trivial one, and healed in two or three days.

Dr. StClair Thomson referred to a paper by Doyen, who had operated on a considerable number of these cases, and who had come to the conclusion that they should be attacked from the

mouth. Doyen's great point was that the operator should push through quickly with the removal, regardless of the abundant hæmorrhage, for the latter ceased rapidly as soon as the growth was completely detached. For the operation itself specially adapted raspatories were advised. Dr. Thomson also suggested the adoption of the Trendelenburg position for operations of this character.

Dr. FitzGerald Powell, in replying, said he was glad his case had given rise to such an interesting discussion, and he thanked the members for the remarks they had made and for the information he had derived from them. In connection with the treatment to be adopted, he thought the first point to be settled was as to the character of the growth. Was it a pure fibroma, a sarcoma, or, as he believed, a myxofibroma? If the latter, its presence should not be attended with such serious consequences, and it was not so prone to invade the antrum, orbit, and other parts, as the pure fibroma or sarcoma. It was softer and grew more rapidly than the fibroma, but not so rapidly as the sarcoma. So far as he could make out, it was not attached to the "basi-occipital" bone. His own feeling with regard to the operation was that it would most likely be successful; and his intention was to do a preliminary laryngotomy, then split the palate and examine the tumour and its attachment thoroughly, and, if necessary, lift the periosteum from the hard palate, and chisel away as much of it as was required to expose the origin and facilitate its removal. He hoped to show them the growth at a later meeting.

Case of Recurrent Papillomata of Larynx.

Dr. Bronner (Bradford) showed sketches of a case of recurrent papillomata of the larynx before and after the local use of formalin. A man of forty-nine had been treated for papillomata for several years, and a large number of the growths had been removed by forceps every two or three months. Various local remedies had been tried. A formalin spray was used for three months, and the growths had to a great extent disappeared, and there had been no recurrence during the last nine months. The spray was now used only one day in the week.

The papillomata were large, finely divided, of cauliflower appearance, and sprung from the vocal cords, ventricular bands, and interarytænoid fold. They frequently gave rise to severe attacks of dyspnœa. After the use of formalin the papillomata became much smaller and round; the finely-pointed excrescences had disappeared altogether. The ventricular bands were nearly normal, but the vocal cords were still irregular and thickened.

In reply to Dr. DUNDAS GRANT,

Dr. BRONNER said, among other applications, he had used salicylic acid, but it had not the slightest effect.

Dr. BOND asked the strength of the sprays used.

Dr. BRONNER replied that he began with sprays of the strength of 1 in 2,000, but gradually increased this till he employed a solution 1 in 250, or even stronger. He would like to know if any other members of the Society had had any experience of formalin.

Case of Acute Ulcer of the Faucial Tonsil. Shown by Mr. WYATT WINGRAVE.

Married female, aged thirty-two, was seen on Tuesday, December 14, when she complained of sore throat and painful swallowing of three days' duration. On examination, a single ulcer about the size of a shilling was seen on the right faucial tonsil. The outline was sharply defined, edges red, while the base was of a grayish-white colour, and the slough was readily removed by throat cusps, exposing a rough, mammillated surface. The surrounding tissues were apparently normal. There was but very slight constitutional disturbance, temperature being 100·2°. There was no history of syphilis, but she had lost her father and one sister from consumption. Two days later the ulcer was unchanged in appearance, and her only trouble was constipation of the bowels. On December 21 the ulcer had quite gone, leaving a ragged depression in the tonsil.

Scrapings were examined and showed mono- and multi-nucleated lymphocytes, free epithelial squames, streptococci, staphylococci, and numerous slender rods which stained faintly with methyl blue. There were no tubercle nor Klebs-Löffler bacilli. The history, clinical signs, and the microscope having enabled one to exclude syphilis, diphtheria, and tubercle, it was diagnosed as acute ulcerative tonsillitis, since it conformed in all respects with the classical description of Moure.

Mr. Lake exhibited a case two years ago, and described a special braded form of bacillus as predominating. In this instance the slender, pale staining rods were the most numerous.

Case of Paresis of Soft Palate. Shown by Mr. WYATT WINGRAVE.

A married man, aged thirty-four, had complained of pain and a sense of constriction in his throat for four weeks, and of a change in his voice of one week's duration.

He stated that he had syphilis fourteen years ago, and had enjoyed fair health till a month ago, when he became short of breath, had attacks of giddiness and headache occurring frequently

He noticed that he was gradually losing control over his bladder, and his knees gave way. Later still, food returned through his nostrils, and his voice became nasal. Deglutition was painful.

On examination, the soft palate was markedly paretic, and he evidently swallowed with difficulty, and could not pronounce his gutturals. The vocal cords were normal in colour and texture, but abduction seemed sluggish. Although the eyeballs were somewhat prominent, paresis of the ocular muscles was not observed, nor of the facial or lingual. Sensation and reflexes were normal.

He was at once ordered 5-grain doses of potassium iodide, and in the course of three weeks has shown marked improvement, although the palate is still paretic and his voice still somewhat nasal in quality. Deglutition is painless and normal.

The PRESIDENT said the patient had had some difficulty in swallowing, together with a very sore throat, and as diphtheria seemed to be excluded by the absence of the knee-jerks, he would suggest that it was a local neuritis due to the inflammatory condition of the patient's larynx.

Growth or Granuloma of the Epiglottis for Diagnosis. Shown by Mr. WAGGETT.

The case of a robust man of sixty, complaining merely of slight hoarseness of four months' duration, sent to the hospital for removal of a papilloma of the uvula. Laryngoscopic examination showed an epiglottis much curled, deflected to the right, and concealing the vestibule of the larynx. A mammillated excrescence was to be seen projecting from the posterior surface of the epiglottis, near its right border. This excrescence had been white in colour at first, but had on a later examination appeared purple. The posterior part of the right arytænoid region could be seen red, swollen, and immobile during phonation. No glands in the neck; no evidence of pulmonary tuberculosis. One brother died of phthisis. A history of gonorrhœa. After fourteen days' exhibition of potassium iodide, the patient expressed himself as better, but the laryngoscopic image was unaltered.

Digital examination was not feasible.

Case of Œsophageal Pouch. Shown by Mr. BUTLIN.

I show here the fifth pouch which I have removed from the œsophagus. Like all the others, it was situated at the junction of the pharynx and œsophagus, and projected on the left side behind the œsophagus. The symptoms had been noticed for about eighteen years in a female fifty-nine years old, and were the typical

symptoms of pressure-pouch: return of particles of undigested food a day or more after they had been swallowed; escape of gas and food on pressure; the absence of wasting; and the impossibility of passing a bougie further than about 9 inches from the teeth. There was no actual bulging in the neck. The operation presented peculiar difficulties on account of the large size of the pouch and consequent deviation of the course of the œsophagus. On this account it was exceedingly difficult to pass an instrument into the stomach, even when the pouch was exposed in the neck, separated from its attachments and drawn upwards. This was, however, accomplished before the pouch was cut out.

The patient is now convalescent. The result of the five operations has been four recoveries and one death. I think, if I had had the experience of this case before I removed the pouch in the fatal case (the third in order), that I should not have lost the patient. I probably should not have proceeded to take the pouch out after exposing it, as I could not, even then, pass any instrument into the stomach. I look on that as a necessary preliminary to the safe removal of an œsophageal pouch.

The PRESIDENT congratulated Mr. Butlin on the great success of his treatment in these rare cases of œsophageal pouch.

Mr. BUTLIN asked if anyone knew of any case having been done in this country; he himself had not heard of any.

Case of Double Abductor Paralysis under Treatment by Intramuscular Injections. Shown by Dr. PEGLER.

H. H——, forty-four, married, and in very good general health, came to the Metropolitan Throat Hospital in June, 1899, complaining of loss of voice and some difficulty in breathing on inspiration, especially when hurrying. The voice was strident and disagreeable, but not aphonic. He admitted having had chancres at the age of twenty-two, when he was put through a mercurial course. On examination the vocal cords were seen in the cadaveric position, or, if anything, rather nearer the middle line, and they remained so on deep inspiration, the right cord abducting rather more than the left. On phonation they adducted slightly. A small conical projection was visible in the interarytænoid space. The biniodide was administered freely by the mouth. In about ten days the small growth disappeared, and the patient felt much benefit both as regards breathing and voice. About a month ago, following the example of my colleague, Mr. Lake, I began, and have continued, using intramuscular injections of perchloride (1 in 120). The cords now move, if anything, a little better, and the patient insists that

there is a still further improvement in his voice. He prefers the injections in every way. About 20 minims of the solution are injected into the buttock twice a week.

The PRESIDENT said that Sir Felix Semon had seen this case of laryngeal abductor paralysis, and thought one might be called upon to do tracheotomy for it. It was one of those cases which were always under a cloud.

A Case of Tubercle of the Larynx. Shown by Mr. CHARTERS SYMONDS.

The patient, a woman aged forty-eight, came to the throat department at Guy's Hospital in October last, complaining of loss of voice. The left ventricular band and cord were occupied by a deep red firm infiltration, extending the whole length. In the centre was a depressed irregular gray surface with raised edges. There was slight mobility of the cord and arytænoid, the appearances closely resembling those of malignant disease, more especially as the arytænoid was quite normal, and there was a total absence of the gelatinous infiltration commonly seen. At this stage the diagnosis of malignant disease presented some difficulty. To remove any doubt, a portion from the centre of the ulcer was removed, and proved microscopically to be tubercular granuloma. Subsequent to this a history of hæmoptysis some years previously was obtained. No disease was found in the lungs.

At the present time the appearances resemble closely those above described, except that the gap in the centre is larger, on account of the operation, and the cord is slightly more movable. The patient is pale and thin, and exhibits signs of pulmonary trouble.

The object of showing this case is to mark the resemblance of this form of tubercle to that of epithelioma. Recognising that tubercular tumours may remain with little alteration for considerable periods in the larynx, and thus closely resemble malignant disease, I brought this patient to illustrate that point. I may add that in a recent case the solid tubercular growth was sufficient to occlude the larynx. In this case there was no ulceration, no expectoration, none of the gelatinous swelling; in fact, all the appearances closely resembled carcinoma.

Dr. CLIFFORD BEALE asked whether there had been any obstruction of the larynx before the piece was removed. He thought that in cases of submucous tubercular infiltration without breach of surface, the swellings might remain for long periods without change, or even with diminution. He had shown such cases at

previous meetings, and in one instance, under observation for five years, the patient had died, and the larynx showed that there had been no real obstruction and no breach of surface. After removal of a part of the swelling, a raw surface must remain, as in the present case, and if the patient happened to be bringing up tubercle bacilli in the sputum, there was danger of reinoculation.

Rhinolith. Shown by Mr. CHARTERS SYMONDS.

The specimen shows a calcareous laminated wall enclosing a cavity. When recent, this cavity was occupied by some soft, grumous material, which may have been an old decolourized blood-clot or some inspissated mucus. It was removed from a boy aged eleven. He had had a cold for a couple of months, and it was noticed in the later stages that the discharge was confined to the right side, and had become sanguineous. The rhinolith was removed by a probe. There was no history whatever of the introduction of a foreign body, nor was there any evidence of old disease in his nose. He was the son of well-to-do parents, and therefore had not been neglected.

The object of exhibiting the specimen is, first, to show its peculiarities, and, secondly, to note the short duration of the symptoms caused by a foreign body which must have existed for some years. That this must be the common history in such cases is well known. In another instance, where a friable calcareous mass was removed, the symptoms were also of short duration, but here there was a history of the introduction of some rose leaves into the nose six years previously.

Case of Tertiary Specific Ulceration of the Ala Nasi. Shown by Dr. DUNDAS GRANT.

The patient, a married woman aged thirty-six, came under my care on account of an ulcer on the right ala of the nose of about two months' duration. The ulcer was about the size of a sixpence, and in the centre there was a small portion of tissue which appeared to be true skin, but infiltrated. The ulceration furrow around this was deep, and the edges considerably thickened and infiltrated.

It had first appeared six months previously to my seeing her, as a white speck, followed by spreading ulceration, but had healed up under the action of medicine, presumably iodide of potassium. In the fauces there were cicatricial changes such as would result from tertiary ulceration, involving the loss of the uvula.

Six years ago the patient suffered from a sore throat, which lasted some weeks, and was accompanied by a rash and by loss of

hair; and four years later she had severe ulceration of the throat. She has two children, the youngest of which is thirteen years old.

Presumably this specific affection dates about six years back.

Case of Tuberculous Ulceration of the Pharynx and of the Lower Lip. Shown by Dr. DUNDAS GRANT.

J. R——, aged forty-two, who looked much older, came under my care complaining of sore throat and cough, which had gradually developed during the last three months.

The voice was husky, deglutition was painful, and the cough was accompanied by the expulsion of a yellowish-coloured sputum tinged with blood. On inspection, there was seen on the left half of the palate, uvula, tonsil, and anterior pillar an extensive ulcer, which on the flat surfaces was very shallow, but owing to its dipping into the irregularity of the part appeared in some places to be excavated. It was pale and the floor was covered with dusky, grayish granulations, from which exuded a slight moisture. The edges were not everted, and there was no induration on palpation. There was a fiery-red areola. There were unmistakable signs of tuberculosis in both lungs, especially the right, and the diagnosis was made of tuberculous ulceration. A scraping, however, was not found to contain tubercle bacilli, but the examination will have to be repeated. The glands are scarcely perceptibly involved. On the lower lip there is a deeper ulcer with soft, slightly œdematous edges, the base being covered by a yellowish scab, the condition being probably a secondary focus of tuberculous inoculation.

Case of Swelling about the Bridge of the Nose. Shown by Mr. WAGGETT for Mr. STEWART.

A boy of eighteen, exhibiting indolent swelling about the bridge of the nose and œdema of the skin in both orbital regions, a condition very similar to that of the cases shown at the November meeting. The swelling commenced two years ago, and had been under observation now for eight months with permanent improvement. There was a history of a kick on the nose three years ago, and several blows had been received since.

Iodide of potassium had effected no change, and the same was to be said of the continuous application of the icebag for ten days.

Ulceration of Alæ Nasi. Shown by Mr. CHARLES A. PARKER.

The patient was a female, aged twenty-two, who had suffered from ulceration of the nose for two years. It affected both alæ, but extended more on the right side than on the left, and there was considerable loss of tissue.

The diagnosis rested between syphilis and lupus, and the opinion of the Society was invited as to which of these two troubles was the cause of the ulceration. The patient had been on potassium iodide for three weeks, but had not taken it with any great regularity.

The PRESIDENT: It struck me as lupus or chronic tubercle.

Dr. DUNDAS GRANT: I should say lupus decidedly.

Dr. LAMBERT LACK: I should say syphilis.

Mr. PARKER thought it rested between syphilis and lupus, and treatment alone would settle the question.

Case for Diagnosis: a Boy, aged Ten, suffering from Aphonia. Shown by Mr. ROUGHTON.

Dr. PEGLER thought the boy could scarcely be considered aphonic, as he had succeeded in making him speak in a fairly audible though feeble voice. With reference to treatment, he thought the fault lay perhaps as much with the respiratory muscles as with those of the larynx. He therefore recommended a course of exercises in breathing, as the boy exhibited deficient chest expansion, and his vital capacity was probably much below par. The speaker was directing his attention to this point in similar cases at the present moment, and in an extremely obstinate case of functional aphonia now under his care he found the breathing much at fault, the vital capacity being 80 in place of 150. The hope was that by remedying this defect the loss of co-ordination between the muscles of respiration and phonation would be restored, and there seemed some promise of its fulfilment. In the boy's case the same plan was worthy of a trial, as in any case the exercises could but be beneficial.

The PRESIDENT concurred as to the advantage to be derived from exercises such as those mentioned by Dr. Pegler. He started regular systematic exercises of the chest in a patient, whom, however, he had not seen since. Sir Felix Semon had suggested it was much more of a spastic condition than an ordinary aphonia. He (the speaker) did not think the air current was sufficiently large to put the vocal cords into proper action.

Case of Double Uvula. Shown by Mr. DE SANTI.

Mr. SPENCER doubted whether the case should be termed one of "double uvula." The bands appeared to be congenital, stretching across between the posterior pillars of the fauces, and presumably were remains, at the junction between the stomodæum and the fore-gut, of the primitive septum.

The PRESIDENT thought it looked as if some ulceration had been

present, though there was no history of scarlet fever; it did not look like a congenital production.

Case of Tubercular Laryngitis in a Man aged Thirty-one. Shown by Dr. FitzGerald Powell.

When first seen on November 16, 1899, he complained of loss of voice and some difficulty in breathing.

The patient enjoyed good health until five years ago, when he caught a severe cold and lost his voice; he has regained it somewhat, but it has been husky ever since. Two months ago the voice got worse. Twelve months ago he had an attack of dyspnœa, but otherwise has not felt the breathing to be laboured, though at night he is seen to have considerable stridor.

On examination, the general appearance of the larynx is rather red; the glottis is little more than a chink. On the right side the arytænoid is fixed, and the cord is obscured by the false cord, which is drawn over it, and is ulcerated. On the left the vocal cord is broad and thickened, and is covered with granulations. In the posterior commissure, rather to the left, there is a pedunculated growth, which flaps to and fro on inspiration and expiration.

His family history is good, and I can find no history of syphilis.

Signs of cavity and consolidation are found in the lungs, though no bacilli were found in his sputum on examination.

On November 29, when he was last seen, he was much better, and the breathing during sleep quite free from stridor.

The right cord can now be seen beneath the ventricular band, the left cord is smoother, and there appears to be much more breathing-space.

Mr. Spicer thought this was a very complicated case, possibly a "mixed" case of tubercle and syphilis.

Dr. FitzGerald Powell apologized for not being able to give notice of this interesting case at an earlier date, to enable it being put on the list of cases to be shown. He regretted not being able to have had the opinion of the members, though he believed some of them had seen the case, and thought with him that it was a case of syphilitic ulceration with later tubercular infection.