

in one of which the Pouch was removed under Local, in the other under General Anæsthesia."

W. S. SYME.—"A Series of Cases of Maxillary Antral Disease. Some points of interest."

Readers of papers are requested to send in abstracts of their papers without delay to the Hon. Secretaries for publication in the *Proceedings* of the Section. It is hoped to publish the papers *in extenso* in the JOURNAL OF LARYNGOLOGY.

On Friday afternoon, from 2.30 p.m. till 4 p.m. a series of demonstrations will be given, including one by Dr. W. Hill on "Radium in Oesophageal Disease," and one on "Rhinoplasty," by Messrs. Gillies and Hett.

A museum of interesting specimens, etc., is being organised.

The ordinary Clinical Meeting of the Section will follow the demonstrations, commencing at 4 p.m.

In the evening at 7.45 p.m. the Section Dinner will be held at the Café Royal, and as this will be the first social gathering since the outbreak of the War a large assembly of members and friends is expected.

All communications regarding the Congress and the Dinner should be made to the Hon. Secretaries of the Section: Mr. F. A. Rose, 68, Wimpole Street, London, W. 1., or Dr. Irwin Moore, 30A, Wimpole Street, London, W. 1.

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## Abstracts.

### PHARYNX.

**The Lingual Tonsil: General Consideration and its Neglect.**—Herman B. Cohen. "The Laryngoscope," September, 1917, p. 691.

The number of nodules in the lingual tonsil averages sixty-six. The size varies from one-half to six millimetres. They rest on a basement-membrane of fibrous tissue analogous to the capsule of the faucial tonsils. The lymphatic drainage empties into the suprahyoid glands and the submaxillary and deep cervical glands. The two portions of the tongue (anterior and posterior) have different origins, the sulcus terminalis being taken as the division between the oroglossus and the pharyngo-glossus. The part behind the pharyngo-glossus contains the lingual tonsil. The anterior portion differs completely from the posterior portion anatomically, physiologically and pathologically. The lingual tonsil is the last to undergo atrophy.

The diseases of the lingual tonsil are similar to those of the faucial tonsil, but are usually milder.

Superficial varices only make their appearance when the deep varices have acquired a certain development. The trunk of the lingual nerve, the seat of glossodynia, is accompanied by a satellite vein. All neuroses in this situation may be attributed to superficial and deep varices. A constitutional or acquired debility of the vasomotor system is the chief cause. Some cases occur at the menopause. Other ætiological factors are constipation, hepatic cirrhosis, and chronic intestinal disturbance. The symptoms are cough, "foreign-body" sensation, paræsthæsia, voice-changes, hæmorrhage and respiratory distress, constant pain at the root of the tongue, pain on swallowing referred to the base of the tongue and

region of the hyoid bone. The neurotic element is highly demonstrated in those individuals. Globus hystericus is frequently due to some lesion of the lingual tonsil. Casadesus reported a case of nocturnal asthma cured by the cautery applied to the lingual tonsil. The barking cough of puberty is a frequent occurrence due to slight enlargement of this tonsil. This constant, irritating cough is sufficient to cause impairment of health, and give the patient great mental anxiety from his belief that he has tuberculosis. Twenty-five per cent. of the pathological changes in the lingual tonsil occur in professional voice-users. Marked hyperplasia occurs in middle or adult life, but is seldom seen in children. It is more common in the female. Varicose conditions have been found to be more common in the male sex. In pregnancy, where the persistent cough cannot be explained, it would be well to always look for hypertrophy of the lingual tonsil.

*Treatment.*—General treatment consists in the removal of alcohol, tobacco, and irritating or hot foods. For varix silver nitrate, from 12½ to 25 per cent. This drug or the cautery should be tried in slight hypertrophic conditions. A mixture which Cohen uses is tincture of iodine (one drachm to the ounce of glycerotannin). After a course of treatment two or three times weekly, with little or no improvement, we should consider operative measures. A large pair of curved scissors may be used, but Cohen prefers the lingual tonsillotome; for varicose conditions the galvano-cautery. For after-treatment massage the wound with a cotton applicator dipped in a mixture of equal parts of glycerin, tincture of iodine and tincture of perchloride of iron at intervals of twenty-four hours.

Cohen described several cases: *e. g.* a male, aged thirty-two, had an attack of tonsillitis ten days before Cohen saw him. He was directed to use gargles, but received no benefit from their use. He began to have painful dysphagia. The condition annoyed him so much that he was tempted to end his life. Examination revealed a swollen posterior portion of the tongue, diseased tonsils, and oedema of the epiglottis. Under cocaine anæsthesia Cohen made several scarifications in the glosso-epiglottic space followed by a deep incision of the left lingual tonsil. Pus at once oozed out. Recovery.

In 3000 dispensary cases 55 showed abnormal conditions of the lingual tonsil. Thirty-seven were females and 18 were males. Twenty-two per cent. were under 20 years of age, 29 per cent. between 20 and 30, and 49 per cent. were 30 and above.

*J. S. Fraser.*

**Foreign Body (a Living Fish) in the Pharynx.**—Moh. Zaky Shafëi.  
"The Practitioner," vol. ci, p. 348.

The patient was a young fellah, aged eight, who was fishing in the Nile. Having caught a small trout, he carried it between his teeth. It glided into his pharynx and asphyxiated him. When seen by the reporter half an hour later he was unconscious, cyanosed, and breathing with great difficulty. The mouth was gagged open and an unsuccessful attempt made to dislodge the fish. It was, however, removed after several other attempts, apparently losing its tail in the process. The boy was unconscious for forty-five minutes, requiring artificial respiration, strychnine injections, and other restoratives. Nothing is said as to the fate of the fish, which was a Nile trout 6 in. long and 3 in. broad at its widest part.

*Macleod Yearsley.*

**NOSE.**

**The Treatment of Suppuration of the Nasal Sinuses.**—E. B. Gleason.  
 "The Laryngoscope," January, 1918, p. 1.

Till about four years ago Gleason leaned toward the teutonic opinion that the only adequate treatment of suppuration in the nasal accessory sinuses was complete exenteration by radical operation. Since that time he has gradually recognised that a number of untoward results follow such radical procedures as the Killian frontal operation. The nasal discharge was not cured but only modified; the headaches were lessened, but replaced by disagreeable sensations. Similar unsatisfactory results may follow Ballenger's operation on the ethmoid. Gleason holds that radical operations on the accessory sinuses are justifiable in only a very limited number of cases, and even then only after every other method has failed to yield even fairly satisfactory results. Gleason advocates the use of the suction apparatus after an application of 2 per cent. cocaine in the region of the ostia. After the secretion has been removed Gleason injects 10 per cent. argyrol into the sinuses by means of a hypodermic syringe with a long nozzle. The suction apparatus should be provided with a vacuum gauge, as a negative pressure within the nose of more than 20 inches of mercury is often painful and usually causes hæmorrhage. Gleason's apparatus acts not only by withdrawing the secretion but also by producing hyperæmia. The patient must breathe through the mouth during the time the instrument is being used. MacWhinnie has described the action of the suction apparatus as that of a "combination vacuum cleaner and Bier's congestion apparatus." The instrument may also be used as an aid to diagnosis by replacing the more lengthy posture test. Gleason has been favourably impressed with the results obtained from his apparatus in preventing (1) the recurrence of nasal polypi and (2) the formation of crusts in ozæna.

*J. S. Fraser.*

**LARYNX.**

**Treatment of Laryngeal Tuberculosis.**—C. Caldera. "Bol. d. Prof. Grazzi," xxvi, p. 1.

Tuberculosis of the larynx must be regarded as one of the graver lesions of the tubercle bacillus, as the organ is of capital importance in the vital functions. One of the earliest symptoms is dysphonia, followed sooner or later by aphonia, and often accompanied by pain, which is either spontaneous or induced by movements of swallowing.

As a result of numerous observations the writer has come to the conclusion that laryngeal tuberculosis is not difficult to cure. It can be overcome much better than the closed forms of tuberculosis.

No one method of treatment is reliable in all cases. In cases where the patient is certainly going to die of pulmonary tuberculosis probably absolute silence and the application of analgesic medicaments are enough, as more vigorous forms of treatment would uselessly increase the sufferings of the patient and lower his resistance. To produce analgesia, insufflations of antipyrin, cocaine, orthoform or anæsthesin are useful. Injection of the superior laryngeal nerves with alcohol gives considerable relief.

If, on the other hand, the patient is in good condition, more energetic forms of treatment are indicated. For lightly infiltrated forms, silence, sun therapy, painting larynx with antiseptics (tachiolo) are recommended.

When the infiltration is more marked and accompanied by œdema, and more especially if there is ulceration, the galvano-cautery is the method of choice. When the infiltration is extensive deep streaks must be made with the cautery. Ulcers must be cauterised to complete carbonisation of the tissues. If possible the cartilages should not be touched. If the cauterisation is deep the reaction is minimal, but if superficial there is a severe reaction afterwards. If the ventricle is affected it must be freely opened up by a transverse cut across the false cord with either a cautery point or a hooked knife. In vegetative forms the cautery is not to be recommended as it causes too much destruction. The growth should be removed with forceps.

It is of course very important that general therapeutic measures should be carried out along with whatever local treatment is indicated.

*J. K. Milne Dickie.*

### THYROID GLAND.

**The Thyroid and Internal Secretions.—J. C. Verco.** "Medical Journal of Australia," December 2, 1916.

Under what Verco styles "a romance of medicine," he gives the history of how a number of different workers made observations on the relation of the thyroid gland to the animal economy. In 1850 Curling reported two cases of "absence of the thyroid body connected with defective cerebral development." Twenty-one years later Hilton Fagg cited cases, like Curling's, of mental and physical dwarfs with absence of their thyroids. Galt, Ord and Greenfield carried our knowledge a little further. In 1882 Kocher, who had removed numerous goitres, described a condition, which he named cachexia strumipriva, which followed on the removal of the goitre. This condition he attributed, not to the absence of the thyroid which he had taken away, but to injuries of important nervous structures in the neck unintentionally inflicted during the operation. Felix Semon at this time drew an able generalisation. He believed that cachexia strumipriva and myxœdema are one and the same disease—that cretinism is an analogous condition, and the cause the absence of the thyroid gland or loss of its function. His theories were put to the test by Victor Horsley, who, by a series of experiments on monkeys and other animals, proved that Kocher's cachexia strumipriva was due to loss of the thyroid, and not to injuries to other structures in the neck—that this and myxœdema are one and the same disease. Cretinism is myxœdema in early life. Horsley also suggested a remedy—the grafting of a thyroid in the tissues of an animal which had been deprived of it. The steps onward to the present method of thyroid feeding are detailed.

*A. J. Brady.*

### TRACHEA.

**Fibroma of the Trachea.—J. B. Horgan.** "British Medical Journal," December 14, 1918.

A boy, aged nine, previously robust, had an attack of measles three months ago, and since then had suffered from dyspnoea at irregular intervals. When seen by the writer there was orthopnoea, cyanosis and inspiratory stridor.

No breath-sounds were audible in either lung, but there was a loud vibratory sound over the upper sternal region. Direct examination

showed a normal pharynx and larynx, but a dusky-red globular tumour was visible, low down in the trachea.

As immediate relief was necessary, low tracheotomy was performed under local anæsthesia, but the obstruction was found to lie beyond the reach of the tracheotomy tube. Accordingly, by means of Luc's nasal forceps passed down through the wound the tumour was grasped and removed, when easy breathing was at once restored.

Five days later, examination by lower tracheoscopy showed that the site of origin of the growth was the anterior tracheal wall just above the bifurcation. This was cauterised, and the patient made a good recovery.

The tumour was a hard, bilobed, pediculated mass of fibrous tissue. Had it occupied the trachea alone it would have blocked the lumen, but it doubtless lay astride the bifurcation and extended into each bronchus.

The site in this case was unusual: the majority of tracheal growths originate in the posterior wall.

According to StClair Thomson, 50 per cent. of tracheal tumours are malignant, and of benign tumours papilloma occur more frequently than fibroma. The growths arise as a rule from the posterior wall, and their frequency diminishes as the tube descends. The present writer does not share this view, but finds, from an investigation of recorded cases, that the subglottic is the region most commonly affected, the lower end comes second in frequency, whilst the intervening area is least liable to tumour growth.

A good list of references accompanies this paper.

*Douglas Guthrie.*

### EAR.

**Epithelioma of the Middle Ear.**—F. A. Burton. "The Laryngoscope," October, 1917, p. 755.

Malignancy of the middle ear is extremely rare. Less than fifty cases have been reported. One case was diagnosed microscopically as cancer but was rapidly cured by mercurial treatment. In most instances the diagnosis was only made after operation. Out of sixteen cases collected by one observer eleven had been preceded by otorrhœa of long standing. Very few instances of metastatic tumours have been reported when the ear was the primary focus of disease. Burton suggests that in all cases of chronic otorrhœa which occur in patients after middle life and in which the growth shows a tendency to recur, a microscopical examination should be made. It is only by early diagnosis that it is possible to extirpate the growth.

Burton records the following case: Female, aged forty-three, complained of pain [and aural discharge with very offensive odour of five years' duration. There was no vertigo or spontaneous nystagmus. Weber lateralised to the affected ear. For six months the patient had noticed slight impairment in the movement of the jaw and face muscles. The external meatus was filled with a polypoid growth which bled excessively, and there was slight pain on pressure over the mastoid. The polypi were removed with a cold snare and the bleeding was controlled by packing. In a few days the canal refilled with polypi. The probe now revealed loss of the posterior wall of the bony canal and the pathologist reported epithelioma. X-ray treatment gave relief from pain for a short time only. Two months later the pain was extremely severe and

there was a discharge of pus through a fistula over the mastoid. Operation showed a thin shell of bone covering the cancerous tumour in the mastoid. The wound was left open. This operation gave great relief. Later abscesses formed in the neck, two of which were opened externally and one through the mouth. There was also complete right facial paralysis, paralysis of the right vocal cord and great difficulty in swallowing. By this time the hearing in the right ear had completely gone. The lymphatic glands, however, did not become enlarged. The patient became very emaciated and death occurred eight months after her first visit. A limited autopsy showed that most of the temporal bone had gone. There were no meninges over the adjacent cerebellum, which was macerated. The semi-fluid tumour extended upward to the tentorium and down into the sheaths of the cervical muscles and vessels. Pus burrowed in every direction. The tumour communicated with the nasopharynx by way of a patulous Eustachian tube. *J. S. Fraser.*

### MISCELLANEOUS.

Vincent's Angina.—Thomas Hubbard. "The Laryngoscope," November, 1917.

Hubbard thinks that a large number of cases are not diagnosed. Laboratory study of all ulcers and false membranes is necessary to positively timely diagnosis. The experienced laboratory worker can differentiate between the *Spirillum buccalis*, the *S. dentium* and the *S. pallida* by dark field illumination. The disease process may invade the nasopharynx or hypopharynx and larynx and also the œsophagus. Some cases so resemble diphtheria that one is tempted to ignore the negative Klebs-Loeffler findings and waste precious time on serum, but the most common error is to mistake the case for syphilis and to resort to mercurials. The necessity of careful study of all of these obscure cases is further emphasised by the strong probability that the arsenical group of spirochæticides exhibit a specific action in Vincent's angina quite comparable to their specific action in syphilis. One fatal case had an ulcerative process that involved the tissues behind the tonsil, exposing the angle of the jaw and finally eroding a large blood-vessel.

The local treatment of Vincent's angina recommended is as follows: Perborate of sodium in powder, a mild, non-irritating gargle like Dobell solution, and glycerole of iodine applied only to necrotic or false membrane areas. In cases that do not yield promptly to this treatment, cacodylate of sodium  $2\frac{1}{2}$  to 5 gr. in twenty-four or forty-eight hours (if the kidneys are not affected). In the malignant type, not improving under the above treatments, give neosalvarsan 0.6 grm. (average body-weight adult) intravenously. *J. S. Fraser.*

### REVIEWS.

*War Injuries and War Diseases of the Ear, Nose, and Throat.* By Prof. Dr. RHESE. Pp. 272. Wiesbaden: J. F. Bergmann, 1918.

This book is interesting as giving the experience of a German otologist on war injuries. Certain sections are well written, e.g. injuries to the labyrinth, syphilis of the ear, etc., and results of experimental work are