removed from lateral surface of left ala of the thyroid cartilage; opening made in cartilage with gouge and hammer and almost the whole of the left ala taken away with biting forceps, exposing the inner perichondrium. Eight needles (half milligramme each) inserted into tissues thus exposed; wound temporarily closed with stitches. Needles removed forty-eight hours later. 27.3.28.—Tracheotomy tube removed. Indirect laryngoscopy shows swelling of false cords: no dyspnœa. Patient's convalescence retarded by ischio-rectal abscess which was dealt with by a general surgeon. 17.4.28.—Still some swelling of left vocal cord which only moves to a slight extent.

Dr SYME thought that after all cases of thyrotomy one had the same anxiety for a time. Granulations formed, and in his few cases he had waited. He would never attempt to take a bit away. He would rely on the fact that he had removed the growth widely at operation and that it would be almost impossible for a recurrence to take place in the time.

Dr FRASER said he was not fortunate enough to be present at Mr Harmer's demonstration which he gave recently at St Bartholomew's Hospital, but those who were present had told him (the speaker) that it was a marvellous demonstration of what radium could do in malignant disease of the larynx. He (the speaker) had since had another case in private where he had adopted the same method—tracheotomy, excision of practically the whole of one half of the thyroid cartilage, insertion of radium needles which were left in for four days. The case had done well so far, but of course it was far too early to come to any conclusion. These were the sort of cases which should be reported upon at another meeting.

ABSTRACTS

THE LARYNX

The Duplicated Vocal Cord Question. W. BERGEN, Münster. (*Zeitschrift für Hals-, Nasen-, und Ohrenheilkunde*, Band xix., Heft 5.)

In a typical case of this rare condition there was a white band under each vocal cord forming apparently a second glottis. Under careful examination by probing after thorough local anæsthetisation it was found that these bands did not move. As compared with these, the real vocal cords were more vascular and more concave in their vibrating portions. The voice was rather high-pitched and slightly hoarse. The condition is a congenital anomaly of development and not cicatricial in nature. The subject has received attention from Citelli.

JAMES DUNDAS-GRANT.

Abstracts

The Etiology of the Furrowed Vocal Cord. Contribution to the Clinical Study of Spontaneous Cure of Tuberculosis of the Larynx. D. VAN GANEGHEM. (*Annales des Maladies de l'Oreille, du Larynx, du Nez et du Pharynx*, February 1928.)

Among the cases of chronic hoarseness there is a class of patient who shows perhaps in an otherwise normal larynx, a narrow linear depression on one or both vocal cords running parallel and close to the free border and extending more or less from the anterior commissure to the vocal process. This gives the appearance of a reduplication of the free border and prevents complete adduction of the cords on phonation, a small elliptical space being left between them.

From a series of seven cases observed by him the writer discusses fully the etiology of such a lesion. He advances various hypotheses such as that it may be due to a congenital malformation, a trophic lesion, simple catarrhal processes, an acute non-specific ulceration (*e.g.* measles, scarlet fever, etc.) or a healed syphilitic laryngitis, but only to exclude all these by his arguments. The conclusion that it must be due to a spontaneously healed tuberculous lesion is forced upon the observer owing to the weight of evidence usually forthcoming from a careful study of the family history and the patient's own past and present clinical condition.

Although there is no known therapeutic measure for cure of the chronic hoarseness in these patients, the knowledge of the significance of such a lesion is important from the point of view of preventing, as far as possible, fresh pulmonary and laryngeal attacks.

L. GRAHAM BROWN.

Submucous Hæmorrhage of the Vocal Cords by Vocal Effort. E. ESCAT. (*Annales des Maladies de l'Oreille, du Larynx, du Nez et du Pharynx*, November 1927.)

Submucous hæmorrhage of the vocal cord is a rare accident and though usually produced by sudden vocal tension, particularly in singers, can also be brought about by coughing, sneezing, loud laughter and nausea.

Earlier writers in reporting such cases have stated that the essential pathological condition is a rupture of the fibres of the inferior thyro-arytenoid muscle with consequent secondary interstitial hæmorrhage of the intra-muscular vessels. The author of this article, however, after a critical examination of these recorded cases and from his clinical observation of cases met with in his own practice, is of definite opinion that a single primary rupture of the vascular network that surrounds the vocal cord takes place, a rupture followed by submucous extravasa-

tions without muscular rupture. In favour of this theory of primary hæmatoma he advances numerous arguments chief of which are :—

(1) The rapidity of resolution even in cases that appear very grave, *e.g.* ten to twelve days.

(2) The *restitutio ad integrum* of the vocal function in a relatively short time, *e.g.* usually a few weeks.

(3) The almost constant presence of an inflammatory condition of the laryngeal mucosa before the accident. This diminishes the extensibility of the submucous blood vessels and facilitates their rupture during the stretching of the vocal bands.

(4) The very frequent coincidence in women of the menstrual state.

(5) The anatomical disposition, extremely favourable to the accident, of the submucous arterial and capillary network of the inferior vocal cords.

As regards the prognosis he is not pessimistic like certain other laryngologists but believes that this, especially in professional singers, depends upon the manner in which complete resorption of the hæmatoma takes place and on giving an adequate rest to the voice. This he illustrates by giving a detailed history of the case of a famous singer whom he was able to observe over a period of twenty-eight years and who had during that time several recurrences of her trouble.

L. Graham Brown.

Burns of the Larynx. H. Flurin and J. Magdeleine. (*Annales des Maladies de l'Oreille, du Larynx, du Nez et du Pharynx*, December 1927.)

The late war with its employment of toxic gasses, classified as vesicating, suffocating and irritating, added considerably to the former etiology and pathology of burns of the larynx, and their attendant complications and sequelæ. Moreover, burns resulting from radiotherapy especially in the treatment of cancer of the larynx, also must now be taken into account.

The authors fully describe the pathological anatomy, symptomatology, sequelæ and treatment of all the various lesions produced by every known agent.

To avoid burns of the larynx (late necrosis of cartilages) in treatment with radium or X-rays they advocate before irradiation a series of preliminary operations, viz., tracheotomy, resection of the cartilages of the larynx and more or less complete surgical excision of the neoplastic lesion.

A full bibliography is added. L. Graham Brown.

Abstracts

THE ŒSOPHAGUS

Methods of Treatment of Severe Cicatricial Stenosis of the Œsophagus. J. GUISEZ. (*Bulletin d'Oto-Rhino-Laryngologie*, March 1928.)

In this category Guisez only deals with those stenoses caused by the swallowing of caustic solutions (90 per cent. of all cases), hot liquids (rare), those following on retained foreign bodies, and several cases due to war wounds. Children under the age of 12 years formed 66 per cent. of his cases, and his statistics included 12 cases of infants of less than 3 years.

The basis of treatment depends on œsophagoscopy, whence the diagnosis can be made certain by actual vision, and the number, form, and nature of the stenoses ascertained together with their subsequent retrodilatations.

He employs, as a rule, local analgesia for the adult, for infants below the age of 4 no anæsthetic at all, and for older children ethyl chloride.

He describes the method of dilatation of the strictures, generally multiple, by means of the initial filiform catheter, leaving this in place, if necessary, four to five hours, and then following on with a series of bougies of increasing size which can be screwed on to the filiform catheter.

This method suffices in those cases where the stricture is readily dilatable, but when the cicatricial tissue is extensive and not likely to remain permeable he employs his method of circular electrolysis, which he describes in detail.

In some cases preliminary gastrostomy has been found necessary, and alone may suffice to render the stricture permeable by giving rest to the œsophagus and thus alleviating the local spasm due to the accompanying œsophagitis. If not, the manœuvre of retrograde catheterisation may be carried out by means of a gastrotomy sufficiently large to admit a direct view of the cardia (method of Delagénière). Retrograde catheterisation, although often advised by others, he condemns as dangerous and impracticable. In short, he comes to the conclusion from his own experience that if one does not succeed in passing the filiform bougie under endoscopy one will not succeed any more readily in passing it from below upwards, even after a gastrotomy. Such cases as these must then rest content with a simple gastrostomy, or be left to the care of the general surgeon for more complicated operations, *e.g.* œsophagectomy.

The article is illustrated by diagrams.

L. GRAHAM BROWN.