dehiscence three millimetres in size, through which the jugular fossa communicated immediately with the internal auditory meatus. In another preparation in which the jugular fossa was enlarged so as to reach the upper surface of the petrous bone, there was a dentate dehiscence on the posterior surface of that bone.

Prof. POLITZER suggested that in cases of dehiscence between the jugular fossa and the auditory meatus subjective noises might be occasioned by a swelling of the jugular vein and pressure on the auditory nerve.
Dundas Grant (Trans.).

DUTCH LARYNGOLOGICAL, RHINOLOGICAL, AND OTOLOGICAL SOCIETY, ARNHEIM.

Third Annual Meeting, June 9th, 1895. ("Monatschrift für Ohrenheilkunde.")

President—Prof. GUYE.

Dr. J. H. REINTJES. *Case from which a Growth had been Removed from the Entrance of the Larynx.*

A boy aged ten had a swelling of the right side of the face in May, 1894, which gradually subsided by August. In July his breathing became very noisy, and in November he suffered from increasing dyspnoea. He had no other discomfort, but had wasted considerably. When seen on November 6th, 1894, there was no glandular enlargement. On depressing the posterior part of the tongue a red swelling was seen occupying the whole of the lower half of the pharynx. It consisted of two lobes. The first occupied the space between the epiglottis and the posterior wall, and extended over the left ary-epiglottic fold. By laryngoscopy the other lobe could be seen pressing downwards into the pharynx. During respiration, which was very difficult, the pale but otherwise normal epiglottis rose to a slight extent from off the tumour. The latter, which had a smooth surface, was of a dull red colour, immobile, soft, and readily bleeding on palpation. Considering the short duration of dysphagia, as also of the relatively slight interference with respiration, its deep origin could be eliminated, and it seemed pretty certain that it arose from the right margin of the epiglottis or from the ary-epiglottic fold. The writer took it for a sarcoma. On the 12th November an operation was performed with preliminary tracheotomy and insertion of Trendelenburg's canula. Under anæsthesia the palpation was much easier. The tumour arose from the right ary-epiglottic fold with a narrow base. An attempt to pass a snare round it was unsuccessful. By means of a forceps a portion of it could be removed, and a hook came through the tissue. On account of the dangerously severe hæmorrhage the author avoided removal of the growth by bits and determined to practise subhyoid pharyngotomy. This being done, a galvano-caustic snare was passed round the tumour, which was thereby removed. The cautery was also applied to the site of the

tumour and the wound was brought together by stitches at different depths. Trendelenburg's canula was removed and an ordinary one inserted. Nutrition was kept up by means of a stomach-tube introduced through the nose. The growth was found to be four centimètres long, three wide, and two and a half thick, and on histological examination was found to be a carcinoma.

On the 15th November the tracheal canula was removed, and the patient was able to drink milk. There was considerable reactionary swelling in the neck, and on the anterior surface of the epiglottis there was a white exudation. The patient was dismissed on the 22nd November. He was again seen on the 10th December, when he had a swelling of the face and again breathed audibly. There was found between the root of the tongue and the epiglottis a swelling and two white spots (perhaps caused by the stitches of the middle stage); there was, further, upon the left ary-epiglottic fold a small swelling, which, four days later, increased to the size of a hazel nut.

On the 8th January it was again smaller. The epiglottis was still thickened, and the space between it and the tongue still filled up. Again, on the 10th February, the patient was seen, and the swelling on the left ary-epiglottic fold had disappeared, both folds were irregular and thickened, and the swelling of the epiglottis had gone down.

On the 22nd April the patient appeared well and took his food satisfactorily; he had no discomfort in the throat; he only snored when lying on the left side. The epiglottis was normal, drawn somewhat to the left and backwards. Nothing abnormal could be detected at the site of the growth. On the left side there can be seen some folds where the epiglottis and the rest of the mucous membrane had been stitched after pharyngotomy. The swellings, which at first were taken to be a rapid recurrence, and which disappeared so astonishingly, were probably due to the attempts of the stitches to find exit.

In view of the absence of recurrence for so many months, doubt was felt as to the correctness of the anatomical diagnosis; and Prof. Spronck, of Utrecht, was good enough to examine the growth for the second time, and to report it as being a sarcoma with alveolar formation. It gave the impression as though the alveoli were formed of endothelial cells. Without doubt cells could be met with in the growth which surrounded the vessels. The growth might be considered as an endothelioma, or even a perithelial sarcoma. He was not without anxiety as to the prognosis, but he thought that it tended to be favourable. In literature similar cases had been described in children in which no recurrence had occurred.

Dr. A. C. H. MOLL (Arnheim). *Demonstration of Two Cases of Tuberculosis of the Larynx.*

The first came under treatment in the previous year. On laryngoscopic examination there was found great swelling of the epiglottis, infiltration of the right ary-epiglottic fold, growths in the interarytenoid fold, infiltration of the ventricular bands, especially the right one; the left vocal cord, as far as could be seen, was normal. Rhonchi were heard at

the apices of the lungs, and the sputa contained bacilli. The treatment began with splitting of the epiglottis and cauterization with pure lactic acid, while creosote was administered internally. The difficulty in swallowing diminished considerably, but the incision did not heal. From both sides on several occasions infiltrated portions were removed.

In winter the patient was taken into the hospital, and the initial improvement again disappeared. His pyrexia was between 38° and 39° C., and respiration became embarrassed. In February tracheotomy was performed, and painting with lactic acid resumed. The general condition has improved, dysphagia and expectoration diminished, the cough is less, the patient feels much stronger, and believes he is going to recover. Unfortunately, of late the general condition has become worse. When the patient was before the Medical Society a few weeks ago all those who were present were persuaded of the favourable general condition. If the patient recovers from this retrogression, and endolaryngeal treatment proves itself insufficient, I think of carrying out laryngotomy, or perhaps laryngectomy.

The second patient, aged forty-four, when he came four years ago under treatment was emaciated, with severe dysphagia, violent cough, hoarseness, and dyspnoea. He traced his cough to influenza, with subsequent pleurisy, two years before. He has been deaf for a year, and had difficulty in swallowing for half a year. In the larynx there can be seen distinct swelling of the epiglottic folds. The epiglottis was so pendulous that the larynx could not be seen. The apices of the lungs were affected. Tracheotomy was performed, and the temperature, which at first was high, sank within fourteen days to normal. The whole time the general condition has improved; he looks better, coughs less, has less expectoration, and has lost his aphonia. The difficulty in breathing has not quite disappeared, as there is still distinct swelling of the left ventricular band, in consequence of which the left vocal cord cannot be seen. The right one is healthy. In this case, therefore, tracheotomy has not only counteracted the danger of asphyxia, but has exercised an excellent influence on the laryngeal process, just as Moritz Schmidt has described in such cases. In my opinion, if the pulmonary disease is not too extensive, it need not contra-indicate tracheotomy.

Dr. KROL was of opinion that the laryngeal disease was undoubtedly secondary, and considered extirpation of the larynx as contra-indicated.

Dr. MOLL quite agreed that the laryngeal tuberculosis was secondary, but compared it to a tuberculosis of joints or bones, when the lungs are not infrequently affected without this being considered a reason for abstaining from surgical treatment of the local tuberculosis. The larynx should be dealt with just like a diseased joint. The diseased process in the lung would only be a contra-indication when it was such as to prevent the patient from standing the operation.

Dr. PEL regarded this patient from the general clinical standpoint, and had no doubt that a genuine tuberculous dyscrasia was present, and thought, therefore, that the patient could not stand a severe surgical operation. Comparison with *surgical* tuberculosis did not hold good in this case, because the general dyscrasia was in the foreground.

Dr. MOLL: When one compares the previous melancholy condition of the patient with that which followed treatment the favourable effect of this was unmistakable. This proves that the lung affection does not exclude local interference, but it happens by chance that for the last few days the patient is not as well as he has been.

Dr. BRONDGEEST was of the opinion that one must always look at the frightful pain of laryngeal tuberculosis from a surgical point of view, and that it should be our duty to adopt energetic measures.

Dr. BURGER thought that from a surgical point of view laryngectomy was by no means indicated in this case. Laryngectomy was, in his opinion, only indicated when complete healing is to be expected, and he agreed with Dr. Krol in regarding extensive affection of the lungs as an absolute contra-indication.

Dr. MOLL for the moment did not think of carrying out this operation but he thought rather of partial laryngectomy.

Dr. C. REINHARDT. *Two Patients Treated according to the Panse-Körner Method.*

These were cases of chronic suppuration of the middle ear, with caries and high perforation of the membrane of Shrapnel, along with protruding granulations.

Numerous methods of treatment having failed, he had determined to lay open the cavities of the middle ear. The skin incision went down to the bone and was parallel to the insertion of the auricle, extending for a finger's breadth in front of it at the upper end, so that the concha could be entirely turned out to the front, especially after the postero-superior membranous wall of the meatus was raised with a fine raspatory, so that the whole meatus could be everted like a funnel. He always left the anterior and lower membranous walls of the meatus in position, in order to avoid the occurrence of artificial stenosis in the meatus later on. When the osseous meatus is thus exposed there can be seen by direct light the membrane, the perforation, the granulations, and the remains of the hammer. The posterior osseous wall of the meatus is chipped away from without inwards right into the antrum, so that (particularly during the removal of the most medially situated part) great care is required to avoid injury of the inner wall of the tympanum, the facial nerve, or the semicircular canals, by means of a right-angled bent silver probe or Stacke's protector. The chief point is, however, to have good illumination of the field of operation, which at this depth is apt to be very much in the dark. In this way the osseous lateral wall of the attic is removed, and the remains of the drum, membrane, etc., can now be removed. The meatus, tympanum, attic, aditus, antrum and the upper cells of the mastoid process are thrown into one single cavity. In the cases at present described there were only a few cells remaining in the mastoid process, and they were filled with granulations.

The next point is the preparation of the flaps as recommended by Panse and Körner. The after-treatment is carried out through the external meatus, and is much facilitated by the widening of the orifice. He has already operated upon twelve cases by the above method. He

attaches great importance to the selection of cases. He excludes cholesteatoma on account of the certainty of recurrence. Tuberculous caries is also unsuitable for this operation. All depends upon what is found in the course of the proceeding. If there is found to be only a circumscribed caries of the ossicles or of the pars ossea, primary closure ought to be carried out. In case of caries of the inner wall of the tympanum, much caution is required. In one case the parts had to be reopened, because the caries of the inner wall extended under a so-called pseudo-epidermic coat, and the disease could not be satisfactorily reached through the meatus.

The advantages of the Panse-Körner flap are that the after-treatment is shorter, as the epidermization of the cavity can take place from the four borders of the wound; and, secondly, that the cosmetic effect is extremely good.

Dr. A. C. H. MOLL. *Two Patients operated on according to Zaufal's Method.*

The difference between this method and the previous one depends on the plastic methods employed in regard to the flaps. In many cases the skin ought not to be employed, especially when it has been already undermined. Preservation of the skin makes the operation more difficult, especially in the narrow meatuses of children. Further, it is in many cases necessary to reach the deeper parts easily, in order later on to scrape away or cauterize the granulations. There is always a very strong tendency to contraction. It is, no doubt, a very beautiful result to get the wound to heal in ten days, but this can only be exceptionally accomplished. If, as Zaufal has described, and as Dr. Moll has done, the membranous part of the upper and posterior wall of the meatus is separated, there is at once a large amount of space, the anterior wall remains intact, and the epidermization goes on quite perfectly. Dr. Moll always commences by removing the malleus through the intact meatus, so that this delicate operation may not be interfered with by hæmorrhage. Thereafter he makes an extensive incision on the mastoid, and at right angles to that a second one in a forward direction, and, if necessary, even a third backwards, so that the whole inclined plane of the meatus may be freely exposed. After this an india-rubber tube is inserted into the meatus, and upon it, from behind, the cuticular wall is incised; then a knife is introduced through the wound, and at the upper and posterior wall two horizontal parallel incisions are made. This piece is then removed by means of a raspator. The antrum is then opened at the typical spot, and from the opened antrum a probe is passed into the aditus. In this way the antrum is opened from without inwards. Lastly, the lateral wall of the attic and the whole superior wall of the meatus are chiselled away so that the incus is exposed, the osseous wall of the posterior section of the meatus is removed, with preservation of the part in which the facial nerve lies. The cavity is cleared out, irrigated with sterilized water, and then plugged with iodoform gauze—partly from the wound, partly from the meatus.

The first patient was a girl, operated on in the past year, who had suffered from severe headache and chronic otorrhœa. The cavity has healed up. The headache, which gradually diminished after the opera-

tion, returned again when the patient resumed her work, but was less than before.

The second patient was a child, whose meatus was filled with pus, and behind the ear there was a swelling, pressure upon which caused a copious outflow of pus from the meatus. The meatus was undermined and perforated, making a very poor skin for plastic operations. There was only a little remnant of the membrane remaining ; the ossicles were present, but the malleus was carious and imperfect. The wounds have now healed up, and from the normal meatal orifice it can be seen that the postero-superior wall of the meatus is absent, and the interior of the mastoid cells and the antrum and the attic, all covered with epidermis, well in view. The hearing power is one mètre for whisper, and two mètres for ordinary conversation.

Dr. REINHARDT could not understand what benefit could be derived from throwing away epidermis.

Dr. BURGER asked how Dr. Reinhardt carried out the after-treatment in the larger number of cases in which he did not close the wound from the first.

Dr. REINHARDT replied that he kept the wound open until healthy granulations showed themselves in the depths of it ; only then he allowed the retro-auricular opening to close by granulation. In cases of cholesteatoma he made a persistent retro-auricular opening by means of flaps of skin derived from the scalp, which he considered the best means in view of the certainty of recurrence. A good deal had been said about the cosmetic aspect of the persistent opening. This opening was especially important in people who did not keep under regular observation.

Dr. V. H. VAN ANROOY. *A Case of Recovery from Primary Laryngeal Tuberculosis.*

The patient, aged thirty-seven, had from the end of 1893, on and off, difficulty with his voice, and on account of increasing hoarseness he consulted Dr. van Anrooy in February, 1894. There was found a diffuse redness of the vocal cords, and a small ulcer upon the slightly swollen right ventricular band immediately in front of the arytenoid. The patient complained of nothing except hoarseness. His general condition was good. He had never had any serious illness, very little cough, and no expectoration. The lungs on repeated examination were found sound. In the sputum there were no bacilli, and there was no evidence of previous or present lues. Treatment with iodide of potassium produced no effect. Owing to other circumstances the patient was unable to place himself under local treatment until May, and during the interval the laryngeal disease had progressed : the ulceration had extended on to the swollen right arytenoid region and forward upon the vocal cord. At this time he had difficulty in swallowing and occasional pain in the right ear. The writer then removed with the curette the granulating edges of the ulcer on the right vocal cord, and sent the fragment to Prof. Siegenbeck van Henkelom, of Leyden, who returned a diagnosis of unquestionable tuberculous disease. Further treatment consisted of curetting, with subsequent rubbing in of pure lactic acid. The ulcers have completely cicatrized, and the only remaining trace is an unevenness of the surface

of the right ventricular band. There is no trace of inflammation or infiltration. The voice, which in May, 1894, was very weak, is quite clear; the movement of the vocal cords normal. The patient is unable to economize the use of his voice, therefore healing has been rather slow--only complete at the end of October.

Dr. SCHLEICHER. *Demonstration of a Galvano-Cautery Handle with a Rheostat.*

This instrument has attached to its handle a rheostat, on which there is a metal slide; and as the loop of the galvano-cautery is shortened in the process of operation more and more of the resistance of the rheostat comes into the circuit, so that the current is kept the same throughout, and a tendency to the burning through of the wire is avoided. This appliance is intended to do away with the necessity for having an assistant at hand to diminish the strength of the current as ordinarily employed. He recommends strongly the snare devised by Chardin, in which the wire is not carried through the usual long tubes.

Dr. ZWAARDEMAKER congratulated the speaker upon the excellence and simplicity of his rheostat. *Dundas Grant (Trans. and Abs.).*

FIRST SPANISH CONGRESS of OTO-RHINO-LARYNGOLOGY.

Madrid, October 18th, 1896.

THE organizing commission of this, the first Spanish Congress, is composed of Drs. Urunuela, Cisneros, Gonzalez Alvarez, Compaired, Forns y Rueda, of Madrid, and Dr. Verdos (Barcelona), Dr. Sota y Lastra (Seville), Dr. Moresco (Cadiz), Dr. Casanova (Valencia), Dr. Añese (Bilbao), Dr. Fundarena (Tolosa), Dr. Aguirre (Pamplona), Dr. Royo Galindo (Saragossa), and Dr. Santiuste (Santander). The following officers were elected:—President, Dr. Urunuela; Vice-President, Dr. Gonzalez Alvarez; Secretary-General, Dr. Compaired; Second Secretary, Dr. Forns; Treasurer, Dr. Rueda.

Those proposing to visit the Congress will have special rates granted by the railway companies, and by certain hotels in Madrid, and arrangements will be made for the inspection of museums, official establishments, etc.

Three weeks before the Congress a complete list will be published of communications to be made.

The Congress will meet on October 18, in Madrid.

The subscription will be 25 pesetas.

Administrative matters will be under the direction of Drs. Gonzalez Alvarez and Rueda, the social arrangements under that of Drs. Cisneros and Compaired, and the arrangements with public bodies under that of Drs. Urunuela and Forns. Further details as to this Congress will be published later.

R. N. Wolfenden (Trans.).