articulation is threatened with ankylosis as a result of constant irritation the obvious remedy is rest to the irritated parts. To this point Panse has already drawn attention. If, then, we were able to diagnose the presence of a hyperostosis at the oval window before the onset of deafness—say, by observing obvious discoloration of the membrane or hyperostoses elsewhere—we might arrest the disease by dividing the tendon of the tensor tympani, or by removing that part of the malleus to which it is attached.

In cases of ankylosis with an intact labyrinth, it might be advantageous to perform a mastoid operation, and to open a new fenestra at the tuberosity of the ampulla (of the external semicircular canal?), as hyperostosis rarely occurs at this place.

But before these suggestions can be confidently adopted, it will be necessary to carry out many more *post-mortem* investigations upon people whose hearing has been carefully tested during life.

ENDOTHELIOMA OF THE FRONTAL BONE.

BY NEIL MACLAY, M.B., C.M.,

Surgeon, Throat and Ear Hospital, Newcastle-on-Tyne.

W. F——, aged sixty-seven, the subject of illustration, consulted a doctor on February 15, 1911, on account of a painful swelling over his right orbit. The practitioner describes the condition as a red, fluctuating, circumscribed lump, the size of a walnut, situated over the inner limit of the right eyebrow. The presence of pus was diagnosed and an incision made; only blood escaped, and a friable new growth projected from the wound.

Four days afterwards I saw the patient and found a fungating mass, in situation already named, which entirely obscured any evidence of incision and extended fully $\frac{1}{4}$ in. from skin surface; the centre of growth corresponded with position of anterior wall of right frontal sinus.

A probe could be passed easily into sinus and down through fronto-nasal duct. Great destruction of bone had taken place; not only two thirds of anterior sinus wall but a good part of posterior wall had disappeared, and the growth extended $1\frac{1}{2}$ in. towards frontal lobe.

The pathological report submitted by Prof. Stuart McDonald described the structure as an endothelioma with much evidence of necrosis.

Surgical interference was not advised, and in spite of rapid growth little or no pain existed till a fortnight before death, which

took place in April, 1911, and was preceded by left-sided clonic convulsions.

The history of the case shows that no subjective symptoms

existed till a week before advice was sought, and then only pain was complained of and some slight bleeding from right nostril.

A small ill-defined swelling over right eyebrow was first noticed by patient's friends about the close of the year 1910, and was thought to be due to a knock. Subsequently, as size of lump increased, it was regarded as a "blind boil," and received some domestic attention.

There were no eye signs or symptoms at any time.

I am disposed to regard frontal sinus as the seat of origin of growth.

SOCIETIES' PROCEEDINGS.

PROCEEDINGS OF THE ROYAL SOCIETY OF MEDICINE—LARYNGOLOGICAL SECTION.

April 7, 1911.

DR. P. WATSON WILLIAMS, *President, in the Chair.*

SPECIMEN OF A PEDUNCULATED GROWTH ON AN ELONGATED UVULA.

BY MR. HERBERT TILLEY.

The specimen was removed from a male, aged thirty, who said that the growth on his uvula had been present as long as he could remember, but had given rise to no irritation or coughing until the last three months. The uvula measured nearly 1 in. in length, and from its lower end hung a pedunculated growth. The stalk measured $\frac{3}{4}$ in., and the small tumour is about the size of a dried pea. In order not to spoil the specimen no section of the growth has been made, but it is probably a small fibroma.

Dr. PATERSON said he had seen a similar case, where the uvula was longer than in this case, as it had to be hooked up with a probe to see the tip, which had a papilloma on it. He did not know whether the patient in Mr. Tilley's case complained of symptoms actually caused by the little growth at end of a long uvula. In his (the speaker's) case it was observed accidentally, and it produced no symptoms whatever, proving that a long uvula need not produce discomfort, and should not be sacrificed merely on account of its length.

The PRESIDENT (Dr. WATSON WILLIAMS) said that whereas an elongated uvula was at one time removed fairly frequently, it was now relatively rarely done. But it was possible to jump to an opposite conclusion, and say an elongated uvula never caused symptoms. But that was not true, for his own had caused trouble at one time years ago, but after it was shortened the trouble it gave rise to disappeared.

AN IMPROVED FORM OF HAY'S PHARYNGOSCOPE.

BY MR. HERBERT TILLEY.

This improved pharyngoscope gives a larger image, and the lamps are prevented from touching the pharyngeal wall and so causing discomfort. If cocaine is previously applied to the posterior pharyngeal wall the instrument causes no retching, and it is useful for demonstrating lesions to novices who cannot use the posterior rhinoscopy or laryngeal mirrors.

Mr. TILLEY, in answer to the President, said he had found it useful