

SOCIETY PROCEEDINGS.
NEW YORK ACADEMY OF MEDICINE.
SECTION ON LARYNGOLOGY AND RHINOLOGY.

Regular Meeting, January 25, 1911.

LEE M. HURD, M. D., CHAIRMAN.

(Continued from page 821.)

DISCUSSION.

DR. SMITH said that in the cases presented by Drs. MacKenty and Cocks, he saw no material cosmetic improvement over those operated upon by the Killian method, in fact, he believed that for large sinuses no operation yet devised could compare with it for the avoidance of deformity. He furthermore believed that the operation cited by the gentlemen was nothing more than the original Jansen operation and felt that a new name for it was uncalled for.

He himself believes that a great many cases operated upon externally could be cured by internal methods without endangering the patient's life, although it necessitated longer and more careful treatment. A number of cases coming under his observation had finally recovered, when at times it had seemed almost imperative to perform some external operation. He considers it good surgery to treat a case for a year or two if by so doing a recovery is obtained without external deformity.

DR. MACKENTY said that a few years ago Dr. Berens had called his attention to this method of operating for sinus cases, and he had used it exclusively in all cases operated on since. The removal of the floor of the sinus gives good access and good drainage, and leaves practically no deformity. This operation is applicable in large sinuses as well as small ones. The only reason for opening through the anterior wall of the frontal sinus is to more thoroughly inspect and curette the upper portion in very high sinuses. Even these can be cleaned out by removing a little of the overhang on the orbital ridge. The method is applicable to deep and wide sinuses. If a window is made it should be made only large enough to allow thorough inspection and curetting. The entire anterior wall above the bridge should not be removed unless diseased. It is necessary to take a strong, deep suture at the angle of the wound, so as to draw the periosteum tight in order to bring the flap back

into the proper place, thus bringing the superior oblique into its normal relation. He never uses any drain in his cases, but sews the wound up. The stitches are removed on the next day. If left in over twenty-four hours, they leave stitch-hole scars. He used a cigarette drain, in the nose, as it comes out much easier than gauze packing.

DR. W. W. CARTER told of a case of frontal sinusitis which he showed the previous year, which had been operated upon ten months earlier. At that time there was considerable criticism of his method, but having seen the case only a week ago and the result being perfect, he ventured to recall it. The patient had suffered terribly from sinusitis of the left side for six or eight years, and the Caldwell-Luc operation of complete exenteration of the ethmoid and sphenoid cells had been performed, without effect. He then made an opening in the anterior wall of the frontal sinus as large as a ten-cent piece, curetted the sinus, and made a large opening following the naso-frontal duct into the nose, drained it, and closed the opening into the frontal sinus. In twenty-four hours the drain was removed, and the woman got well, and has remained so, the case having been seen within the last month. He would not advise this in all cases, but in this particular instance there was a small sinus with no pockets or diverticula, and the operation worked all right; the opening from the frontal sinus into the nose still remains, and is as large as a small lead pencil.

DR. COCKS said that Dr. Van Wagenen had inquired about diplopia following these operations. In a few instances there was a transient diplopia, lasting from a few days to two weeks. In the first case presented there was diplopia for ten days or two weeks when looking at objects in the upper part of the visual field. This was due to a temporary involvement of the superior rectus muscle, and is unusual. The ordinary diplopia encountered is, of course, due to temporary interference with the functions of the superior oblique muscle.

DR. MACKENTY said that the cases were thoroughly treated in the clinic before being operated upon radically. Dr. Cocks had been very particular about that, and had operated upon no cases that had not been thoroughly treated by other methods for months.

Benign Angio-lymphoma of the Tonsil.—Unusually Large Tonsil.

-By JOHN HORN, M. D.

The patient, a girl, 16 years of age, came to him recently to have her tonsils removed. Upon examination he found on the right side

the largest tonsil he has ever seen. It was pedunculated and extended into the rhino-pharynx. He removed a piece from the upper and another from the lower anterior end. The hemorrhage was slight. The pathologist reported it to be a benign angio-lymphoma.

Primary Epithelioma of the Tongue.—By WOLFF FREUDENTHAL, M. D.

Dr. Freudenthal said that the patient had appeared to-night without his knowledge, but that he was glad of the opportunity to present him, as he exhibited a very interesting picture of the pharynx, and had been under radium treatment. The man was 76 years of age, and had been well up to ten years ago, when he had a paretic stroke, and was incapacitated for some time. He is not yet quite normal mentally. Two months ago he commenced to have difficulty in swallowing and his speech became bad. Examination showed a bleaching left tonsil, absolutely white, as though it had been cauterized. The white spread very rapidly, and is still spreading. A small piece was removed and sent to the pathologist, and proved to be a rapidly-growing malignant neoplasm, affecting the tonsil and tongue as well. These cases of primary epithelioma of the tonsil are rare.

Dr. Freudenthal said that he has another patient, much younger, under radium treatment. He made an incision from the outside and inserted a tube, and last week the patient went around for five days with the tube in the mass, coming from Brooklyn every day to report. He is holding his own, and the mass appears to be much smaller. As it is a case of malignant epithelioma, he would not venture to say what will be the outcome.

Angio-fibroma of the Larynx. By S. W. THURBER, M. D.

The patient was an Italian carpenter, 31 years old, seen in Dr. Simpson's service at the Vanderbilt Clinic three days before. His history is negative, except for hoarseness coming on after a cold about three years ago. He has had no dyspnea at any time and can climb ladders, run and do his work without any discomfort. One year after his hoarseness developed, he had an attack of laryngitis lasting about thirty-six hours, during which time he spit up some bloody mucus.

He presents in his larynx a purplish tumor, half an inch in diameter, protruding from the right ventricle in its anterior half and covering the laryngeal opening, but not interfering with the motion of the cords which lie beneath.

While this tumor had the appearance of being very vascular, there was but once in its history when there had been any bleeding from it. Dr. Thurber would like the opinion of some of the members of the Section as to the best method of removing it. He himself was inclined to take it out with a cold wire snare.

DISCUSSION.

DR. SIMPSON said that the appearance of the tumor would suggest an angioma. On general principles he would use a snare to remove it, hugging the attachment to the commissure very closely. The chances were that there would not be very much hemorrhage.

DR. MAYER said that he would not attempt endo-laryngeal removal, fearing profuse hemorrhage, which might be fatal. He would prefer doing an external operation on the larynx, where with a Pacquelin cautery he could check the bleeding if it occurred.

Stenosis of Lower End of Esophagus. H. L. AKIN. *West. Med. Rev.*, Feb., 1911.

Three cases are reported by Akin. He emphasizes several points, first of which is the importance of having the proper kind of bougie. The only reliable instrument, in his opinion, is a long 24 or 25-inch whalebone bougie, stiff enough so that it will not bend, but will go straight through where it is directed. His second point is the use of the silk thread swallowed the day before so as to allow it to become firmly engaged in the bowel below the stomach. This is a simple but highly commendable procedure, he asserts, because it enables the operator to introduce the bougie or dilator directly to the permeable point of the stricture and to use such force as is required to pass on into the stomach with a certain knowledge that his instrument is not going to deviate to the right or left and perhaps make false passage into the lung or pleural cavity. Akin favors dilatation of the stricture whenever this is possible.—*Ex.*