

tonsillitis. He had since suffered from a sensation of dragging in the left side of his throat, worse on swallowing. Some shooting pain was experienced in the left ear, in which also he was slightly deaf at times. As first he was inclined to associate these sensations with the previous tonsillitis, but as the discomfort increased he examined his throat carefully, at first by sight and then with his finger, when he discovered a firm substance about the middle of the left tonsil. On examination with the mirror the throat appeared normal. With the finger a hard nodule was felt about the middle of the tonsil. It gave the impression of being situated in the tonsil and movable with it. A cartilaginous nodule suggested itself, though the dragging sensation on swallowing, the pain shooting into the ear, and a feeling of resistance rather than of actual swelling on that side of the neck externally, made one keep in mind the possibility of it being a long styloid process. The tonsil was enucleated with the snare under local anæsthesia. Firm resistance was encountered on tightening the snare. After removal of the tonsil on examining with the finger a sharp point of bone was felt piercing the sheath of the constrictor. The muscle was pressed outwards as far as possible and a portion of the styloid process an inch in length was broken off with forceps. The after-history was that of an enucleation, and the symptoms previously complained of disappeared.

Probably in these cases, and certainly if one could be sure of the diagnosis without removal of the tonsil, it would be better surgery, as being aseptic, to remove the styloid process through an external incision.

The moral of the case is that one should examine with the finger when there is nothing to *see* to account for the symptoms complained of.

OTOLARYNGOLOGICAL CASES FROM A MILITARY HOSPITAL.

By ARCHER RYLAND, F.R.C.S.E., LIEUT., R.A.M.C.

Pan-sinusitis of long standing treated by Radical Operation on Affected Sinuses—Recovery, and return to duty in ten weeks.
—Pte. F——, aged twenty-two.

March 16th.—Patient complained of nasal obstruction chiefly

on the left side, a foul discharge from both sides of the nose, and impairment of the sense of smell. The history was one of at least twelve months and probably more.

All ordinary signs of long-standing sinus sepsis were present. There was a slight deviation of the septum to the left, and on the right of septum a large basal spur. A mass of polypi filled the left nasal fossa.

The polypi were removed. A day or two later exploratory puncture of the left antrum revealed the presence of several drachms of stinking pus.

The left middle turbinate and overlying mucosa were so far necrosed that approach to the frontal sinus on that side was unusually free. On lavage of the frontal sinus, a quantity of thick offensive pus was removed.

On investigation of the sphenoid sinus, the ostium was identified surrounded by diseased and polypoid mucosa. There was no evidence that its cavity actually contained pus.

The following operations were performed, and in the order stated:

(1) Caldwell-Luc on left maxillary antrum. (Previous to the procedure the antrum had undergone a daily lavage for three weeks, with purulent return on each occasion.)

(2) Ethmoid and fronto-ethmoid curettage; local anæsthesia (repeated after an interval of a few days).

(3) Luc's operation on left frontal sinus. Sinus was large. The mass of thickened polypoid mucosa, smooth and bulging on its outer surface when first exposed, was removed *en masse*, together with its extension into the fronto-nasal duct, leaving the osseous walls perfectly clean. The distance from the roof of frontal sinus to the anterior nares 8.4 cms.

(4) Exposure of sphenoid ostium; local anæsthesia. Removal of neighbouring diseased mucosa. Enlargement of ostium by removal of bone laterally and inferiorly around its margins. (Posterior wall of sinus measured 7.6 cms. from the anterior nares.)

The above operative treatment, together with non-operative treatment, extended over a period of ten weeks. At the end of that time all accessory sinuses were free from disease.

Chronic Suppurative Otitis Media. Acute Mastoiditis and Labyrinthitis.—Pte. F. W——, aged twenty-four. The patient had a chronic middle-ear suppuration on the left side. An acute mastoiditis supervened, followed in a few days by signs of acute labyrinth involvement.

When first seen the patient complained of mastoid pain, ear discharge, headache, giddiness, vomiting, and staggering gait.

On examination, there was a spontaneous horizontal nystagmus to the right, well marked. With regard to left ear, there was a copious discharge, flakes of cholesteatoma in attic region, mastoid tenderness over antral region and also over tip of process. The fistula test was negative, and the caloric test gave a normal response. Operation was determined by increase of general mastoid tenderness, increase of vertigo, and persistence of nystagmus and vomiting.

Radical mastoid.—Flakes of cholesteatoma were found in the aditus and attic. Exposure over a small area of a normal lateral sinus wall. There was considerable disease in the neighbourhood of the external semicircular canal, which showed on the most prominent part of its convexity a very obvious erosion. On examination with probe it was found that no fistula was present. No operative measure was taken with regard to the labyrinth.

Following the operation the vertigo and vomiting rapidly got better, and both had ceased in forty-eight hours. The nystagmus lasted for twenty-one days. It gradually assumed a horizonto-rotary character and eventually disappeared three weeks after the radical operation.

The healing of the mastoid cavity and wound followed a normal course.

Severe Self-inflicted Wound of Larynx; Primary Suture; Tracheotomy; Recovery.—H. R——, aged twenty-three. On examination of this case shortly after infliction of the wound, it was found that the cavity of larynx had been extensively opened by a deep horizontal incision across the front of the neck at a level through the thyro-hyoid membrane, just above the upper borders of the thyroid alæ. The sterno-mastoid muscle on neither side was involved. There was a complete severance of the thyro-hyoid membrane. The thyroid and cricoid cartilages were widely separated from each other, and the posterior wall of the pharynx, uninjured, was freely exposed to direct inspection.

Operation: The hyoid bone and the thyroid cartilage were approximated by means of deep catgut sutures encircling the hyoid bone above and piercing the upper part of the thyroid alæ below. The upper and lower halves of the thyro-hyoid membrane had retracted to such an extent that it was found impracticable to secure their free edges and unite them.

Tracheotomy was performed, and the original wound in the skin and superficial tissues was closed in the usual manner.

Recovery without pulmonary complication, hæmorrhage, or interference with laryngeal movements.

SOCIETIES' PROCEEDINGS.

ROYAL SOCIETY OF MEDICINE—LARYNGOLOGICAL SECTION.

March 5, 1915.

Dr. JOBSON HORNE, *Vice-President, in the Chair.*

Angeioma (Bleeding Polypus) of Nasal Septum.—**William Hill.**—Female, aged twenty-five. A vascular growth, which has bled on several occasions, is seen springing from the anterior end of the right vestibular surface of the nasal septum. It has been noticed for six weeks, and is increasing. Eradication by surgical diathermy was proposed.

The CHAIRMAN regretted that their President, Dr. William Hill, had been unavoidably prevented from presiding. The nature and treatment of "bleeding polypus" of the septum of the nose was familiar to them all. The situation of the growth, in Dr. Hill's case, on the most anterior part of the vestibular surface of the nasal septum was perhaps a little unusual. The case reminded him of one which he had brought before the Laryngological Society of London many years ago.¹

Dr. PEGLER agreed with the President's diagnosis; as sometimes happened with these angeiomas, the growth started from the septal wall of the vestibule close to the junction of skin and mucous membrane. He hoped that Dr. Hill would preserve the specimen by removing it entire in the usual manner.

Report upon Dr. Hill's Specimen of Septal Angeioma.—The growth, somewhat mushroom-like in shape, cut vertically, belongs to the close-textured, soft-cell type of *fibro-angeioma*. The convex surface is overlaid by fibrinous plasma containing leucocytes. Around the base is stratified epithelium sending in many prolongations of prickly cells. Thick fibrous trabeculæ ramify into the body of the growth from the pedicle, and merge in the dense meshwork of connective tissue sustaining endothelioid cells and enclosing abundance of blood sinuses, mostly very small. Lymphocytes have freely infiltrated an extensive area towards the periphery.

L. H. PEGLER.

Left Recurrent Paralysis associated with Mitral Stenosis.²—**L. H. Pegler.**—The patient (deceased) was a Jewish girl, aged nineteen, who came to the Metropolitan Throat Hospital in July, 1914, complaining of hoarseness on awakening and vocal disability which had dated from the previous January. This was found laryngoscopically to be due to

¹ *Vide Proc. Laryng. Soc. Lond.*, 1896, iv, pp. 31, 32.

² See also p. 328, of this issue.