NEW YORK OTOLOGICAL SOCIETY.

Stated Meeting, January 27, 1914.

DR. F. WHITING, PRESIDENT, IN THE CHAIR.

Radiographic Plate Showing an Alveolar Abscess, With a Small Fragment of a Tooth in Situ.

DR. T. PASSMORE BERENS presented a radiographic plate showing an alveolar abscess, with a small fragment of a tooth in situ. The patient, a woman fifty-eight years of age, had had all the teeth of the upper jaw extracted six or seven years ago. Following this there was swelling in the canine fossa of one side, which would become larger and then smaller, until last November, when it was opened by the family physician and a large quantity of pus was found. He referred the patient to the speaker, who, upon operation, discovered the fragment of tooth in the bottom of the large cavity, with inflammation around it, and a cyst fully three-fourths of an inch in diameter, which was filled with pus. The upper border of this cyst was connected with the antrum of that side.

DISCUSSION.

DR. THOMAS J. HARRIS said he was called in to see this patient while Dr. Berens was operating. The unusual feature about the case was the large size of the cavity and its connection with the antrum.

DR. WILLIAM H. HASKIN recalled having reported, in 1908, three cases similar to the one cited by Dr. Berens. Since that time he had had seven or eight more. It was not an uncommon occurrence to find these remaining roots. It was likewise not uncommon to find teeth which have never erupted. He had had a case, a patient over sixty-two years of age, in which there was a history very similar to that of Dr. Berens' case. Extraction of the teeth had not relieved the pain, and on account of acute inflammation in the jaw the patient was sent to him. An unerupted upper lateral incisor was found

and removed. In each of three other cases, upon operating he encountered fully formed teeth. In one case there was a tooth which could not force itself down, and the root had developed upward, extending along the floor of the nose. The tooth was the shape of a comma. In another case there was a large dentigerous cyst. This was opened and swabbed with nitrate of silver solution, and the following day a hard, blackened mass was detected with a probe. It proved to be an odontoma on an unextracted root, and was probably the cause of the original pain. The man had had all his teeth extracted, without relief of pain.

DR. STEPHEN H. LUTZ cited a case in which a completely carious tooth had turned around and the crown had erupted into the antrum.

Fistula at the Apex of the Semicircular Canal.

DR. T. PASSMORE BERENS mentioned a case of fistula at the apex of the semicircular canal in a man fifty-five years of age, with a history of long standing suppuration. The patient was now convalescing after a Schwartze-Stacke operation, and the symptoms had almost entirely disappeared.

Venous Anomaly in Mastoid Operation.

DR. WENDELL C. PHILLIPS related an experience which he had had the day before with a colored female patient whose history was rather indefinite before the operation. She had had chronic suppuration for many years. A simple mastoid operation had been performed, and last summer she had had a radical operation. When the woman appeared at his service at the Postgraduate Hospital she had an unhealed radical mastoid wound. There was considerable inflammation in the postauricular region. He attempted to clear out by making a large wound and a large flap. As he began to curette the granulations from the attic, he found an unusual amount of hemorrhage. Just at this moment one of the house staff said he had operated upon this patient last summer, at which time there was very profuse hemorrhage. The pathologist had reported angioma. Proceeding with the present operation, further erosion of the bone, causing exposure of the dura, was found, and a mass was encountered between the oval and

round window posteriorly and the prominence anteriorly. As the granulations were cleared away he came down upon a large vessel which, from the color, was thought to be a vein. It was about the size of the external jugular, and was of sufficient size to cause him not to open it. He could not determine what it was. Whether it was an auxiliary petrosal, he could not say. It was evidently not the bulb, but it was connected with the lateral sinus in some way. He purposely made a very large incision in the concha; if, therefore, he is successful in closing the posterior wound, he will probably have an opportunity to study the case further.

Abnormality of the Bulb, or Malignancy.

DR. THOMAS J. HARRIS referred, in this connection, to a case reported before the Society last spring, in which he had operated, suspecting a protrusion of the bulb into the external auditory canal. The patient, a young man, had been under his observation for a week. He had been complaining of pain, the source of which the speaker endeavored to discover. In carrying the probe in he touched a protruding mass. After touching it again there was very profuse hemorrhage. The pain increased and the mastoid was explored. Nothing was found in the mastoid but this mass protruding out into the floor. The hemorrhage was so severe that it was impossible to go further. He concluded that the protrusion was the bulb. The immediate results of the operation were favorable. The small mass which was removed at the time was sent to the pathologist, who reported malignancy. The clinical diagnosis wavered between malignancy and abnormality of the bulb. He favored at first malignancy. There had been, however, no return of the growth and no return of the pain. It did not look now like malignancy, yet the bleeding was certainly more than usual with granulations. There must have been chronic suppuration in childhood, but there was no obtainable history of this. He was now of the opinion that the condition was not one of malignancy, but of abnormality of the bulb. A radiograph was taken, but it had no bearing upon the diagnosis or the clinical course. The radiographer insisted that there was trouble in the mastoid antrum, but there was none.

DISCUSSION.

DR. HASKIN thought it not at all uncommon to find the jugular bulb in direct contact with the floor of the labyrinth. He has, perhaps, as many as twenty bones which show this. He believed this to be the condition in Dr. Harris' case, which he saw at the time of operation.

DR. GRUENING said in the specimen presented, the bulb covered the fenestra rotunda. If the incision had been made downward instead of upward, the bulb would have been cut.

Discoloration of Drum Membrane.

DR. J. E. SHEPPARD reported a case in which there was a very dark discoloration of the drum membrane. The patient, a young man, consulted him, not about this ear, but about suppuration of the opposite ear, on which side the mastoid had been operated in 1902. The drum membrane was apparently bulging into the external auditory canal, and was of a dark bluish purple color. The landmarks were practically obscured, with the exception of what he thought was a faint outline of the malleus handle. He would be afraid to cut into it. The hearing for the watch this morning was fourteen inches, normal six feet. The hearing in November was as good as it is now. In looking over the history, taken in 1902, when he operated upon the patient, he found he had made the note that "this membrane appears cicatricial." He had made no note then of any discoloration, which he certainly would have done if it had been present.

DR. PHILLIPS called attention to the frequent occurrence of dehiscence in the floor of the bony canal. In this case, however, there was no dehiscence. It had been stated by one who examined Dr. Sheppard's case that these anomalies are more frequent in the colored race.

Hemorrhage in a Hemophiliac Male Child Two Years Old.

DR. SHEPPARD recalled having reported to the Society last spring a case of hemorrhage in a hemophiliac male child, two years old, resulting from incision of the drum membrane. He had subsequently to do a mastoid operation, which was followed by persistent bleeding. The child was given repeated

large amounts of human blood serum, with resultant cure. Last week a child eight months old, sex unknown, was brought in to him bleeding from both ears. He did not know whether the membranes had been incised, or whether the bleeding was spontaneous. At any rate, the family physician had been trying to stop the hemorrhage by using horse serum in 5 cc. doses. The horse serum appears more dangerous and less effective than human serum. The skin had been abraded around and behind the concha and on the drum membrane. Wherever there was abrasion there was hemorrhage. He had immediately given 20 cc. of human serum, followed by cessation of hemorrhage after two or three hours. There was no history of hemophilia in the family.

DISCUSSION.

DR. HARRIS was reminded of a case, of a baby a few days old, which came under his observation two or three years ago. At the urgent request of the family physician, who assumed all the responsibility, he operated for the removal of adenoids, which proved to be very large for a child of that size. The patient was well cared for afterward, but despite this, severe hemorrhage followed, and in fifty-six hours the child died. The case was not unique. The operation was indicated, and probably had very little to do with the bleeding.

DR. LUTZ asked if any one had had experience with "Coagulin," made by Parke, Davis & Company, from sheep serum. It is put up in ampules, dry and sterile, sterile water to be added when used. It is administered by hypodermatic intramuscular injection. It can also be used dry on a bleeding surface, and quickly causes a clot.

DR. JOSEPH A. KENEFICK mentioned the case of a girl, seventeen years of age, upon whom he had operated for adenoids. She was anemic. There was a history of hemophilia which, for some reason, the family physician did not give. All blood and other examinations were made. He found, to his great surprise, that he had operated upon a hemophiliac. The hemorrhage was persistent and severe, and was controlled for a day or two by packing. Finally he resorted to the use of horse serum, two doses of 50 cc. each. He was unable to state whether the clot occurred in consequence of the packing or the horse serum. At all events, the

"serum sickness" was extremely severe. The glandular swelling and fever lasted for several days. Under hot mustard poultices the glandular swelling subsided. Many cases have been reported in which a clot was secured by the use of horse serum. He referred in this connection to the work on hemolysis which had been done at Mount Sinai Hospital.

DR. SHEPPARD, in closing the discussion, said Welch had had good results in the newborn with the human serum. It was possible to get the serum within an hour or two. The Jewish Hospital of Brooklyn kept this human serum always on hand. They get it from the obstetrical ward, using therefor placentæ giving a negative Wassermann reaction. The question of risk of introducing spirochetæ had been raised, but no trouble in this regard had been experienced.

Suppuration Following Aural Douching.

DR. HARRIS spoke of the mechanical effect, in certain cases, of water upon an old suppuration of the middle ear. For a long time he had thought it a coincidence, but now he is forced to believe that there is some relationship between the use of hot water and the recurrence of suppuration. He had recently noted this in two cases. Each patient came to him for what was thought to be earache. He found impacted cerumen. One had had no suppuration for seven and the other for ten years. Without any instrumentation whatever, and with unusual precautions, the ear was syringed with boiled water. In each case there resulted a suppuration which has been persistent and profuse. Whether the wax, remaining so long in situ, had covered a nest of bacteria which had accumulated there, and which multiplied rapidly when uncovered, he did not know. At any rate, the experience and the results were annoying. The bones were destroyed in each case. One patient was a lawyer, sixty-five years old, who had been treated as a child by a seton put in his arm.

Replying to a question by Dr. Whiting as to whether the supposed cerumen might not have been inspissated discharge, Dr. Harris said there was an inspissated discharge later, but the plug which he removed was characteristic cerumen. There was no trauma at all. The cerumen was very dry, and there was no pus behind it. There had been no discharge for years.

DISCUSSION.

DR. LUTZ said it was not an uncommon experience to clear out impacted cerumen and to find a large perforation in the drum membrane and a tympanic cavity filled with discharge. He had seen suppuration appear in an ear that had been apparently dry, and had considered that there was an opening in the membrane, that this had become plugged with cerumen, and that when the cerumen was removed the suppuration was started up again.

DR. HARRIS, replying to a question from Dr. Berens as to how he knew the plug was dry, said this could be judged from the appearance of the plug. There were absolutely no symptoms. It would seem that the plug, acting as a tumor, would have been the cause of pain.

DR. BERENS said he had asked the question about the plug of cerumen being dry because several years ago he had a similar experience, and for ten years he had not used a syringe at all. He used instruments exclusively. If these plugs are examined, one will sometimes see a cast of the inner wall of the tympanum, frequently presenting a little moist point of pus. If examined, they would no doubt prove to be filled with bacteria.

DR. SHEPPARD agreed with Dr. Berens with reference to douching, and was surprised that Dr. Harris laid emphasis upon the fact that he used no instruments. It had long been his practice to use instruments instead of water, particularly in old cases, and where the drum is known to be perforated.

DR. GRUENING considered the removal of a plug of cerumen by means of the syringe the most comfortable for the patient. Dry plugs could be softened with carbonate of soda, after which they could be easily removed. A patient with impacted cerumen might also have otitis media. Pain always indicated other trouble besides impacted cerumen. He believed the douche to be entirely harmless, but he thought the diagnosis of otitis media should be made before removing the plug.

DR. JOHN D. RICHARDS called attention to the possibility of mistaking eczema of the canal for cerumen. The syringe used in this condition may set up trouble which might persist for some time. He also recalled a case of cerumen in which the syringe had been used to remove the wax, and this had

started an eczema which lasted for four years and which was exceedingly annoying. This patient had never had eczema before, and since that experience he removed wax with instruments whenever that was possible.

DR. GRUENING added that when the canal is filled with a hard mass consisting not of wax but of desquamated epidermis, this accumulation can also be softened with carbonate of soda. It would be difficult to remove such a plug with instruments. When the soda has acted long enough the plug can be easily washed out. He never uses instruments in removing wax or any plugs which form from continued desquamation. This desquamation is not black, but of a yellowish white color.