(*November* 2, 1917.)

Complete Paresis of the Left Vocal Cord due to a Mediastinal Growth.

By IRWIN MOORE, M.B.

PATIENT, a male, aged 45, attended the Great Portland Street branch of Golden Square Hospital, on September 18, complaining that three weeks previously a piece of meat had stuck in his throat and was only released by being pushed down by a bougie. Since this he has had a sore throat, hoarseness of the voice, and has only been able to swallow semi-solid food. His former weight was 11 st., but since this occurrence he has lost 2 st. When first seen by the exhibitor on October 5 considerable œdema of the arytænoids and upper part of the larynx was observed and the vocal cords could not be seen.

There has been progressive emaciation during the past two months. Patient has a cough, with slight sputum and dyspnœa. His previous health has been good, and there is no history of syphilis.

On October 12 the œdema having cleared up, the left vocal cord was seen lying in the " cadaveric " position.

On October 18 Dr. Halls Dally kindly saw patient for me, and reports as follows:—

Examination of the chest revealed impaired percussion note over the upper two-thirds of the left lung, front and back, the note being dull from the lower border of the clavicle to the third rib. Over this area the breath sounds are feeble, and crepitations were audible above and below the left clavicle, and in the left interscapular space at the level of the sixth and seventh thoracic vertebræ.

Blood Count. — Red cells, 5,000,000 per cubic millimetre; white cells, 12,000 per cubic millimetre; colour index, 0·7 per cent.; hæmoglobin, 70 per cent.

The radiogram of the chest shows a shadow with ill-defined outline extending from the mediastinum over the left upper lobe and upper portion of lower lobe. The appearances of this shadow suggest a mediastinal new growth invading the left lung (H. D.).

DISCUSSION.

Dr. SYME: I should like to mention two cases of recurrent paralysis. A man was operated upon under ether for hernia, and a week later he lost his voice. I saw him three weeks after his operation. He had complete paralysis of his left cord. The œsophagoscope and screen showed no cause. In October his voice had returned. He has now abductor paralysis. I thought there might have been dragging on the chin at the time of the operation, and hæmorrhage into the sheath of the nerve, but there was no trouble with the anæsthetic. The other case was that of a girl with a scar on the left side of the neck, the result of a removal of glands three years previously. Two months ago she lost her voice, and had complete paralysis of the left cord. This is passing off, and there is now paresis of the abductor.

Dr. W. HILL: I think it is mediastinal growth, but it is curious there should be recurrent paralysis, unless the aorta has been pulled down, which does not appear to be the case. It might be due to a gland higher up.

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Illustrations of Nasal Endo-rhinoscopy (Epidiascope).

Shown by P. WATSON-WILLIAMS, M.D., Major R.A.M.C.

THIS series of twenty-nine drawings, illustrating endo-rhinoscopy, emphasizes the value of the exact inspection of the nasopharynx and the posterior portion of the nasal passages, more particularly for the detection of pathological conditions which, by all other means, are invisible.

Some of the cases illustrated show small streams of muco-purulent discharge from one or both sphenoidal sinus ostia, or from the middle meatus posteriorly, and in some of the examples probes are shown entering the sphenoidal and frontal sinuses. Examples of minute polypi in the spheno-ethmoidal region of early malignant growths in the naso-pharynx are included. Other illustrations show changes in the opening of the Eustachian tube in swallowing as compared with the appearance during quiet respiration. The great majority of the illustrations have been taken with the Holmes' modification of Valentin's nasopharyngo-scope; there is only one example of the picture obtained by Wolff's instrument to show the disadvantage the inversion of the image yields: the more restricted area coming into view.