FIG. 1.—Malignant “Mixed” tumour of Submaxillary Salivary Gland.

FIG. 2.—Radiogram showing erosion and destruction of lower border and lower part of the body of the mandible.

CASES SHOWN AT F.R.C.S. DEMONSTRATION.

By CAMERON MACLEOD, F.R.C.S.

(Surgeon-in-Charge Out-patients Charing Cross Hospital and Surgeon to Out-patients Hampstead General Hospital.)

I. Malignant "mixed" tumour of Submaxillary Salivary Gland.

A. K., male, aged 63, french polisher by occupation.

History. Two years ago first noticed a small swelling under the left lower jaw. It slowly increased in size until the end of March, 1939 when, following the extraction of a lower molar tooth, rapid enlargement occurred. There has been a feeling of weight and a constant dragging pain.

Examination. A large swelling is situated in the left submaxillary region (see Fig. 1 [Art Plate]). The skin over it is stretched and somewhat bluish in colour. The surface is irregular, the more well-defined areas being translucent. Some areas are firm and leathery or elastic in character, others are soft and fluctuating. The swelling is almost completely fixed to the lower jaw and can be palpated readily with a finger on the floor of the mouth. There is no lymphatic gland enlargement. No primary focus can be found in the mouth, pharynx or larynx. Temperature and pulse are normal. A radiogram (see Fig. 2 [Art Plate]) shows erosion and destruction of the lower border and lower part of the body of the mandible extending from in front of the angle to the left side of the symphysis menti. The appearances suggest that the tumour is arising from the soft structures and involving the bone secondarily.

Discussion. The length of history and slow growth for the first two years followed by rapid increase in size suggests a simple tumour which has undergone malignant degeneration. The "mixed" tumours of the salivary glands exhibit this feature. The fact that the tumour can be readily palpated bimanually with a finger on the floor of the mouth suggests an origin from the submaxillary salivary gland. The history is too long for a primary carcinoma of the submaxillary salivary gland and possibly also for a fibro-sarcoma of the mandible. No primary focus can be found and as no other lymphatic glands are enlarged it seems unlikely to be a secondary mass of carcinomatous glands.

No response has followed a course of radio-therapy.

2. Chronic Syphilitic synovitis of knee.

J. W., male, aged 29, bath attendant by occupation.

History. Eight months previously he remembers having strained his left knee but had noticed nothing abnormal until three weeks ago when the knee became swollen. There was no pain except when the joint was fully flexed.

Examination. A moderate effusion is present in the left knee joint. The synovial membrane does not appear to be thickened nor is there any thickening of the peri-synovial tissues. There is no wasting of the quadriceps muscle. The right knee joint is normal.

Pharynx. There is marked scarring of the left faucial region and of the posterior wall of the oro-pharynx. The soft palate is almost completely destroyed and the uvula is attached to the remains of the right half.

Eyes. The patient wears dark glasses and has attended Moorfields for interstitial keratitis. There is a paralysis of the right internal rectus muscle.

Wassermann reaction is strongly positive.

Radiogram of left knee joint shows no bony changes.

Progress. Rapid improvement occurred on potassium iodide and mercury by the mouth, and one week later the effusion in the joint had completely disappeared.

Discussion. Most of the candidates diagnosed this as a traumatic synovitis although the history of injury occurred so long previously. In all joint conditions the importance of a complete general examination is evident.