with a tumour mass, which it was proposed to remove, three-quarters of the size of its head, and shock was likely to be, and indeed proved to be, considerable. On the other hand, if the child was allowed to grow, so, too, would its attached twin, and a proportionately more extensive operation would be called for, probably necessitating general anaesthesia. It was perhaps remarkable that so large a mass did not result in any difficulty at birth; but the mother was young and the child her fourth. Forceps were not used.

Secondly, the leakage of cerebrospinal fluid.—Although every attempt was made to close the spinal theca, a prolonged leakage of cerebrospinal fluid occurred. The fact that this did not become infected was primarily due to the very skilful and sympathetic nursing that the child received. It is, however, possible that the redundant skin flap, at first thought to be a disadvantage, may have partially contributed to this lack of infection by carrying the suture line well over to the left and nearly two and a half inches away from the midline.

Thirdly, the recognition of the spinal anaesthetic effect arising from local anaesthesia after the theca was opened and disappearing within a few hours.

BENIGN CYST OF THE PAROTID GLAND

BY

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(WITH SPECIAL PLATE)

Parotid tumours are common, but simple cysts of the parotid gland are rare. Very few cases of the latter are reported in the literature, and fewer still of cysts communicating with Stensen's duct. Out of 17 cases of tumour of the parotid in my series 10 were benign mixed tumours and 5 malignant tumours, one of which had undergone cystic degeneration. Only 1 among the 17 cases was a simple cyst communicating with Stensen's duct.

The origin of simple cysts in the parotid gland is speculative. Dermoid cysts and cysts of branchial origin may occur, but very few cases are reported in connexion with the parotid gland. In a cyst of branchial origin the existence of lymphoid tissue underneath the stratified epithelium is diagnostic. Cysts may occur in connexion with benign adenomas, and the pathology of these adenomatous structures may be the same as that described by Lenthal Cheatle (1931) in regard to breast tumours. In rare cases fairly large cysts in the parotid gland have been described by Hertzler (1937). With these the histological picture is always of an adenomatous structure with a cystic formation due to association with adenomatous neoplasia or to degenerative change leading to cystic formation in an adenoma or blocking of a main duct. Vitamin A deficiency has also an important bearing upon the nutrition of the epithelium of the lining membrane of the salivary gland. In experimental animals Wolbach and Howe (1925) have shown keratinizing metaplasia in mucous membrane, gland duct, and secreting epithelium in vitamin A deficiency. In children Wilson and Dubois (1923) have demonstrated lesions of xerosis and keratomalacia and also metaplasia of the lining membrane of trachea, bronchi, pancreatic ducts, uterus, and salivary glands. In cases of vitamin A deficiency a metaplasia of the epithelium of the duct to the squamous type, with retention of secretion inside the cavity, may occur. In these cases such changes are general and not localized to one gland. This factor has to be borne in mind in India, as vitamin A deficiency is common in young and old. There is no suggestion, however, of such a deficiency in the following case, in which a cyst communicated with Stensen's duct.

Case Record

A Hindu male aged 60 was admitted with a swelling of two months' duration in the region of the parotid gland and extending into the left cheek. It began as a small swelling in the region of the parotid. He found that the swelling increased in size with the taking of food, but on applying pressure over it the saliva flowed into the mouth and the swelling was reduced to its original dimensions. He was treated by indigenous methods consisting of the application of irritants inside the mouth. Subsequently the pain and swelling increased. He could not without pain empty the swelling by pressure as before. On admission to hospital he was found to be healthy except for the swelling, which on examination was seen to extend from the front of the ear to half an inch behind the angle of the mouth. It was fixed to the parotid gland. It was warm to the touch and ovoid in shape. Its margins were easily defined. Its surface was smooth, and its consistency firm at the periphery and soft and cystic at the centre, with fluctuation. The skin over the swelling was adherent and tender. There was slight limitation of movements of the temporo-mandibular joint. On opening the mouth the left side of the cheek was dry, and on deep pressure, which caused great pain, a drop of yellowish fluid could be squeezed out. The opening of the left Stensen's duct inside the mouth was retracted. After dilatation lipiodol was injected, and a radiograph showed the lipiodol in the cavity in droplets revealing the communication with Stensen's duct (Plate, Fig. 1). Under general anaesthesia the cyst was removed by a transverse incision parallel with the nerves and blood vessels over the most prominent part of the cyst. The cyst wall, which was thin and adherent to the skin, burst during dissection and was found to contain yellow fluid. At the anterior margin of the masseter the cyst was fixed to the duct by a narrow stalk. This was cut across and the cyst removed. A pedicle ligature was applied round the stump, held by forceps near Stensen's duct, and the wound was sutured in layers. After removal of the cyst a persistent parotid fistula was feared, but the wound healed by first intention without formation of a parotid fistula.

Pathological Report.—Section showed that the cyst wall was lined by stratified epithelium, with fibro-fatty tissues in places. No lymphoid tissue was found underneath. There were gland tubules suggestive of its origin from the parotid gland. Nothing was observed that suggested a branchial origin (Fig. 2).

The patient on inquiry after one year states that he is perfectly fit, with no recurrence of the swelling.

Points of Interest

A case of simple cyst communicating with Stensen's duct is reported.

The mode of origin of this cyst is difficult to appreciate, but it is presumed that, being a simple cyst communicating with Stensen's duct, and having some glandular structure round the periphery of the duct without any evidence of lymphoid tissue underneath the stratified epithelium, it began as a cyst in an adenoma arising near Stensen's duct from the glandular structure at the socia parotidis communicating with the duct.

My thanks are due to Dr. T. Bhaskara Menon for his pathological report and photomicrograph.

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M. G. KINI: BENIGN CYST OF PAROTID GLAND

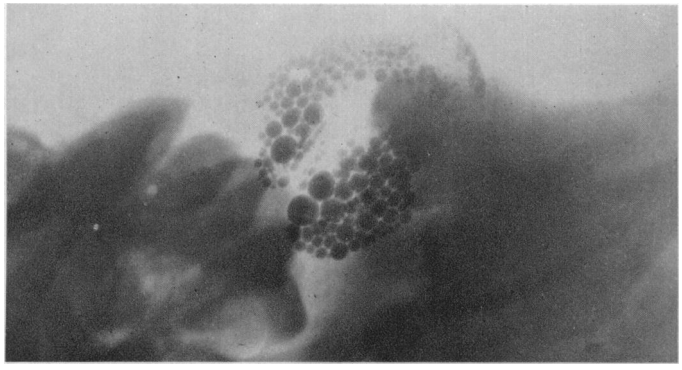


FIG. 1.—Radiograph showing the lipiodol in the cyst.

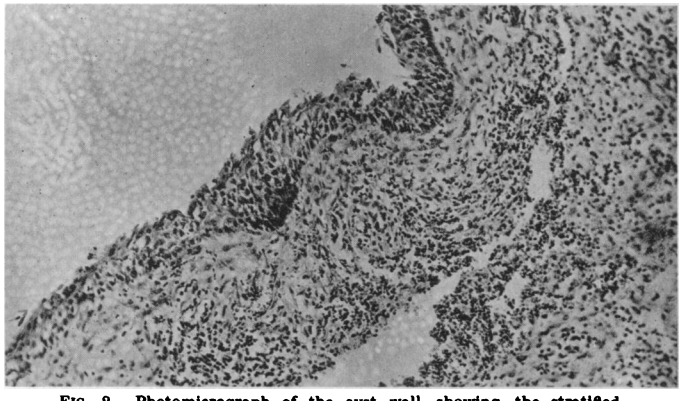
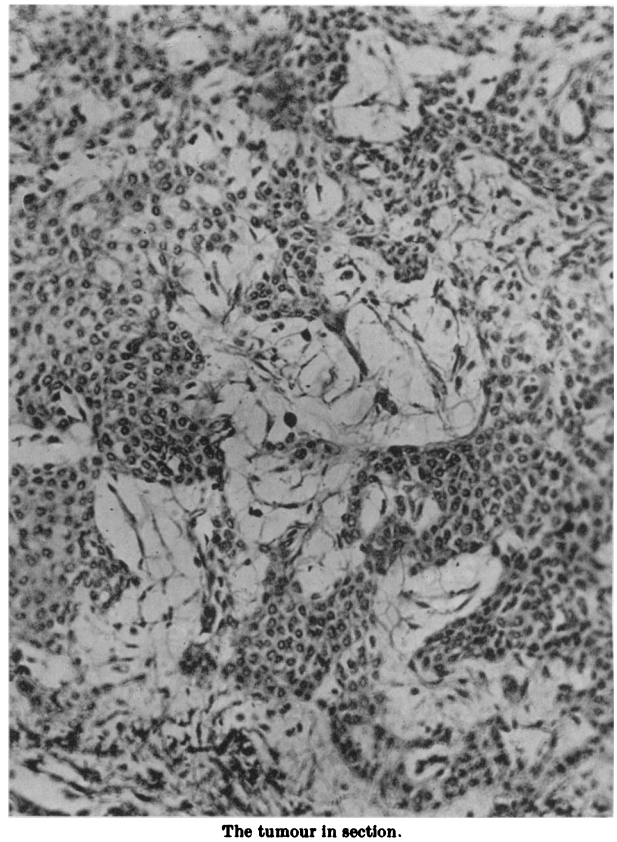


FIG. 2.—Photomicrograph of the cyst wall, showing the stratified epithelium.

J. D. N. NABARRO: GLOMUS TUMOUR



The tumour in section.

H. KENRICK CHRISTIE: NEUROFIBROMATOSIS, OR VON RECKLINGHAUSEN'S DISEASE

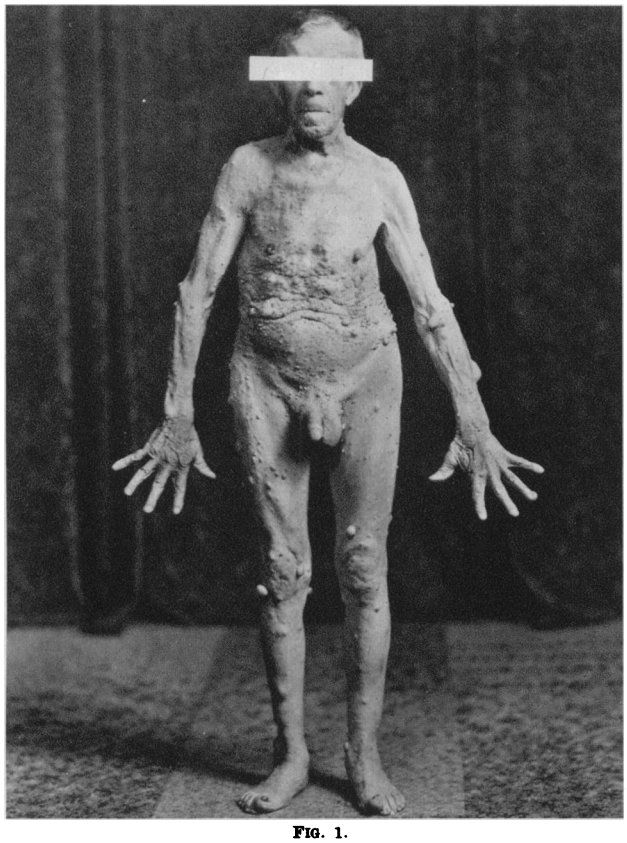


FIG. 1.

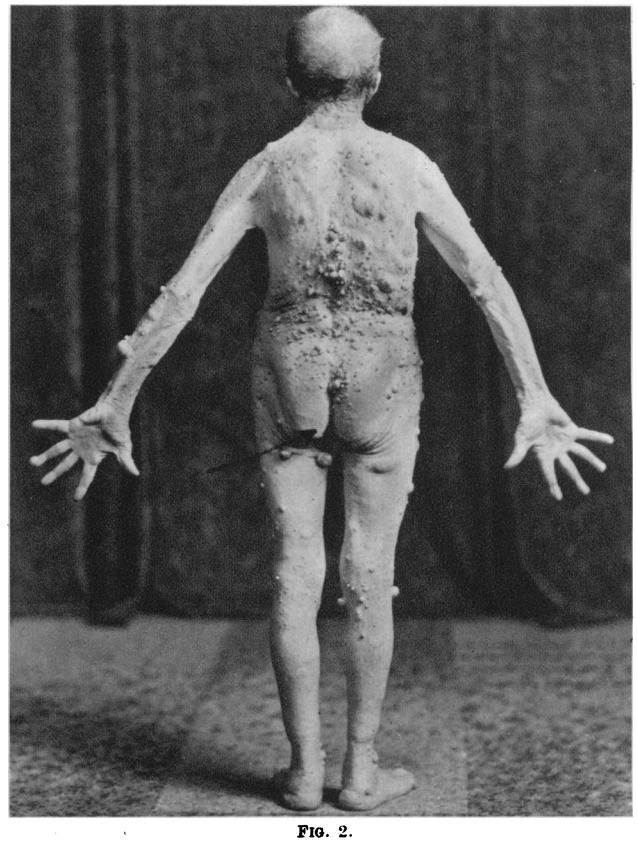


FIG. 2.