

## LARYNX.

**Cheval.**—*Some Points in Connection with Pseudo-Membranous Affections of the Upper Air Passages.* "Journ. Méd. de Brux.," May 26, 1898.

CASES are quoted which lead to the following conclusions:—(1) There are three forms of exudation—the pultaceous, the membranous, and the gangrenous. (2) Naked-eye examination is not sufficient. (3) That certain diphtheritic cases may be cured spontaneously. (4) That we ought to use antitoxin in all suspicious cases. (5) Marmorek's serum is valuable in streptococcal cases, tonics and antiseptics being also used.

*B. J. Baron.*

**Depage.**—*A Case of Laryngectomy for Cancer.* Société Belge de Chirurgie, January 22 and 29, 1898.

THE operation was performed eight months ago; all communication between the trachea and the mouth was shut off. He speaks in a whisper, and there has been no recurrence. The trachea is attached to the skin to avoid all septic contact, and healing took place in ten days.

*B. J. Baron.*

**Gardner, H. Bellamy.**—*Obstructive Laryngeal Affections and their Influence upon Chloroform Anæsthesia.* "Lancet," June 11, 1898.

THE administration of chloroform to patients with a partial laryngeal obstruction is clinically a somewhat comparable procedure to the exhibition of nitrous oxide gas with small percentages of oxygen in surgical operations. The valuable experience gained in the gradual onset of symptoms due to reduction of the oxyhæmoglobin in the blood in these latter cases (easily rectified by increasing the supply of oxygen to be inhaled), has shown definitely that not only in theory is it possible to take advantage of these two factors in the respiratory and vaso-motor compensatory mechanism, but in actual practice the administrator can feel and perceive at every breath where the limits of this slight oxygen deprivation lie, and can detect by the depth of air-intake and tendency of facial colour the phenomena which will follow during several ensuing minutes. It cannot with certainty be stated that the elimination of carbonic acid gas is retarded in cases with mechanical obstruction in the air passage, but, as it is probable, the writer suggests a reference to the remarkable result obtained by Dr. Augustus Waller during his experiments as to the direct action of anæsthetics upon isolated nerve, which showed that when CO<sub>2</sub> was mixed with chloroform vapour in the gas chamber the recovery of electro mobility in nerve-tissue was more pronounced than after chloroform alone.<sup>1</sup> This bears very directly upon the cases related in this paper, and should be carefully investigated in future work. At this point the foregoing remarks should be clearly defined as a dangerous doctrine for any but those who are in constant association with the administration of anæsthetics. The actual fatal result of a more or less sudden obstruction to respiration during chloroform narcosis has been so frequently reported, and the warning is so thoroughly appreciated by all experienced administrators, that this paper cannot be misunderstood in merely offering an explanation of certain satisfactory symptoms in otherwise desperate cases.

*StClair Thomson.*

**Heller.**—*Foreign Bodies in the Air Passages.* "Münchener Med. Woch.," June 21, 1898, No. 26.

THE author recommends syringing of the naso-pharynx in order to produce forced expectoration, which is often successful in removing foreign bodies. It may also

<sup>1</sup> Dr. A. Waller, "Brit. Med. Journ.," Nov. 20, 1897, p. 1473.

be used to remove false membrane or accumulation of secretion. He describes three successful cases in which it was tried, one of which was a child, one year old, with a piece of almond impacted in a bronchus, where it had been for four weeks. *Guild.*

**Hopmann.**—*Tumour of the Glottis removed by Thyrotomy.* "Münchener Med. Woch.," June 21, 1898.

THE author showed a girl, aged sixteen, who complained in June, 1897, of loss of voice, dyspnoea, and attacks of suffocation at night. The glottis was filled with a flesh-coloured, rough, dense tumour, the size of a cherry, which concealed the vocal cords. The tumour grew from the left towards the right side, with a broad basis, slightly movable, and could not be drawn into a snare or guillotine. It causes considerable stenosis.

After applying cocaine an attempt at removal was made with an endolaryngeal knife and forceps. The patient was unable to cough up the blood. She became unconscious from asphyxia. Tracheotomy and artificial respiration were done with success. Fourteen days later thyrotomy was done. The tumour was removed. The left vocal cord was divided, and was sutured with catgut after removal of the tumour and the part attached to it, which was principally the region of the left ventricle and false cord, as far back as the posterior laryngeal wall. Wound healed in fourteen days. Some months later there was slight cicatricial stenosis, which was overcome with Schroetter bougies. The girl speaks with a loud—somewhat hoarse—voice; respiration is quite free, and she is quite able to work. The laryngoscope shows extensive cicatrization of the left laryngeal side, and fixation of the cicatricially contracted left vocal cord and arytenoid (ankylosis spuria). On phonation closure is effected by the right vocal cord passing over to the left, which is fixed.

The microscope showed a non-malignant adeno-fibroma with the form of a papilloma—proliferation of the false cord with the formation of papillæ on its free surface. The papillæ are surrounded with a margin of stratified cylindrical epithelium. The tumour histologically showed an interesting analogy to the papillary proliferation of the inferior turbinate (soft papilloma, strawberry polypus). Papillary tumours of the larynx, especially of the false cords, consisting of cylindrical epithelium, are very rare. On the other hand, papilloma (hard), consisting of pavement epithelium on the vocal cords, are frequent, while in the nose they are rare. *Guild.*

**Kronenberg** (Solingen).—*Stenosis of the Upper Air Passage.* "Münchener Med. Woch.," June 21, 1898.

A BOY, aged five, has severe attacks of suffocation, which constantly occur as soon as he falls asleep. Examination shows the child to be badly nourished, pale, and somewhat cyanotic. Chest barrel-shaped; heart displaced slightly to the right; larynx free. Numerous adenoids, which were removed. In spite of this attacks recur. When awake breathing is quite free; the child is lively; there is no trace of dyspnoea in any position or movement. As soon as the child falls asleep the breathing begins to cease, evidently owing to some obstruction, in from one and a half to two minutes; it is absolute. The child awakes owing to deficiency of air, and the cycle is renewed. This goes on, with short interruptions, the whole night. It is worse in the dorsal position, but also occurs in every position. It is only relatively free in the prone position.

He attributes the condition to falling back of the tongue basis. Slighter degrees have been observed in badly nourished infants. He does not remember any case where the condition was so marked that there was danger to life. Central or

peripheral paralysis may be excluded, as when awake there is no trace of dyspnoea. The condition most closely resembles the difficulty in breathing in anæsthesia, where the tongue falls back. Here, also, if the lower jaw is pushed forward, the difficulty disappears. An instrument was designed to effect this. Galvanism was applied, the muscle tonus improved, and after a time the apparatus could be dispensed with.

*Guild.*

**Manasse, P.** (Strasburg).—*A Case of Double Cerebral Abscess, with Fistula into the Ventricles; Optic Aphasia; Recovery.* Arch. of Otol., April, 1898.

THE patient was a woman, aged forty-two, with old-standing otorrhœa and recent severe headache, vomiting, and fever, followed by loss of consciousness. The typical radical operation was carried out, and a puncture was made into the pulsating temporo-sphenoidal lobe, thick pus being withdrawn. The abscess was found to extend far backwards, and undoubtedly into the occipital lobe. After a few days considerable improvement had taken place; but aphasia was present in so far as when looking at objects she was unable to remember the name for them; whereas the sound produced by the object, or the sensations on handling it, enabled her to name it at once—that is to say, that the association between the appearance and the name was interrupted; whereas the association between the other qualities and the name was still intact. The natural supposition is, therefore, that the strands uniting the visual centre in the occipital lobe with the speech centre in the frontal were damaged by disease. This form of aphasia—"optic aphasia"—would indicate a lesion in the direction of the visual centre, and, in this case, a temporo-sphenoidal abscess that had extended very far back. On the seventh day, during the dressing, a large quantity of thick, offensive pus shot out on removal of the tampon from the abscess cavity; and, on insertion of the finger, it was found that there was a second cavity, lying far forward. This was opened more freely. Some days later a large quantity of light, clear fluid flowed out of the cavity; and, on illumination, a necrotic spot was found close to the posterior horn, having near it a small three-cornered slit, from which cerebro-spinal fluid flowed out with each pulsation of the brain. Recovery ultimately ensued, in spite of the existence of this fistula communicating with the ventricles.

In regard to the interesting features presented by this case from the point of view of cerebral localization, the writer refers to an observation of Zaufal and Pick.<sup>1</sup> In their case—in which there was an abscess in the medullary substance of the left temporal lobe—there was optic aphasia, with slight paraphasia, sight being insufficient to guide the patient to the name of the object, and requiring to be assisted by both touch and hearing. In Manasse's case the patient could not name a bell when she saw it; but, as soon as she heard it ring, she named it at once.

*Dundas Grant.*

**Munche, Prof. Schreck.**—*Laryngitis Exudativa.* "Munchener Med. Woch.," No. 26, 1898.

LARYNGITIS EXUDATIVA has been used to embrace a series of affections. Miliæra (sudamina) were first described by Lori. They occur as small vesicles on the epiglottis and aryepiglottidean folds, causing smarting or the feeling of the presence of a foreign body. In acute or chronic catarrh pointed excrescences may occur corresponding to obstructed and dilated glands.

M. Schmidt has described cases of confluent vesicles with clear contents.

A better known eruption is herpes laryngis, usually accompanied by eruption on the skin or lips.

Varicella and variola are rare; they usually occur along with the skin affection or they may precede it.

<sup>1</sup> "Prager Med. Woch.," XXI., 1896.

In foot-and-mouth disease, or epidemic stomatitis, small vesicles form in the larynx, which burst and ulcerate.

Aphthous ulceration of the epiglottis and palate has been observed in cases of vulvitis and colpitis aphthosa.

Pemphigus is comparatively rare; it may be one-sided and confined to the larynx; disease of the skin may precede or follow it. The eruption usually heals without ulceration and cicatrization, but occasionally stenosis is caused by thickening, hypertrophy, or cicatrization after ulceration. The prognosis is usually unfavourable owing to relapses and long duration of the disease, which leads to marasmus or intercurrent diseases. A second group, without vesicles, is formed by urticaria, lichen, impetigo, and erythema. The symptoms of laryngeal urticaria depend on the size, number, and situation of the eruption. Smarting, hawking, hoarseness, loss of voice, and dyspnoea have been observed. Lichen ruber planus forms either bright red and thick nodes or flat plaques, which may be situated on the epiglottis or interior of the larynx. There may be disagreeable sensation on swallowing or speaking.

Impetigo herpetiformis is excessively rare. Seifert observed on the epiglottis plaques with irregular edges and greyish white covering, on removal of which an eroded surface was left. The edges of the plaques appeared somewhat raised above the mucous membrane. Quite as rare is erythema nodosum and multiforme. The infiltration may be absorbed or ulcerate. Erythema exudativa has also been observed with solid nodular infiltration, which became necrotic and ulcerated.

*Guild.*

**Neuenborn** (Krefeld).—*Stenosis of the Air Passage.* "Münchener Med. Woch.," June 21, 1898.

A PATIENT, sixty-one, had influenza, December, 1897; this was followed by dyspnoea, which made tracheotomy necessary in March, 1898. Epiglottis in the middle perpendicular, the large lateral portions acutely angular, hanging down, and shaky; by each inspiration they are sucked in so that the glottis is closed; on erecting the epiglottis with a sharp hook the stridor ceases. The vocal cords are white, about three millimètres from each other; voice is clear.

*Diagnosis.*—Paralysis of the aryepiglottidean muscles after influenza. The paralysis retrograded after the tracheotomy.

The term "aryepiglottidean muscles" is chosen with deference to the view of Moritz Schmidt ("Text-book," p. 14) that the oblique muscles are now mostly considered as the origin of the aryepiglottidean muscles.

**Onodi, A.** (Buda Pest).—*On the Voice Centre.* "Monats. für Ohrenheilk.," Jan., 1898.

THE existence of a cortical centre for phonation is generally admitted, and also the fact that this centre in each cerebral hemisphere acts upon both vocal cords. The occurrence of crossed paralysis of the cords from cerebral lesion is disputed. Onodi claims to have shown by experiment that (in the dog) neither unilateral nor bilateral extirpation of this cortical centre causes any permanent change in phonation. The whole brain above the corpora quadrigemina may be removed without destroying the voice. Loss of voice first appears when the brain is completely divided at the upper part of the medulla above the vagus roots. These facts go to show that the cortical voice centres play but a subordinate part, and Onodi considers that they justify the assumption of a subcortical centre for phonation, localized between the posterior pair of corpora quadrigemina and the vagus roots. The existence of such a centre explains the fact that the voice is retained after the cortical centres and basal ganglia have been destroyed or the entire brain above the medulla removed. It explains the occurrence of voice in children upon whom

perforation has been performed, and in monsters in whom the medulla is developed as far as the corpora quadrigemina.

Onodi concludes that it is quite impossible to localize, even approximately, a voice centre in the human brain.

Probably, in the dog the subcortical centres fulfil functions which in man belong only to the cortex.

P.S.—Onodi quotes a case of perforation in which the child breathed and cried. The brain had been cut off from the medulla at the level of the anterior corpora quadrigemina, much in the same way as in Onodi's experiment in the dog, the result of which it thus confirms for the human subject. *William Lamb.*

**Verco, J. C.** (Adelaide, South Australia).—*Foreign Bodies in the Air Passages.*

"The Australasian Medical Gazette," May 20, 1898.

NOTES of four cases of foreign bodies in the air passages.

The first, a girl aged three. A water melon seed remained in the air passages for three weeks, causing considerable cough. The trachea was opened, and the first cough expelled the seed through the opening.

In the second case a water melon seed remained lodged in the right bronchus of a boy, aged three, for five months, setting up severe symptoms. It was eventually spat up.

In the third case a tooth slipped into the larynx of a woman aged twenty-seven, and set up pleuro-pneumonia. It was coughed up after twelve weeks.

In the fourth case a woman, aged thirty-nine, was having some teeth extracted under gas when one slipped into the air passages. After giving rise to considerable trouble, it was coughed up after three weeks. The mischief it had started continued, however; the cough gradually got worse, with abundant muco-purulent fetid expectoration, and she eventually died from suffocation due to the bursting of an abscess in the right lung. *StGeorge Reid.*

**Von Stein and Juschzenkoff.**—*Cystically Degenerated Neoplasms, surrounding Both True Vocal Cords.* "Monats. für Ohrenheilk.," Feb., 1898.

THE patient, a widow of fifty-eight, complained of attacks of dyspnoea, often with loss of consciousness and almost complete aphonia. Some emphysema and cyanosis. Ill eight years.

Larynx: False cords congested, with indistinct outline. Instead of the true cords, one sees two elongated oval swellings of a dirty bluish colour. They extend right up to the false cords and are hyperæmic at the base. During phonation the swellings come together and close the glottis, except for a little triangular interval, posteriorly. Examination with the sound shows that the tumours are soft and elastic, giving one the impression of greatly dilated veins. The base of each swelling is movable.

Anti-phlogistic treatment being ineffectual, ten per cent. cocaine was applied, and five pieces were removed with forceps. The tumours seemed at first to have disappeared; the true cords came into view, and the voice returned; but, two days later, the patient was completely aphonic; and, on examination, the true cords could not be seen, but instead of them were four strips or flaps of milk-white tissue, with red points here and there. On each vocal cord were two of these flaps or ribbons—one on the upper surface of the cord, the other on the under surface. During deep inspiration they could be seen to flutter in the air-stream. It was clear that the new formations were really two thick-walled bladders, surrounding the true cords and partly filled with liquid, as shown by the sudden collapse and disappearance of the tumours. When the remains of the bladder walls were swollen from inflammatory reaction, they became visible as flaps or tags of tissue

fluttering in the air-stream. These remains were partly removed by operation and partly coughed up.

Microscopic examination showed layers of squamous epithelium, with a small quantity of soft, gelatinous connective tissue, consisting of a stroma, insoluble in acetic acid, and cells, groups of red corpuscles, leucocytes, and cells with large nuclei. The authors conclude that the tumours had undergone mucous degeneration.

*William Lamb.*

## E A R.

**Alderton, H. A.** (Brooklyn, N.Y.)—*Some Unusual Aural Cases.* "Ann. Otol., Rhinol., and Laryngol.," No. 1, 1898.

### I. *Case of Diplacusis Binauricularis Echoica.*

Mr. Leslie M., aged twenty-seven years, an athlete rather over-trained, came to my office, November 23rd, 1897, complaining of deafness and tinnitus in the left ear, the deafness being noticed accidentally. On examination, he heard the watch twelve inches; whisper, forty-five feet; speech, forty-five feet; external ear normal; Mt. somewhat dull and thickened; Eustachian tube easily penetrated by catheterization, with no improvement to hearing. The Galton whistle was heard at the mark  $\frac{1}{10}$ ; Weber heard on vortex, forehead, and teeth, in the middle line, all better in the right ear.

Tuning-forks :

RINNÉ.	ac	ac	ac	ac	ac	ac
Schwabach ..... {	20	16	15	50	62	40
bc	11	3	4	6	13	27
T. F. ....	C-1	C	C1	C2	C3	C4

With the C<sub>3</sub> fork by BC, when placed on the mastoid process of the left ear, two notes were heard (with the finger in the right ear to shut out AC), one a little later than the other; at the end of thirteen seconds the note heard by the left ear ceased, while that heard by the right ear continued to be heard for seventeen seconds more. The test was repeated a number of times, always with the same result. The C<sub>3</sub> fork was the only one that gave such a reaction. Unfortunately, the patient, though unusually intelligent, because of a lack of musical ability was not able to tell whether the interval between the notes was harmonic or otherwise. The explanation seems to be warranted that the right ear heard the note as elicited, and, because of its superior functional ability, heard it across the head, even while the left ear was perceiving it; the pathological changes in the left ear were of a nature to alter the musical character of the note and to limit its duration, while at the same time delaying its transmission so that the effect of an echo was produced. Bone conduction throughout, except for the C<sub>4</sub> fork, was reduced. We must, therefore, believe that we had to do with a change in the transmitting apparatus as well as of the perceiving apparatus, even though Rinné does not lend countenance to this stand.

### II. *Two Cases of Peculiarly Shaped Exostoses of the External Auditory Canal.*

Case 1.—Bertha W., aged eighteen years, came to me January 13, 1898, giving the following history:—For six and a half months has had an occasional shrill whistling noise in both ears; hearing good; for two or three weeks some swelling and tenderness of the inferior maxillary articulation; itching in the canal. No