

Weber, F. P.—*Case of Dysarthria and Delay in Learning to Speak following Cerebral Disturbance in Infancy.* "Roy. Med. Chir. Soc.," April 25, 1899.

The patient, who belongs to a healthy family, is now seven years old. The history is that at two years of age he was just learning to speak like other children, when he was attacked by some acute disease with cerebral symptoms. This illness left him unable to speak, but apparently unaffected in other ways. When seen at five years of age he was able to utter peculiar sounds, doubtless an attempt at articulate language. He was physically fairly well developed, could hear well, understand what was said to him, and appeared to be of average intelligence. He then gradually began to speak, though with obvious difficulty in getting the sounds out, and with great defects in pronunciation, dropping the consonants at the end of most words, and replacing the sounds of *K*, *G* (hard or soft), *Ch*, and *S* by a *D*-sound or *T*-sound. Such "lalling"-like defects, together with stammering, rendered his speech most imperfect. He could recognise single figures and the letters of the alphabet, but could hardly recognise even short words when shown them on paper. He sometimes made mistakes in writing his own Christian name, although he had doubtless been repeatedly drilled at it. He could not recognise his name when shown it in printed characters. He seemed, in fact, almost word-blind. Such was his condition at the age of seven, when seen in January, 1899. He is now making rapid progress in pronunciation.

The condition may best be accounted for by supposing that the infantile illness injured the cortex of both cerebral hemispheres, chiefly affecting the speech-centres (parts concerned in some of the most highly-differentiated functions of the brain). The present case and similar cases differ from the typical ones of cerebral diplegia, with bulbar (pseudo-bulbar) symptoms, in the fact that the movements of the palate and the mechanism of swallowing are not in the least affected.

The speech defect in this case, as in other similar cases, is probably a minor form of what has been described as "idio-glossia" by Hale White and Golding-Bird, and for which F. Taylor has suggested the terms "idio-arthritis" or "idio-phasisia."

A practical point in regard to the present case and similar cases is that the speech-centres, although damaged by some early disease, seem, nevertheless, capable of ultimate fairly normal development. This is confirmed in the present instance by the rapid progress which the boy is making since real trouble has been taken in teaching him by the oral and other methods.

THYROID, Etc.

Baurowicz, A. (Cracow).—*Thyroid Gland Tumours in the Interior of the Larynx, Trachea, and Bronchi.* "Archiv für Laryngologie und Rhinologie," Bd. viii., Heft 2.

The first reference to a tumour of thyroid gland tissue causing stenosis of the lower part of the larynx was made by Ziemssen in 1875. The patient was a man, aged thirty, who had complained of difficulty in breathing for some weeks. The laryngoscope revealed nothing of importance, and, as he had a moderately large struma, compression of the trachea was suspected. Owing to suffocative

attacks, tracheotomy had to be performed. Erysipelas afterwards set in, and caused the patient's death. At the post-mortem examination a cylindrical tumour was found in the larynx, extending downwards on the left side from the middle of the cricoid cartilage. It was 2 cm. long and 1 cm. thick, and presented a smooth surface. It consisted of thyroid gland tissue. Ziemssen supposed that the struma had grown into the larynx between the cricoid and thyroid cartilages.

In 1878 Bruns published two additional cases. The first was aged thirty-two years, and had suffered since his seventeenth year from dyspnoea, which recently had increased. The lumen of the larynx beneath the vocal cords was almost entirely filled by a smooth hemispherical tumour, which was attached to the right lateral wall and a part of the posterior wall. The growth extended from the fourth tracheal ring to beneath the right vocal cord. Bruns did not consider that the tumour had grown into the air-passages, for the rest of the thyroid was not much enlarged, and there was no perforation of the wall. He thought that a small lobe had been separated by constriction during development.

Brun's second patient was aged fifteen, and had suffered from gradually increasing difficulty in breathing for three years. There was no enlargement of the thyroid; the voice was normal. The laryngoscope disclosed a tumour beneath the glottis, situated on the right and posterior wall, and occupying about two-thirds of the lumen. It had a broad attachment and a nodular surface. Laryngo-tracheotomy showed that the tumour extended from the second ring of the trachea to beneath the right vocal cord.

The fourth case was described by Heise in 1888. The patient was aged twenty-six, and had complained of dyspnoea for five years. The thyroid gland was not enlarged. The growth, which was as large as a hazel-nut, sprang from the left and posterior part of the trachea. Tracheotomy was performed, and the tumour was then found to extend 5 cm. downwards from the first ring.

A short time afterwards Bruns referred to another case which had been discovered by Roth in the course of a necropsy. A dense growth as large as a pea was found beneath the plate of the cricoid. Roth regarded the tumour as a congenital displacement of thyroid gland tissue.

In 1888 Radestock reported the case of a woman aged twenty-one, at the entrance to whose right bronchus a growth was discovered at the post-mortem examination. It was rounded, as large as a hazel-nut, and completely closed the bronchus. Its structure corresponded to that of the thyroid gland, with colloid degeneration. The thyroid gland itself was not markedly enlarged, and, as no connection was found between it and the tumour, the latter was regarded by the author as a separate struma.

In 1892 Paltauf reported a case based on clinical and post-mortem observation. The patient, a girl aged nineteen, had complained of difficulty in breathing for about four weeks. This had rapidly increased, so that tracheotomy became necessary. Some days later the laryngoscope disclosed a cylindrical red tumour beneath the right vocal cord. Anti-syphilitic treatment produced no improvement. The stenosis was also treated by dilatation for a considerable time without benefit. Finally, an abscess formed in the left lobe of the thyroid gland, and led to the patient's death. The growth was as large as a bean, and extended downwards from the lower edge of the thyroid cartilage.

The author reports the following case: He was consulted by a woman aged twenty-one, who wore a cannula, and presented on the left side of the neck a scar running along the anterior edge of the sterno-mastoid. About four months previously the patient had been operated upon. The trouble was of a year's duration. At the onset she noticed a growth on the left side of the neck. Six months later this was associated with difficulty in breathing, which increased greatly in the weeks preceding the operation. Laryngoscopy showed the left vocal cord perfectly stationary in the middle line. The obstruction was situated above the cannula, and consisted of a tumour seated on the left lateral and posterior wall, which filled the lumen of the lower part of the larynx, extending down to the tracheotomy wound. It was smooth, elastic, red, and covered by unaltered mucous membrane. The fact that a struma had been previously present in the left side allowed of the assumption that the tumour was of a goitrous nature. From the wound in the trachea an incision was carried upwards, dividing four tracheal rings and the cricoid. The growth was now found to measure $2\frac{1}{2}$ cm. in length and $1\frac{1}{2}$ cm. at its thickest part. Having been removed, the wound within the trachea was examined, and a brownish-red parenchyma, which is so characteristic of the thyroid gland, was seen in the spaces between the tracheal rings. The growth, therefore, had not been removed from its base. The microscopic examination fully confirmed the diagnosis of a thyroid gland tumour.

The author discusses the mode of origin of these tumours. In his opinion they grow from without. In Radestock's case, in which there is the suggestion of an intra-tracheal accessory thyroid, the growth was really an adenoma.

Leaving Roth's and Radestock's cases out of account, there are six on record. From these we see that the thyroid gland tumours are always seated in the lateral and posterior walls in the lower section of the larynx and upper part of the trachea. Their size varies; they are usually cylindrical; they have an extensive attachment; they are covered by unaltered mucous membrane; and, as a rule, are smooth, but may be nodular. They occur mostly in young persons. In four of these six cases there was an enlarged thyroid gland.

In making a differential diagnosis, the benign tumours have to be taken into account—*e.g.*, fibromas, papillomas, adenomas, enchondromas, and lymphomas. The presence of an enlarged thyroid is of help. Perichondritis of the cricoid must also be excluded. Of malignant growths, sarcomas are the commonest, but carcinoma may also present a similar appearance.

The prognosis is very favourable, as these tumours apparently do not tend to recur. Owing to their extensive attachment beneath the glottis, it is possible to remove them only by tracheotomy or laryngo-tracheotomy.

In a postscript the author mentions another case that has recently been published by Bruns.

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