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A REMARKABLE COMPLICATION OF SO-CALLED CATARRHAL PNEUMONIA.¹

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THE case, of which the report follows, was of interest in several particulars. (1.) It was a case of catarrhal pneumonia following whooping-cough. (2.) It was accompanied by an amount of ulceration and loss of substance in the soft palate and pharynx such as I have never seen, or found reported as occurring in this disease. (3.) The pulmonary disease has been arrested. (4.) The extent of the adhesions following the ulceration was very great. (5.) The patient with perfect ease swallowed liquids and solids through an opening at the base of the tongue only a quarter of an inch in its long diameter.

P. F., fourteen years old, applied at the clinic for laryngoscopy at the Massachusetts General Hospital in 1873, on account of sore throat. A careful inquiry into the history of his case elicited the information that in the winter of 1870-71, he had had whooping-cough; he whooped two months, but had had cough ever since. During the winter of 1872-73 he had ear-ache for two or three months, followed by sore throat. He had lost thirteen pounds in weight, had night sweats, and at times pain under the right clavicle. He had never had hæmoptysis. He at this time had great pain on swallowing. The temperature and the pulse were not noted. An examination of the chest did not show anything abnormal on percussion, but on auscultation abundant moist bronchial râles were heard over the right upper lobe, most marked under the clavicle; other regions of the chest were normal. On examination of the throat, deep ulceration was seen in the pharynx; the uvula was gone, and there was extensive ulceration of the soft palate. The edge of the epiglottis was thickened and ulcerated; the interior of the larynx was normal. This was an appearance such as I had seen only in syphilis; the most minute investigation of the patient failed, however, to discover any other evidence of this disease in him, hereditary or acquired. His mother is dead, the cause of her death unknown. He has not seen his father for many years. The only other child in the family died in

¹ Reported to the Boston Society for Medical Observation, April, 1874.

infancy. From the history of the case and the physical signs, he was considered to have catarrhal pneumonia of the upper lobe of the right lung, and the ulceration was believed to be of that kind which in the larynx often accompanies disease of the lung, and which has been called "tubercular." He was put upon cod-liver oil and whisky and the ulcerations were touched with solid nitrate of silver three times a week. He has led an easy life with his grandfather ever since, and has improved steadily. He had very little trouble in swallowing after the first two months. The caustic applications were continued about six months; as the ulcerated surfaces were then looking very much better and there was no soreness on swallowing, the nitrate was discontinued, and the oil mixture alone used.

During the spring of 1874, feeling well, he absented himself from the clinic for six weeks, and when he returned the throat presented the following appearances: the ulceration had nearly healed, but with cicatrization and adhesion to a remarkable degree, the soft palate and pharynx being so closely adherent that there was an opening of only the size of a pin-head, through which air could hardly pass; the base of the tongue was united to the lateral and posterior walls of the pharynx by a mass of cicatricial tissue in which was an opening about a quarter of an inch in its longest diameter, through which he breathed and swallowed. He said that he had no difficulty in swallowing. He looked remarkably well. Pulse 78, strong; respirations, 22-24. He had very little cough, but there was dyspnoea on exertion. He had regained the thirteen pounds which he had lost the year before, and had gained two pounds additional. The voice was clear, but nasal. The sense of smell was very much impaired; taste was normal. On careful examination of the right upper front of the chest during cough, a few moist râles could be heard here and there, but the number had very much diminished. The other regions of the chest were found to be normal.

Remarks. 1. The first point to which I will call attention is that the attack of catarrhal pneumonia followed whooping-cough. This is a frequent occurrence and one which should be more carefully watched for and guarded against. The usual manner of its development is from atelectasis of some of the lobules of the lung. The occurrence of atelectasis in whooping-cough has long been recognized, but the development of catarrhal pneumonia from atelectasis has been only recently carefully studied and minutely described by Bartels and Ziemssen. These facts should lead us to be much more careful than is customary in the treatment of whooping-cough, especially in children, and the ordinary method of abandoning them to their fate, as if nothing could be done for them, is reprehensible. The chief thing to be avoided as far as possible is the catarrhal complication, the extension of which into the small bronchi is liable to plug them, and cause atelectasis. Oppolzer believed that cases

could usually be terminated in a few weeks by confining them in a room of uniform temperature. It is very important also to moderate the paroxysms of cough in any way possible; if the child is not too young, by the administration of opiates even, as the cough itself, as in ordinary bronchial catarrh, acts as an irritant to the mucous membrane.

2. The amount of ulceration and the loss of substance of the soft palate are such as one is inclined to refer at once to syphilis. But there is no evidence of this disease. Mr. Hutchinson had a case of a young girl of eleven in which there was ulceration, with loss of the uvula and a perforation of the soft palate; but there was no recorded pulmonary disease. He said of the case that if it was hereditary syphilis, it was one of a new class, as the peculiar appearance of the teeth was wanting.¹ The relation of ulceration in the throat to pulmonary disease is not by any means clear.

Niemeyer, while hesitating to admit any ulcers as tubercular, in which the disease, instead of springing from isolated nodules, develops from diffuse degeneration of mucous membrane, says that this kind of laryngeal ulceration never occurs when the lungs are not the seat of tuberculosis; and he believes it to be beyond doubt that miliary tubercle of the larynx, as well as the diffuse form, takes root upon the same soil as that from which tuberculosis of the lung is developed. The statement that tuberculosis of the lung must precede the laryngeal ulceration would be admitted by very few at the present day, if we employ the term tuberculosis in its more restricted sense; and many modern observers would doubt it, even if tuberculosis were used in its old sense. It has occurred probably to all laryngoscopists to see cases of laryngeal ulceration, which they at once felt must be so-called tubercular, and in which for weeks and months no sign of the pulmonary disease, which indeed always finally appeared, was manifest. Niemeyer truly says that these ulcers are not produced mechanically from the violence of the cough, for the cough in bronchial dilatation is often more severe; nor by the accumulation of acrid secretion at the affected spot, for the secretion of bronchial dilatation and gangrenous vomicae is more foul, acrid, and corrosive than that from tubercular cavities.

I think that the most we can say in regard to these cases is that there is a tendency to degenerative action both in the lungs and in the larynx; this becomes manifest first sometimes in one organ and sometimes in the other; in the present case this degenerative tendency was manifested exceptionally in the pharynx and soft palate.

3. The pulmonary disease in this case is undoubtedly arrested, as shown by the improvement in general condition, subsidence of cough, and not only the non-extension of the physical signs but also the marked diminution of those which had previously existed. Such re-

¹ *Lancet*, January 22, 1870.

sults are of course rare compared with the number of cases of the disease, but they warrant in us a greater hope than we formerly possessed.

4. The result of the healing of the ulceration is worthy of notice. While such an amount of ulceration has not been observed in connection with pulmonary disease, neither has such an amount of cicatrization and adhesion. Cases which bear any resemblance to this have been, as far as I know, invariably syphilitic. Instances of complete adhesion of the soft palate and pharynx are rare, but still they have probably been seen by all familiar with the lesions of syphilis. Those in which the tongue participates to any great extent are much more rare. I have had a case where there was such extensive adhesion between the base of the tongue and the soft palate (with no adhesion to the pharynx) that an opening only large enough to admit the end of my forefinger, which is quite small, remained; this patient, like the one whose case is here presented, had no trouble in deglutition; but there was dyspnoea on exertion.

After one's astonishment at the condition of things has subsided, the question naturally suggests itself, Can anything be done for the relief of the patient? If the adhesions between the tongue and soft palate are cut with the knife or scissors, there is great difficulty in preventing the parts from uniting again, although one must admit that it seems strange that parts so movable should ever unite at all. The syphilitic case, which I have just referred to, with such extensive adhesion of the tongue and soft palate, being from a distance, was sent into the surgical ward of the hospital for operation. The patient did not stay long enough for any great result; I did not have a chance to see him before he had gone. The following was the surgical record: "April 8, 1873. Adhesions between tongue and soft palate partially cut with curved scissors. April 10th. Again contracting; expresses himself as somewhat relieved. April 12th. Discharged relieved."¹

Zimmer² communicates two new cases of adhesion of the soft palate and pharynx, in one of which the base of the tongue was adherent to the soft palate and pharynx, and contraction had taken place to such an extent as to render tracheotomy necessary. The adhesions had been previously divided with the knife without relief. Dilatation of the small opening between the posterior nares and the pharynx had been followed by inflammation about the opening and a defect in the hard palate. When the posterior nares afterwards became completely closed Professor Thiersch perforated the adherent palate, but the opening soon closed again. After one repetition of the operation with similar results, the patient refused to allow any further operating, and was discharged,

¹ A lady has just come under my care in whom the tongue and pharynx are adherent with the exception of an opening about the size of a goose-quill. This is probably specific.

² Inaugural Dissertation, Leipzig, 1868; Schmidt's Jahrbücher, 1869.

wearing the canula in the trachea. His taste was normal, his sense of smell was wanting. In the other case the following operation was performed: A sound was passed through the nose down upon the adherent soft palate, and an incision made upon this through the mouth. The pain and bleeding were slight, and the nose immediately became pervious to air. Up to the sixth day after the operation the condition of the patient was excellent; but on the evening of this day, without any apparent cause, nosebleed set in, and recurred frequently during the night to such an extent that plugging of the anterior nares and of the hole in the palate was necessary. In spite of this and of the application of ice, the bleeding recurred the next day, and the plugs were renewed. Again bleeding recurred four days after, with swelling of the salivary glands, pain in the ears, and a purulent discharge from the left ear. On the next day there was profuse bleeding from the mouth, nose, and the right lachrymal canal; the purulent discharge from the left ear was pretty copious. The fauces were red and swollen. As the bleeding continued to recur, and the patient was growing weaker every day, Professor Thiersch removed a piece of the soft palate an inch square, and treated the wound with the actual cautery. The bleeding stopped at once, and did not recur. In eleven days the discharge from the ear had entirely ceased, but partial deafness remained. The opening between the nares and pharynx had narrowed down to the size of a writing-quill. The senses of smell and taste had not suffered.

In my own case I do not feel inclined to interfere with the palate, and at present I do not care to renew the ulceration in the throat; but if the parts contract still more, and relief is necessary, I propose to divide the adhesions laterally by means of the galvano-caustic knife. By operating in this way we shall be much less likely to have reunion take place. Dr. Elsberg has been entirely successful in operating in this way in three cases of syphilitic membranoid occlusion of the rima glottidis.¹

5. The case with which the patient swallows through this little opening is indeed very remarkable, any kind of food, liquid or solid, being readily disposed of.

OSTEOCHONDROMA OF THE SUPERIOR MAXILLA.

BY W. H. WORKMAN, M. D., OF WORCESTER.

In the Boston Medical and Surgical Journal of January 7, 1875, we notice the report of a case of enchondroma of the superior maxilla, by Dr. C. B. Porter, in which the rarity of the affection is alluded to.

¹ American Journal of Syphilography and Dermatology, January 7, 1874.