THE REMOVAL OF LARYNGEAL TUMORS BY DIRECT LARYNGOSCOPY.

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In a recent issue of *THE LARYNGOSCOPE*, Dr. McCoy of New York records three laryngeal tumors successfully removed through Jackson's separable laryngeal speculum. All the patients were so nervous that cocaine anesthesia had no effect in allaying the sensitiveness of the pharynx and larynx. He then suggested removal under general anesthesia, which was accepted. For some time I have experimented with the separable speculum in the removal of tissue from the larynx under cocaine anesthesia. A hypodermic injection of morphia and atropia is always given a half hour before the examination, and, if the patient seems very nervous, large doses of bromides are given a few days beforehand. The pharynx is anesthetized with a four percent solution of cocaine. The separable speculum is then introduced and the epiglottis and larynx wiped over with a minimum quantity of twenty percent cocaine solution. In a few minutes one is able to pull the epiglottis forward and to see the arytenoid cartilages and the posterior wall of the larynx. More cocaine, which is used sparingly, is needed to allay the sensitiveness of the cords. By these means I have been able to obtain a satisfactory view of the larynx in several nervous patients. In some patients with large, sound middle incisors and short, thick necks, direct laryngoscopy under local anesthesia is practically impossible.

Tumors in the anterior subglottic space are very difficult to remove by the indirect method, because the light is often poor, and reflected light at best is more or less deceptive. In addition a low, flat epiglottis often adds to the difficulties by obscuring the view into the larynx. As one becomes more expert with the use of the speculum, he will realize its superiority over the mirror.

The following case will illustrate the value of direct laryngoscopy in selected patients.—Mr. M. G. B., 50 years old, lawyer, had been hoarse for three years. The hoarseness, which at first amounted to a mere huskiness of the voice, had gradually grown worse until he was forced to give up practice in the court house. From time to time he had consulted specialists who made different diagnoses as to his trouble. Being a man of more than ordinary intelligence, he had conceived the idea that he had sarcoma of the larynx. He had

read several medical works on tumors of the larynx and could discuss benign and malignant growths intelligently. Before coming to Baltimore, he had been told that any operation on his throat would be most formidable and bloody. Soon after leaving his home in Georgia, he became greatly depressed and began to drink to drown his fears. On his arrival in the city, he registered at one of the hotels and continued to drink until his nerves were in a bad state. When I saw him he was in such a shaky condition that four days' treatment was necessary before an examination could be made. The picture in the larynx was as follows: The posterior wall was thickened from epithelial proliferation, both cords were red and thickened, and in the anterior subglottic space a tumor could be seen extending backward for about a quarter of an inch. The growth was so close to the left cord that in phonation it did not reach its normal position in the middle line. The epiglottis was low and broad, making the examination difficult. In view of the facts that the epiglottis was in an unfavorable position for the indirect method, that the patient was extremely nervous from his debauch and that the tumor was below the cords, we decided to attempt removal by direct laryngoscopy. Though the patient had a short, thick neck, the middle incisors were small and he was able to extend his head well. After a course of bromides and morphia-atropia hypodermically, the throat was easily cocainized and a good view of the larynx obtained. With Pfau's universal handle and cutting tips, the growth was removed piecemeal, as was the thickening of the posterior wall. There was little reaction. The next day the voice was better, and the larynx, aside from the chronic inflammation, looked well. I do not believe the tumor could have been removed as well or as quickly with the mirror, if indeed it could have been removed at all. If the larynx can be seen by direct laryngoscopy, operating in the subglottic space is comparatively easy, since the distance is much less than by the indirect method and the view clearer. The number of such operable cases will increase as we become more expert in the use of the speculum. Under general anesthesia intralaryngeal work is made much easier by the use of Dr. Mosher's left lateral position, with the chin flexed, and his spatula for pulling the epiglottis forward. Having tried both instruments under general anesthesia, I can say that Mosher's device constitutes a decided step forward in laryngeal operations. In the near future it is my intention to report a case which illustrates the use of the spatula and the ease of operating through it.

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