THREE UNUSUAL BRONCHOSCOPIC CASES

A. TUMOR IN THE BRONCHUS. B. TRACHEAL STENOSIS. C. TRACHEAL SCLEROMA *

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CASE 1.—Margaret I. W., aged 3 years, was referred to me Sept. 16, 1910, by Dr. Linn Emerson, presenting the following history:

History.—At the age of eleven days she had a sudden attack of obstruction to her breathing, which yielded to treatment after a short time. Until January of the present year, she had been well. At this time she had an attack of gripe followed by a spasmodic cough, the latter remaining ever since. July 4, she had an attack of measles, and on the 25th her breathing became so interfered with that emphysema of the neck and body appeared, lasting several days. At the present time breathes with a loud expiratory effort day and night. Has chronic constipation, prolapsus ani, and a capricious appetite.

Examination.—Child is well nourished and has good color. There is a peculiar, loud respiration showing interference with the expiratory act. The respirations are so loud as to be heard quite a distance and remain of this character day and night, becoming somewhat worse on crying or exertion. There is no rise of temperature, and the child plays about, getting easily tired, however. While she is never cyanosed, her distress in breathing often culminates in an attack of vomiting, but without relief to the breathing. The examination of the chest shows a sudden distention of the entire chest wall at each expiratory effort, except for the lower portion of the left lung. In this part there is dullness on percussion and entire absence of air entering the lung in the left lower lobe. There is no bronchial catarrh. The diagnosis of some form of stenosis of the bronchus at the bifurcation on the left side was made. An x-ray picture, taken by Dr. Jaches, radiographist of Mt. Sinai Hospital, showed an absence of air entering the lower lobe of the left lung. There was no evidence of any foreign body shown in the x-ray picture.

Operation.—At Mt. Sinai Hospital, under gas and ether, bronchoscopy was done on September 30, the instrument used being the Killian hand light with a short tube. The child took the anesthesia very badly and was very much cyanosed. The holding of the epiglottis increased the cyanosis to so marked a degree that it was rapidly withdrawn. In the meantime, Dr. Yankauer, who assisted me, had a long tube attached to another Killian hand light to which he had an attachment for the throwing of ether vapor into the tube during the entire examination, and at my request he introduced the longer tube rapidly into the bronchus. At the bifurcation, directly over the entrance to the left lung, a new growth was seen having the general appearances of a papilloma; there seemed to be several of them with small pedicles and having in all a diameter of one-half inch. These were promptly removed and after their removal the breathing became very much freer, and air again entered at the lower portion of the left lung. The growth was referred to Dr. F. S. Mandelbaum, pathologist of Mt. Sinai Hospital, who reported that, the growth having been placed in formaldehyd solution, it was impossible to test for tubercle bacilli, but that the growth had all the appearances of syphilis.

Subsequent History.—The child recovered from the effects of the anesthesia, air freely entering into the formerly obstructed lung, and on the third day the child was sent to its home.

Five months later the examination of the child showed no evidence of interference with respiration, the cough having gradually ceased, and the child was apparently well. In the meantime the child had been examined by Dr. Sara Welt Kakels, whose report follows: "Well-developed child for her age; weight 26½ pounds; temperature normal. On the skin and visible mucosae nothing abnormal. Of the superficial lymphatic glands, the anterior cervical and inguinal glands are

slightly enlarged. The inspection of the buccal cavity shows a slight hypertrophy of the tonsils; voice and respiration are perfectly normal. Inspection of the thorax shows that the chest walls move freely during respiration, apparently symmetrically on both sides; percussion over both lungs is clear and resonant; lower borders of both lungs normal. On auscultation vesicular breathing is to be heard, on and off harsh over all the lobes of the lungs; heart normal on percussion and auscultation; thymus dullness present. Of the organs of the abdomen, the spleen is not palpable; the liver is very slightly enlarged; its lower border is one finger's breadth below the costal arch in the nipple line, while in the median line it is slightly above a point midway between the umbilicus and the xyphoid process. The urine shows no trace of albumin or sugar. The feces show microscopically no pathologic constituents. The blood-count is as follows: Hemoglobin 70 per cent.; red blood-cells 3,600,000; white blood-cells 10,200; differential count, polynuclears 59 per cent., small mononuclears 30 per cent., large mononuclears 8 per cent., eosinophils 3 per cent. Wassermann's test was negative."

A most careful investigation into the family history as well as that of the child, shows no evidence of specific disease. A summary of the case shows that the clinical diagnosis of a stenosis of the bronchus at the entrance of the left lower lobe of the lung was fully established, and that a happy result followed the removal of the growth. This is a combination that is exceedingly rare.

CASE 2.—Rose L., aged 12 years, an inmate of an orphan asylum, whose past history is necessarily indefinite, was referred to me Dec. 12, 1910, with the following history:

History.—Except for an attack of diphtheria six years ago, followed by a protracted cough, she had been, as far as known, entirely well until four weeks ago when she began to cough, constantly, spasmodically, and without secretion. There was a short, sharp, ringing cough with intervals of a few seconds, sounding more like the bark of a dog than a cough, rasping and very noisy. While not so frequent at night, still it occurred then. All manner of treatment had failed to relieve it; there was no dyspnea; the voice was clear, and there were no râles in the chest. It is almost impossible to express the extreme annoyance to the child as also to its surroundings, occasioned by this noisy cough.

Examination.—The child had hypertrophied tonsils and an adenoid growth, but these were not considered as factors in causing cough. Below the chords, high up in the trachea, there was a tracheal thickening which showed itself not only in the laryngeal tissue but also by direct examination. The bronchoscopic tube was then introduced, and on its introduction it was felt to pass through the firm constriction and the diagnosis of spasmodic cough due to a tracheal stenosis, probably post-diphtheritic, was made. The report of the findings was made the following day to the attending physician, Dr. Gershel, who reported that, immediately following the bronchoscopy, all cough had ceased and this condition of cure of most distressing cough has remained permanent from the single dilatation following the entrance of the bronchoscopic tube. The general appearance of the trachea at the time of examination clinically resembled those cases of tracheal scleroma that I have seen, and the diagnosis would have been investigated were it not for the fact that the child was born in the United States, and no case of this affection originating *de novo* in this country has ever been presented. The examination with the bronchoscope was readily made under local anesthesia.

CASE 3.—Rachel R., aged 18 years, six years in the United States, a native of Russian Poland, was admitted to the surgical wards of Mt. Sinai Hospital, service of Dr. Howard Lilienthal, two and a half years ago, suffering from dyspnea, requiring tracheotomy. Before operating, Dr. Lilienthal requested me to see the case to determine the nature of the stenosis.

Examination.—I found a tracheal thickening with much induration on the line of the cricoid cartilage, and much crust formation in the nose with hyperplasia, and I made the clinical diagnosis of tracheal scleroma. A portion of the thickened tis-

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sue from the nose was removed and sent to the pathologic department for examination. The report came back from Dr. F. S. Mandelbaum, chief of that department, that it was negative. A second portion was removed a few days later and this time it was reported rhino-scleroma. Operation was not advised and the patient was then kindly referred by Dr. Lienthal to the out-patient department of the Mt. Sinai Hospital Dispensary under my care. The dyspnea subsided, the voice was husky and the nasal secretions kept up their crust formations until a year ago when she began again to show symptoms of tracheal obstruction. From this time on dilatation by means of the Killian tubes was practiced every week regularly with the result that the breathing became normal. Of late the dilatation has been done less frequently, about once a fortnight, and the patient is in a very comfortable condition. The bronchoscopic tube in this case enters very readily: the patient has become tolerant and she has been exhibited at various medical societies, usually permitting the introduction of the bronchoscopic tube in about thirty seconds' time. During my absence from the city, the same treatment was followed by Dr. Yankauer.

This case is of special interest in that most cases of tracheal scleroma have heretofore required tracheotomy together with the more or less constant wearing of the canula. This method is surely only palliative.

In presenting these three unusual cases, I conclude that the correctness of the clinical diagnosis was fully established in the first case, while the happy result of complete recovery followed the removal of the growth which failed to show any symptoms of syphilis, and in the absence of all tests must be put down as a benign growth, again illustrating the value of the bronchoscope as a means of diagnosis and an assistance in the surgical treatment of these cases.

In the second and third cases, the bronchoscope was first used as a means of diagnosis and then as a remedial agent, producing cure by rapid dilation in one case, and giving decided relief in the other.

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PLACENTA PRÆVIA—A WARNING

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Within the last two years an unusually large number of articles have appeared in the medical press on the subject of placenta prævia, the last article being the exhaustive one by Ellice McDonald, in *Surgery, Gynecology, and Obstetrics*, of June, 1911. In these different articles, and in the various text-books at my command, I fail to find any reference whatever to the possibility of concealed hemorrhage going on after the leg had been brought down by the Braxton-Hicks method.

That that is a very real danger, however, though undoubtedly very rare, is evidenced by a case which I saw in consultation about two years ago.

The patient was in charge of an unusually well-qualified young physician, a graduate of Johns Hopkins. She was a multipara, whose previous labors had been easy. She had been having slight hemorrhages, but nothing alarming. Further delay, however, being thought inadvisable, she was brought to the hospital for delivery, and I saw her then for the first time in consultation. It was decided to adopt the Braxton-Hicks procedure, and with no difficulty I brought down a leg, as I had done in very many previous cases. The parts were dilating nicely, and thoroughly dilatible, so that it seemed evident that delivery would be accomplished in a short time. As there was no further need for my services I left the patient, her physician exerting steady traction, which seemed to put a complete stop to hemorrhage. Very little blood had been lost during the manipulation. Within an hour, and while I was taking lunch

in the hospital dining-room, an assistant came in and said that he thought the attending physician would like to see me, as the patient seemed to be going to pieces. I left the table instantly, and within a minute was at the patient's bedside. She was dying in collapse, and a glance at the abdomen showed the uterine tumor much larger than before, so that the diagnosis of internal hemorrhage was apparent. I directed the doctor to pull, while I exerted pressure above, and in an instant the child was born, the birth being followed by such a deluge of blood and blood-clots as I had never seen before. The patient was in *articulo mortis*, and expired a very few moments after the child was delivered.

Since the above was written there have appeared, in the *American Journal of Obstetrics*, the papers which constituted a symposium on placenta prævia at the last meeting of the American Gynecological Society. These papers are by Edwin B. Cragin, Edward P. Davis, J. Clifton Edgar, Henry D. Fry and T. S. Newell. None of these papers mentions the possibility of a concealed hemorrhage after the leg is brought down, while Fry speaks positively of "bleeding being absolutely under control" by this method, and advises slow delivery to prevent laceration of the lower uterine segment. A few paragraphs later he adds: "hemorrhage is controlled, and if the delivery is left to uterine action the dilatation is slow and safe."

Had the text-books contained any warning of the possibility of concealed hemorrhage going on in these cases, I think the attending physician would have been on his guard and would have recognized the condition before the hemorrhage had reached a fatal stage.

I have had a rather large consultation experience in placenta prævia, and this is the only death from hemorrhage of which I have had any personal knowledge, and this death can be looked on as in a sense unnecessary.

A MODIFICATION OF SLUDER'S METHOD OF TONSILLECTOMY

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The purpose of this paper is to describe a modification of the method of guillotine tonsillectomy which Dr. Sluder advocated in *THE JOURNAL* March 25, 1911, page 867. This modification has been used by me with unvarying success in seventeen cases; its results have proved equal to any dissection tonsillectomy operation formerly tried. It has invariably removed the tonsil and capsule completely, rapidly and bloodlessly. This modification consists in using the ordinary tonsil snare, passed over the tonsil external to the already applied guillotine. Specifically, after the tonsil has been pressed through the window of the guillotine, by the alveolar eminence of the mandible, and engaged by the blade of the guillotine, in the manner described by Dr. Sluder, the distal end of the snare loop is passed over the guillotine and under guidance of the index-finger is placed posterior to, and thus external to, the tonsil and its capsule. Tightening the snare, in the usual manner for the particular snare, completes the removal.

In the use of this method it has not been found necessary to go in twice for any tonsil, however soft, shallow or imbedded. Dr. Sluder mentions the occasional need of going in a second time for remnants of tonsil or capsule. This is probably due to faulty technic, especially if this modification is used; for, if the tonsil is pressed through the guillotine so that the tonsil is drawn