CASE OF EARLY HODGKIN'S DISEASE IN WHICH ENDOSCOPY LED TO THE DIAGNOSIS.*

DR. LEE M. HURD, New York City.

F. G., female, 20 years of age, first seen by me on January 20, 1920, who consulted me because throat specialist wished to operate on septum and something in throat to relieve cough.

She has had a dry cough for one-and-a-half years, much worse the past four months. Pain over left eye and left side of face for past three months, which usually occurs in the afternoon or evening. Moderate nasal discharge, no impairment of breathing. Adenoids removed sixteen years ago. No sore throat. Teeth and ears O. K. Occasional hoarseness. Has lost ten pounds in past four months. No night sweats or fever. Appetite poor, sleeps well, constipation.

Examination of nose shows pale mucous membrane, slight deviation of septum and hypertrophied middle turbinate. Larynx and trachea, by laryngoscope examination, normal.

Wassermann negative. Von Pirquet positive. Small gland behind left clavicle.

Blood count 5,200,000 red, W.B.C. 16,000, polys 89 percent, S. L. 20 percent, L. L. 4 percent, basophiles 1 percent.

Urinalysis negative except slight trace of albumin.

Under morphin $\frac{1}{4}$ gr., atropin 1/100 and alypin, bronchoscope was passed down left bronchus, one-half inch below carina, where there was constriction and congestion. Manipulation of the constriction produced intense coughing, which a second dose of $\frac{1}{4}$ gr. of morphin did not control.

Blood count, May 2, 1921: W.B.C. 10,600, polys 75 percent, S. L. 20 percent, L. L. 4 percent, basophiles 1 percent.

X-ray examination by Dr. H. M. Imboden: There is a shadow on the left side, which suggests that it arises from the root of the lung, but it does not seem to have any connection whatever with the aorta. A dense shadow is also found super-imposed upon the arch of the aorta. This may be due to the same cause as the shadow previously described. The mass projects slightly into the posterior mediastinum, and as it projects into the mediastinum, it seems quite smooth in outline. This mass pulsated somewhat, but

*Read before the American Bronchoscopic Society, Atlantic City, 1921.

this was probably transmitted from the aorta. It certainly was not extensive.

There are definite changes in the base of the right lung, which are probably due to pressure from the mass in the left side.

Physical examination by Dr. Warren Coleman: Patient looks pale and ill. Heart, throat and teeth show nothing abnormal. The thyroid is enlarged, especially the right lobe. There is a small bunch of glands in the neck above the inner end of the left clavicle. Heart negative.

Lungs: Dullness over the roots of both lungs. Both lower lobes are imperfectly aerated. Both respiratory murmurs are slightly prolonged over the lower lobes. The chest is otherwise negative.

Abdomen: Both recti are very rigid, but move with respiration. Spleen and liver negative. There is tenderness in both iliac regions, especially on the left, low down. Indefinite resistance is felt deep down in the left iliac region, suggesting the possibility of glandular enlargement.

Diagnosis: Probable Hodgkin's disease.

Pathological report by Dr. James Ewing: "The supraclavicular lymph node shows the changes of an atypical Hodgkin's granuloma. The section shows obliteration of all normal landmarks by irregular new tissue, composed of lymphocytes, many reticulum cells, a few eosinophile cells, much fibrosis, no necrosis. The lesion is of rather long standing, and the node hard and fibrous. The structure is not entirely typical of Hodgkin's granuloma, but it is not a tumor, and is not tubercle or lues, so that by exclusion, the diagnosis of Hodgkin's is highly probable. Then, there are in addition many of the histological features of Hodgkins."

Has been under X-ray treatment. Mass in mediastinum has slightly diminished in size. Cough better. Otherwise no perceptible change.*

*December, 1921. Has complete recurrent paralysis of left vocal cord.