

not pitting upon pressure, or presenting that soft, elastic feel of gelatinous growths.

Diagnosis.—The diagnosis of this condition should present no difficulty to the cautious observer. We have the evidences of obstructive nasal catarrh, unilateral in its character, gradual in its onset, and of varying time as to duration. The voice is markedly altered; and to that degree only present in complete obstruction of nasal cavities, or in interference with functions of velum palati. Direct inspection by anterior and posterior rhinoscopy shows existence of polypoid-like, pyriform neoplasms, projecting from nasal into pharyngeal cavity.

The differential diagnosis from mucous polypus is very simple. These gelatinous growths never spring from the seat of attachment of cystic bodies; they rarely ever grow singly, and before reaching the size of these bodies would have many companions; they are soft, indenting to the probe, never giving that firm, solid-like impression imparted by the cystic neoplasm.

From fibroid, sarcomatous and carcinomatous growths, the differential is so simple as not to require description. Is very rare and presents the characteristic pulsation.

Prognosis.—Removal is always attended with absolute relief. No recurrence has ever been noted.

Treatment.—The treatment to be adopted is that of removal of the neoplasm. The simplest method of removal, and the one likely to cause the patient the least discomfiture, would be the preliminary tapping of the cyst, and evacuation of its contents. The empty sac could then be blown forward into the nasal cavity by the patient, where it could readily be grasped by forceps, over which a snare should be threaded and the mass easily enucleated.

This proceeding had to be resorted to in both of my cases, although, I am sorry to say, after I had given them considerable discomfiture by attempting to remove the growth in its entirety.

Cases.—My first case came under my observation November 24, 1889. The patient was a young Hungarian, thirty-two years of age. For ten months past he had noticed a gradually increasing obstruction of right nasal cavity, which had, during the past two months, become almost absolute. He had no pain, although a feeling of discomfort, as though something foreign existed in nasal and pharyngeal cavities, was always present. The alteration of his voice was the condition that annoyed him the most. He is a professor of languages, and it was necessary that his voice should be good. During inspiration, a small amount of air could be drawn through cavity, but expiration was impossible. Left nasal cavity was clear. There was some post-nasal secretion. On examination by anterior rhinoscopy, there was nothing observed in anterior

portion of cavity to give any clue as to cause of interference with the normal function of this organ, but deep within the passage could be seen a reflex, indicating the probable existence of a polypoid growth. In the upper portion of pharyngeal cavity was observed a large pyriform, polypoid looking growth, bearing all the resemblance to a true mucous polypus. The base of the growth could only be seen, as it nearly filled out the whole pharyngeal cavity, above the soft palate. Digital exploration demonstrated the growth to be limited largely to the right side, with its seat of attachment within the nasal cavity. It was dense, non-elastic; not presenting the soft, gelatinous feeling of a mucous polypus. I was lost for a diagnosis. Removal was attempted by snaring through the nose, but while adjusting loop over the growth, with finger in pharynx, the sac ruptured, and the contents, a clear serum, was evacuated; the relief was complete. The patient, while clearing his nasal cavity of serum, blew the sac forward, and it presented itself at anterior nares. Supposing the mass to be free from its attachment, I grasped it with a pair of forceps, tearing off the base, which is here represented. Finding that still some remained, I threaded a snare over a pair of forceps, again grasped the mass, and enucleated it from its attachment. I failed to make measurements, but the growth, which has now been immersed in alcohol for eighteen months, speaks for itself.

My second case presented all the symptoms of the first, above mentioned. The patient was a young man of twenty-three years of age, a lithographer by profession. Had noticed obstruction for six months. The growth was not so large as in former case. The diagnosis was made of cystomata, and growth removed with same mishaps as in former case. Dr. H. L. E. Johnson kindly assisted me in first case, and Dr. H. B. Deale in second.

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LARYNGISMUS DUE TO A CONGENITAL VALVULAR FORMATION OF THE UPPER ORIFICE OF THE LARYNX.

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In this short communication it is my purpose to call attention only to that form of spasm of the infantile larynx due to a congenital valvular formation of the upper orifice of the larynx, a condition that is sometimes overlooked as a cause of noisy respiration in children.

In these cases there is a laryngismus of a mild variety, and as it is so very persistent, it is evident that it must depend upon some local cause. The

subjects of this condition may be perfectly healthy, showing no evidences of rickets or glandular enlargement—the most common causes of that severe form of laryngeal spasm known as laryngismus stridulous. There is no tendency to convulsions, and the respiration is noisy, or reedy, as described by some, being at times quite labored. The spasm is more persistent than in the severer forms of laryngismus, being present to some extent during sleep, and is greatly aggravated upon any excitement, such as sudden awaking from sleep, sudden change from a warm to a cold atmosphere, crying, change of position, dentition and gastro-intestinal disturbance.

According to Goodhart,¹ it was formerly supposed that at this stage of life, the larynx was too yielding, and that when a rush of air was produced by means of a deeper and more hurried breathing than usual, the air could not pass fast enough, and a noisy respiration was the result. From an observation made by Dr. Lees, an English physician, it appears to be due not so much to a yielding of the parts, as it is to a natural condition of them. He made an inspection of a case that died from other causes, and found that the epiglottis was excessively recurved in its vertical axis—"as if bent in half down its middle," thus bringing the ary-epiglottis folds almost in apposition, leaving a mere chink between them.

In 1878, J. Solis-Cohen² called attention to an allied, but much more serious condition, in which the epiglottis was abnormally long, and became incarcerated between the ary-epiglottis folds, causing suffocation. The two cases he reported terminated fatally.

Suckling, an English physician, in the *British Medical Journal* for December 15, 1890, reports one case in an infant 2 months old, and speaks of having observed this affection several times in very young children in the Children's Hospital, London.

Dr. Louis Starr, in a personal note concerning the case I herewith report, states that he has seen a number of cases showing the same congenital deformity, but in none were the symptoms so marked as in my case.

The prognosis of these cases is generally favorable, the difficulty with respiration passing off with the growth of the larynx. [In the way of treatment there is little that can be done, except to give tonics, and keep the child well nourished and free from all excitement.]

The following is the report of an interesting case, and illustrates well the condition I have just described:

In June, 1889, I was called to see a male child 9 months old, suffering from a spasm of the larynx that gave rise to a noisy respiration, and choking symptoms when nursing from the bottle.

The family physician informed me that when the child was 2 weeks old these symptoms were first observed, and they seemed to be increasing rather than decreasing as the child grew older. I was unable at this time to form any definite opinion as to the cause of the trouble, and it was not until I saw the case again at Oakland, Md., where I was called on account of his condition becoming much more aggravated, that I was able to assign any cause for the difficulty. At this time the respiration was noisy and could be heard at a distance of 40 feet or more, being at times distinctly spasmodic in character, and was as loud during sleep as in the waking state. When sleeping, the head was generally stretched back, so as to admit of the air passing in with as little resistance as possible. Examination showed no glandular enlargement, and no evidences of rickets. Other symptoms noted at this time were dilatation of the left pupil, sweating of the left side of the head and neck, phimosis with a very small preputial orifice, excessive irritability, and frequent eructations of undigested milk. It was then ascertained that the child's diet consisted of undiluted cow's milk.

Depressing the base of the tongue, the fauces were found to be congested, and the tonsils moderately enlarged. The epiglottis, as well as could be ascertained, was irregular in outline, and bent backward over the laryngeal cavity.

The spasm at times was so marked that I passed the index finger down to the upper laryngeal cavity, and pulled the epiglottis forward. After this manipulation, the child's respiration was natural for at least a week; but at the end of this period the spasm returned with its former severity.

This I believe to be an exaggerated case of infantile spasm of the larynx due to a binding of the epiglottis causing the ary-epiglottic folds to come almost in apposition, so that during inspiration there was a slight stridor produced. This difficulty with the respiration made a severe impression upon the central nervous system, which was greatly increased by the gastric irritation due to feeding the child with undiluted cow's milk, and also by that due to the phimosis.

The only treatment adopted was to dilute the milk, and to relieve the phimosis, which was done upon his return to Washington, by gradual dilatation. As soon as these sources of irritation were removed, the child commenced to improve as far as his general health was concerned, the respirations ceased to be spasmodic in character, and gradually became normal.

Another case that has recently come under my observation, was the 2 months old daughter of a professional friend. This child had the same characteristic breathing, but not to such a marked extent as in the first case.

No treatment was adopted, and in two months the difficulty had entirely disappeared.

¹ Goodhart, *Diseases of Children*, p. 592.

² Cohen on *Diseases of the Throat*, p. 627.