RECENT PROGRESS IN KNOWLEDGE AND TREATMENT OF UPPER RESPIRATORY TRACT: THE ORO- AND NASO-PHARYNX.*

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It has often been quoted that medicine was far from an exact science, and while this accusation may hold in part, still, I think all will admit, from the gigantic strides of recent years, that we have more than merged from the empiricisms and theories of the past, and that medicine of to-day is fast approaching a remarkable degree of exactness. All departments of our science testify to this advancement, including, to a marked degree, the diseases of the upper respiratory tract, which forms the subject of this evening's symposium, and, I think, we may safely say that this entire region, with its many difficulties, is, by our present means of precision, practically under our complete control as far as inspection and diagnosis are concerned.

In presenting the topic delegated to me, namely, the Naso-and Oro-Pharynx, I shall refrain from discussing well-established facts and conditions, which will not benefit by repetition, referring only to some of those which more or less recently have been the subject of active medical thought.

Relative to the naso-pharynx, it must be said that the importance of adenoid vegetations, in all their relations, has become so thoroughly grounded, both in the lay and medical mind, that that which was once considered in the light of fadism or over zealous medical enthusiasm, is now recognized in all quarters as a subject of the most vital importance.

Among the most recent and important advances in the examination of the naso-pharynx, may be mentioned the Hays' Pharyngoscope (an adaptation of the cystoscope), by which means in the great majority of instances, the whole field of the naso-pharynx may be leisurely examined in detail, with a minimum of trouble to the patient. It is surprising how, by its use, even in very young patients, a complete picture of the vault of the pharynx may be obtained, thus doing away with the annoyance of digital examination and the difficulty of the ordinary rhinoscopic mirror. In older

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patients, to those who are not expert in the use of the rhinoscopic mirror, the use of the Hays' Pharyngoscope reduces the examination of this region to comparative simplicity. Among its benefits may be mentioned the mapping out of various hypertrophies and adhesions about the fossa of Rosenmüller and their removal under vision, through the anterior nares with the pharyngoscope *in situ*. Also the ease with which the Eustachian orifices may be seen, and their catheterization and bougieing accomplished under complete visual control. I do not mean to imply that the pharyngoscope completely supercedes the rhinoscopic mirror in all cases in competent hands, but there are many occasions, in both young and older patients, where an intolerance of manipulation renders the ordinary method difficult or impossible, which difficulty is entirely overcome by the pharyngoscope, and a complete examination is thus easily procured. As in all processes of examination, so in the use of the pharyngoscope, a certain familiarity must be obtained and certain details observed. It is a well-known experience that nearly all examinations in children are attended with more or less apprehension; so the first thing necessary in the use of this instrument, is to gain the confidence of the child, with the assurance that he is not going to be hurt, especially not going to be burned by the lamps, which, as a rule, is his first dread. In passing, I may say that the lamps are "cold lamps" which may be used almost indefinitely without imparting the sense of heat. In nearly all, if not in all cases of both young and older patients, it is best to cocaine the pharyngeal wall, to prevent the irritation of contact,—then with the patient at the proper height, the tongue is depressed with a narrow tongue spatula, the instrument introduced, with the distal prism upwards, behind the soft palate, short of touching the pharynx, the spatula removed, then the instrument being used as a depressor, the patient is asked to close the lips tightly, breathe easily, with palate relaxed, and steadying the head with your left hand, the examination is made by looking through the proximal lens of the instrument; the telescope may be turned at different angles so as to bring the various areas of the pharyngeal vault into view. As the breath of the patient is liable to condense on the distal lens, it is best to rub a little soap or other lubricant on the lens to preserve its brightness. It is best not to use heat as with the ordinary mirrors, as the material holding the lens is liable to melt.

It goes without saying that the examination of older patients by means of this instrument, is much easier in all ways, than that of children. The light may be derived from an ordinary dry-cell bat-

tery which may easily be carried about, or by a reducer when the street current is used. The view that one obtains within the nasopharynx is somewhat magnified, and one must accustom himself to this slight appearance of hypertrophy.

Although it is scarcely within my province this evening, I may say that the pharyngoscope may be used almost with equal facility in the examination of the larynx, with the same attention to detail, only that the proximal lens is turned downwards. The laryngeal picture thus obtained is complete, though somewhat smaller than by the usual laryngeal mirror. It is especially useful in this relation, examining patients in bed who by virtue of their illness cannot be placed in the upright position. I have dwelt on the use of this instrument in detail, as I consider it one of the most valuable additions to our recent modes for examination.

The present establishment as a separate lesion, of ulcero-membranous angina, due to the bacillus of Vincent—hence the name of "Vincent's Angina" marks an advancement in pharyngeal and tonsillar affections, and also emphasizes the close relation between laboratory and clinical observations. The recognition of this lesion clears up many errors and perplexities of previous days, when it was mistaken for syphilis, diphtheria, chronic folliculitis and other ulcerative conditions.

The relation of *spirochaetae-pallida* to primary and especially to secondary syphilitic lesions of the fauces, plays a very important part in recent positiveness of diagnosis of those affections. A typical case of primary or secondary syphilis in this region, is easy of recognition, but in doubtful or poorly-defined instances, the laboratory finding of this protozoa establishes a diagnosis, and guides us in our method of treatment.

The lesions of tertiary syphilis in the pharynx, are, as a rule, of such a nature, that they may be established by gross clinical observation. Hence, the necessity of confirmation by the more recent Wassermann serum test does not become as necessary as in other portions of the body where the syphilitic foci can not be observed.

The oral cavity and, hence, the pharynx, is so abundant in various forms of organisms, that a wide field has been opened for their active study in various forms of infections; the streptococci, staphylococci, Kleb-Loeffler and tubercular bacilli, together with those mentioned previously, are the ones which perhaps have claimed more recent attention as being causative factors in inflammatory actions.

The present status of serum therapy, exclusive of diphtheria antitoxin, seems to have but a limited application to the treatment of inflammatory infections of the pharynx. This is due to various reasons, principally the difficulty of isolating, for the proper vaccine, the prominent causative bacillus, and also the natural tendency to localization and auto-resolution of the ordinary infections—so that the relation between remedy and cure could not be well established.

The use of calcium lactate, in the prevention of immediate and remote operative hemorrhages in the oro-and naso-pharynx, has received considerable recent attention with beneficial results.

Without doubt the faucial tonsils in their various relations have received more recent active impetus than any other topic. This attention has been directed toward their anatomy, structure, function, relation to neighboring healthy and diseased lymphatics, as protective organs, portals of entry to contiguous and remote infections, their relation to tuberculosis, general and local, rheumatism, scarlet fever, grippe and other infections—finally, to the necessity and mode of their removal. It would be impossible for me to discuss these various features in detail. Most of them will be taken up by Doctor Frissell, who is to follow me, and I will content myself by dwelling on the question of tonsillar removal, a topic which I approach with a great deal of hesitancy, as it has been made the subject of so many recent discussions.

I am sure, from the above-mentioned relations, that the profession is becoming convinced that diseased tonsils are a menace to health, and when there is a more widespread understanding of this relation to the health of the individual, the objections to their proper removal will be overcome.

It is not necessarily the extent of the hypertrophy, which should determine removal, though that is very important from an obstructive point of view, but whether or no they are *septic* or carriers of sepsis; submerged and adherent tonsils are often more dangerous than a greater hypertrophy. The lack of time prevents going into detail as to the proper mode of removal of tonsils, whether it should be one of the various forms of so-called tonsillectomy, or whether by enucleation or dissection, which receives the name of *tonsillectomy*. A great deal depends on the necessities of the individual case, the experience of the operator, the conveniences for operation, and the thoroughness with which either mode can be accomplished; a poorly-performed tonsillectomy is just as bad as a poor tonsillectomy, and it is often a question in my mind wheth-

er a properly performed tonsillotomy is not as beneficial in final result as the average so-called tonsillectomy. There is no gain-saying the fact that a diseased tonsil should be removed, and the consensus of present opinion is in favor of complete removal.

Undoubtedly we are in the midst of a revolution as far as these two operations are concerned, and if tonsillectomy, in all its phases, is the proper operation for all cases, why has it lain dormant for so many years while tonsillotomy was the sole operation. There must be a reason. Whether sufficient time has elapsed to show untoward remote results from completely emptying the tonsillar cavity, is, perhaps, a question to be considered. Whether there is not more danger from hemorrhage, traumatism, immediate reaction, and subsequent wound-infection from the various modes of complete tonsillectomy, is also an open contention. I think these points must be fully established before absolute surrender should be given to the newer operation.

Another consideration in the performance of tonsillectomy is the great lack of unanimity in its technic by different operators; among the various modes, we have, complete finger enucleation, combination of finger and instrumental enucleation, complete instrumental enucleation, some by sharp and some by blunt separators, spoon-shaped or otherwise, complete dissection by sharp instruments, the cutting by scissors of the *plica tonsillaris* and completing with a wire snare, and more or less modifications of all methods, then also the question of complete, partial or no anesthetic, and the upright or recumbent position. While admitting the personal equation and skill of the individual operator, I think an attempt should be made toward a uniformity of performance. If tonsillectomy is to be performed, I see no reason why it should not be considered as a thorough surgical procedure, done in a thoroughly surgical manner, with proper light, field of vision, proper assistants, attention to hemorrhage during and after operation and careful detail of dissection. These precautions, I am sure, will lessen the dangers of such an important operation.

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