MEMBRANOUS AND ULCERATIVE PHARYNGITIS OF STREPTOCOCCIC ORIGIN.*

BY S. L. LEDBETTER, M. D., BIRMINGHAM, ALA.

I have thought for some time that I would write a paper on this subject, but not having been able to get cultures in a large percentage of cases seen and the data being so incomplete, I hardly felt justified in doing so. I will report a case illustrating a type of the trouble under discussion.

A few weeks ago I was called in consultation with a friend of mine, the attending physician, to see a child two years old, suffering from dyspnoea and severe throat affection, which was supposed to be diphtheritic. This was the third or fourth day of the trouble. The father and mother had been suffering from severe throat affections but had not developed any membrane. I examined the father's throat carefully. There was at that time nothing visible except the general redness of the pharynx—with slight swelling of tonsils and glands. A few days later he came to my office with what appeared to be peritonsillar abscess, but under treatment the trouble subsided without suppurating.

Examining the baby I found a heavy grayish deposit, covering both tonsils, and extending on to the back wall of the pharynx up behind the soft palate. On wiping away the deposit a necrotic surface was exposed. The nostrils seemed to be almost entirely occluded, submaxillary glands very much swollen, child restless, unable to nurse or swallow any considerable amount of liquids of any kind; drowsy but only able to sleep for a few moments at a time. No laryngeal obstruction, but breathing was hard and irregular, something like the breathing of a patient under chloroform when the tongue drops back into the pharynx, making three or four ineffectual attempts at inspiration when the child would rouse up, open his mouth, and take in a few good full inspirations. Then there would be a repetition of the same conditions. The pulse was small and weak; color bad. He was evidently being rapidly poisoned by carbonic acid gas and the streptococcus infection.

A culture had been taken the day before by a very competent bacteriologist and only cocci were found, staphylococci and streptococci, so the attending physician informed the family that diphtheria had been eliminated and that he felt very much more com-

* Read at the meeting of the Southern Section of the American Laryngological, Rhinological and Otological Society, Atlanta, Ga., January 24, 1903.

fortable over it. In leaving, I said, Doctor, I am afraid you are going to lose your patient, and think you had better tell the family that the condition is critical, so as to let them down a bit easy, in case the child should die. "Oh, I think," said he, "that it will come out all right; however, this afternoon when you go back to treat the throat, you might say to them, that the condition is such that the result is yet doubtful." I had made an application of iodine and carbolic acid to the necrotic surfaces and was to go back at 5 p. m. to repeat the application. When I made my second visit the symptoms were so much aggravated that I told the father that the condition was much worse and the situation critical. I tried to communicate with the attending physician, but could not catch him. The child died about 8 o'clock of the same day.

In this case the nasal obstruction was a large factor in causing death. The nasal obstruction and pharyngeal swelling making difficult breathing. I have seen at intervals a number of cases similar to this one; some in which the most distressing features seemed to be the dyspnoea, others in which death was due to the profound intoxication. I have seen the lips, tongue, pharynx and nasal surfaces covered with dark bloody crusts. The chief characteristic of these cases is the large percentage of fatalities. These are the cases which were formerly classed as true diphtheria. The differential diagnosis being between diphtheria, membranous croup and tonsillitis.

All necrotic and gangrenous sore throats with extensive swelling of the glands of the neck, and all cases of profound intoxication were called diphtheria, while many of the milder cases with small deposits on the tonsils were called tonsillitis. I have seen a number of cases of paralysis of pharyngeal muscles, of eye muscles and even cases of general paralysis following attacks of so-called tonsillitis, while all cases beginning in the larynx confined to the larynx were called membranous croup. These are the cases with low temperature and no glandular enlargement. The point I wish to emphasize is, that if the Klebs-Loeffler bacillus be the cause of diphtheria, then a large percentage of the cases which were once classed as diphtheria of the most malignant type, are not diphtheria at all, but an infection from cocci. In all of these cases there seems to be absolutely no relief to be gotten from antitoxin.

Of course we have cases of mixed infection, beginning perhaps as diphtheria, with a later invasion of the streptococcus. On this account and because it is frequently impossible to get a prompt bacteriologic examination, it is advisable to administer antitoxin in

all cases of doubtful appearance. I make it a rule to give anti-toxin first, then get a culture, if possible, later.

My experience in these cases loses much of its value because of the conditions attending them. They have all been consultation cases and usually hurry calls, frequently out of town. In the majority of them it was impossible to get a culture unless I had taken the precaution to carry a culture tube with me, which I have not been in the habit of doing. I believe I have rarely seen one of these cases more than once, as they generally prove fatal, and very rapidly so. Several have died while I was still in the house. In nearly all, the breathing was considerably labored from pharyngeal and nasal obstruction. In a few instances I have introduced an O'Dwyer tube without benefit. I soon learned that they were not cases for intubation. I have urged in some, the doing a tracheotomy, but I think the cases are few in which a tracheotomy would do good. I did a tracheotomy on one occasion where the disease extended into the trachea. The swelling in the neck from infection of the wound was something terrific. The child died, of course.

I am sorry that my examinations have not been more scientifically conducted. As it is, many of the cases cannot be properly classed. But the point made still holds, that, whether the Klebs bacillus does or does not exist, the presence of a violent streptococcus infection is a very serious condition in which the usual methods of treatment are of but little consequence.

Clinical Experiences with the Suprarenal Gland and its Various Preparations—C. G. FELLOWS—*The Clinique*. December, 1902.

One of its great uses is as a means of diagnosis, owing to its ischaemic action. It augments and prolongs the anæsthetic effect of cocaine. It helps to abort certain forms of inflammations. In operative work either in the eye, ear, nose or throat it gives us a field entirely free, or almost so, from hemorrhage. Although secondary hemorrhages are said to occur more frequently following its use, it has not been so in the author's experience.

As a local styptic it seems to act promptly where other remedies fail.

As to its effects in hay fever, he is not as yet ready to report.

STEIN.