Group IV.—Cured for two years.

Case 12 : Dr. Thumas (letter in June, 1893, telling of continued cure).

Case 13 : Ugórski (with Prof. Baranowski, confirmed the complete healing in June, 1893).

Case 14 : Kopet (no news for a year).

Case 15 : Szulakiewicz (no news for a year).

Case 16 : Heilgehilfe (examined by Dr. Lubliner, perfect healing found).

(To be continued.)

A CASE OF CHRONIC ŒSOPHAGITIS.

By SAMUEL LODGE, Jun., M.D., Bradford, Yorks.

THE comparative rarity of the disease, together with the favourable reception of the case by the Clinical Meeting of the Bradford Medico-Chirurgical Society, have induced me to submit this report.

Mrs. P., aged twenty-four, consulted me on October 15th, 1892. She stated that for the last four years she had felt a dryness and soreness in her throat about the upper part of the gullet, but the mouth was always moist. When swallowing solids or pungent liquids, the "morsel" appeared to pass a sore spot, and, owing to increased moisture in the mouth, she was compelled often to expectorate. This state of affairs continued up to July, 1892, when after swallowing solids she experienced, in addition to symptoms mentioned above, pain over the front of the left chest which radiated towards the left scapular angle. This pain would, after swallowing anything harder than usual, remain for twenty-four hours at least, and was then only relieved by abstinence from solid food. At this time, in spite of feeling always hungry and able to digest any kind of food, she was losing flesh continuously, not daring to take solids. She could swallow solids or liquids, but not with the same readiness as formerly. No history of traumatism, syphilis, or chest affection could be elicited.

On examining the mouth and pharynx, the hard and soft palates were found studded with clear drops of mucus which could be seen oozing from the mouths of the palatal glands. In fact, the palatal mucous lining appeared to be, as the patient aptly expressed it, in "a constant state of perspiration." Clear but viscid mucus was also seen over the whole of the oro-pharyngeal membrane.

Laryngoscopically, what was visible of the laryngo-pharynx was bathed in this mucus, which had evidently to a great extent gravitated there, and which was especially well seen in the hyoid fossæ. There was no evidence of laryngeal disease.

Anterior and posterior rhinoscopy disclosed no abnormality beyond a moderate amount of hypertrophic rhinitis. Palpation of the pharynx and œsophagus gave negative results. The patient was then directed to swallow some water and afterwards some bread. The liquid caused no

discomfort ; the bread brought on the pain. In the case of the bread, deglutition was perceptibly delayed. Auscultation, beyond corroborating delayed deglutition, in the case of the bread, furnished no definite information, as the "pharyngeal sound" (*glou-glou*) obscured the "œsophageal sound."

Several of my medical friends have examined this patient at intervals, but none of them were able to detect any signs of old or present chest disease.

Diagnosis. Spasm was excluded because of constant dysphagia and the fact that liquids were swallowed with much less discomfort than solids.

Malignant disease by age, etc.

Chronic œsophagitis having been diagnosed, a bougie was not passed.

Treatment. An absolutely fluid dietary was insisted upon for a fortnight, and bismuth lozenges were prescribed. After the expiration of the fortnight the patient was much better ; but she declaring her belief that the lozenges did no good, these were discontinued. Light farinaceous food, with eggs and jellies, was then ordered, and in about three months such articles as tripe, minced meat, etc., were permitted. In six months the lady was able to take ordinary diet, but even then a very hard "morsel" sufficed to produce some discomfort in deglutition.

In connection with the foregoing case I desire to express my indebtedness to the late Sir Morell Mackenzie, whose lucid description first called my attention to the true nature of this disease.

REMARKABLE INCREASE IN BODILY GROWTH FOLLOWING the REMOVAL of TONSILS and ADENOIDS.

By PERCY S. JAKINS,

Surgeon to the Central London Throat, Nose and Ear Hospital.

A YOUTH, P. T., aged seventeen, was brought to me two years ago with a view to eliciting my opinion as to the reason of his remarkably short stature. His brothers all measured over six feet, but my patient only five feet three and a half inches, while his weight was only seven stone seven pounds. I was led by his appearance to consider him the possessor of post-nasal adenoids, and possibly enlarged tonsils. On examination this view was confirmed, and I recommended the necessary operative procedures, which I carried out next day. These were entirely satisfactory, and I saw no more of the patient for two years, when he called upon me in the person of a well-grown man, having in that time increased in height from five feet three and a half to five feet ten inches, and in weight from seven stone seven to ten stone. His brothers had attained the stature already mentioned considerably before his age, and the change in him beginning *immediately* after the removal, the inference was inevitable that the change was more or less directly the result of the operation.

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