RECURRING PAROTITIS IN A HEALTHY CHILD*.

BY FAYETTE C. EWING, M.D., ST. LOUIS, MO.

Fellow of the British Rhinological, Laryngological and Otological Association, Etc.

Ephraim M., son of the writer, since the second year after his birth has been subject to recurring attacks of swelling and inflammation of the parotid glands, apparently idiopathic. The swelling has always manifested itself suddenly, as a rule developing to its fullest extent during the night, with little or no constitutional symptoms.

With one exception it has been unilateral. These attacks have occurred at irregular intervals of a few months to a year, becoming notably less frequent as the child has grown older. They are attended with pain on pressure and mastication, but it is never intensely acute.

There has been no attendant enlargement of the lymphatics, nor the slightest hypertrophy after subsidence of the acute symptoms.

These swellings have always disappeared without treatment within three days, generally decreasing somewhat in twenty-four hours.

Fever has been absent. The subject is a vigorous boy, aged eight, and considerable of an athlete for his years. He has never been specially subject to colds, nor shown the catarrhal diathesis. Family history good, phthisical history confined to two great-aunts.

He will be remembered by Dr. Dundas Grant, who removed his hypertrophied tonsils during the writer's stay in London, 1893.

There were no adenoids. The last return of the swelling was on the left side six months since.

To confirm my diagnosis that the swelling did not affect the lymphatics, I took him to Dr. P. Y. Tupper, of St. Louis, who fully acquiesced in my opinion.

Numerous, and the latest standard works on general surgery and pediatrics have been consulted to find some mention of conditions to parallel this, but with negative results.

The nearest approach are probably the five "obscure" cases reported by Raymond Johnson, *Lancet*, April 1896. He clearly eliminates as an etiologic factor, mumps, enlarged lymphatics, calculus and the sympathetic parotitis of pyemia, typhoid and the complicating swellings of abdominal diseases and injuries, emphasized by Mr.

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Stephen Paget which are due to the inflammation of the lining of Steno's duct.

In Mr. Johnson's cases the gland was tender to touch, but not acutely so, it was also hard and occasioned discomfort in mastication.

The ages ranged from fifteen months to thirty-three years. In several slighter cases, the socia parotidis alone was affected, and in one case it was attacked first. The conclusion was that the swellings were due to the inflammation of the lining membrane of Steno's duct, preventing the outward flow of the secretion. The case herein reported resembles the Johnson cases in its behavior and obscure origin, being evidently without connection with the ordinary and well-known causes of parotid inflammation.

Without feeling justified in a positive opinion, the writer is inclined to consider this a case of simple infectious disease of the duct of Steno (said duct probably extra patulous) causing swelling of the gland by a microbe, the identity of which is unknown. In the *Journal de Med., Ed. de Paris*, January 1, 1896, Regnier, surgeon to the Laribiosiere, reports three cases of infection through Steno's duct, but with an accompanying constitutional disease, and points out the fallacy of considering parotid inflammations invariably caused by secondary inflammation of the lymphatic glands.

The glandular pockets are infected, the result of inflammation of the canaliculi. The inflammation originates in the mouth.

Chassaignac was the first to direct attention to this variety. He declared it to be canalicular.

Virchow and Weber also observed cases where pus and lesions were in the canals and alveoli. Grog, as far back as 1873, attempted to prove that all parotid inflammations with a general cause, are secondary to some inflammation in the mouth which extends to the gland. More recent histologic and bacteriologic researches of Dupre and Claisse are confirmatory of this position.

We may justify this supposition by our knowledge that the liver, kidneys and breasts may be infected through their secretory ducts. Further, we know that an abscess is most likely to occur in cases of lymphatic origin, while the knife will bring little or no pus at the time when the inflammation is in the glandular pockets, though it may be pressed out later. Duplay's work on pathology affirms that infection may arrive by way of the lymphatics, but in such event it is not the parenchyma of the gland, but the lymphatic ganglia that are affected. Since the abscess resulting from lymphatic infection always shows pus on opening, it is important to consider the location

when diagnosing. We herein conclude that infection may reach the parotid glands either by way of the lymphatics or through their excretory canals. In the one case we have Chassaignac's canalicular parotid inflammation or acinous adenitis, and in the other, simple adenitis.

The mildness of the attacks in the case here reported is taken to mean that the pathological process never advanced to pus formation. Hence, the designation above, "simple infectious." The unusual good health, absence of fevers and constitutional disturbances, mildness and rapid subsidence, absence of concurrent affection and repeated recurrence, seem to render the case worthy of discussion.

The Surgical Treatment of Malignant Disease of the Larynx—

D. B. DELAVAN—*Therapeutic Gazette*, Vol. xxii, No. 7.

Indications are beginning to appear which show that the future of this class of patients is not as dismal as one would suppose, judging from statistics of past years. Of late the proportions of successful operations has been quite satisfactory. Though the operations are of recent date, the work recorded in them should be carefully considered. Three groups of operations are offered: (1) Thyrotomy, with or without partial laryngectomy; (2) complete laryngectomy by the Solis-Cohen method; (3) complete laryngectomy in cases of extensive laryngeal disease with glandular involvement.

1. Every malignant growth of the larynx of intrinsic origin which can be dealt with should be treated by an operation in the absence of a decided indication to the contrary, and the operation should be performed with the least possible delay.

2. Every tumor of the larynx suspected to be malignant, of intrinsic origin, of limited extent, and apparently within reach of free removal, justifies an exploratory thyrotomy in a suitable patient, and in the absence of infiltration of the surrounding structures and of affection of the lymphatic glands.

3. The method of operating as pursued by Butlin and Semon is recommended. In the case operated upon by J. Solis-Cohen, the several ends of the trachea were brought to the external edges of the cervical incision and there retained, thus cutting off communication between the pharynx and lungs. The advantages of this procedure are very evident. The danger from inspiration pneumonia is greatly lessened; swallowing is easily accomplished; the power of phonation can be satisfactorily acquired (as shown in three cases operated upon in this manner); the patient's comfort is greatly increased, as the wearing of an artificial larynx is not necessary.

LEDERMAN.