THE REPORT OF THE REMOVAL OF TWO PHARYNGEAL TUMORS (FIBROMA AND LYMPHOMA) WITH THE LIGATION OF THE EXTERNAL CAROTID IN ONE CASE.

F. PHINIZY CALHOUN, M. D., ATLANTA, GA.

The report of the two following cases of pharyngeal tumors, while interesting to the writer, is called to your attention for the following reasons:

1. Neoplasms of large size in the pharynx are not common.
2. The growth is usually slow, and should there be a recurrence after operation, it is usually rapid.
3. Ligation of the carotids is not usually practiced in their removal.
4. The loss of blood at the time of the operation, and the shock following, is usually severe without carotid ligation.

CASE I.—Master W., aged fifteen, had suffered from nasal obstruction for almost three years. He was a mouth breather, and his physiognomy and general build was that typical of a patient with adenoids. He was an inmate of the Deaf and Dumb Academy at Cave Spring, Ga., and was considered a pupil of only moderate intelligence. His father and mother were double first cousins, and there were three other children in the family who were mutes.

At my first examination, the boy was quite thin, anemic looking, and, as previously mentioned, a mouth breather. There was a constant muco-purulent discharge from both nostrils, and air could not be forced through the nose, either by inhalation or exhalation.

After the mucous membrane of the nose had been shrunk by a weak solution of cocaine and adrenalin chloride, an obstruction could be seen in both posterior nares. With a long probe this obstruction moved only a very little.

Looking into the mouth, a round glistening mass, slightly injected with a few blood vessels, were seen to hang below the soft palate on each side. They could be readily moved with a probe. With a small rhinoscopic mirror, the whole post nasal space was seen to be filled with multiple, rounded tumors, all springing from a common base, the superior and posterior walls of the pharynx. Introducing the finger behind the soft palate, these multiple tumors could be easily

felt, and by pressure, forcing the tumors out of place, the chonae were found well open. The whole posterior wall was much thickened.

A diagnosis of fibroma of the naso pharynx was made.

A small piece was snared for microscopic examination, and the report of the pathologist, Dr. Geo. S. Dixon, of New York, in brief is as follows:

"The growth is a fibrous polypus with endothelial proliferation, especially about the vessels. I do not think it is malignant, but the patient will bear watching."

The first operation was attempted without an anaesthetic, and a quantity of this hard, fibrous tissue was removed with a pair of volsella forceps and curved scissors. As the patient lost considerable blood, and was becoming weak, he was placed in bed, and after a few days, he was up and about, and was allowed to return to his home within a week. An examination of his naso-pharynx was made before his departure; and it was found by palpation and inspection, that only a small portion of the tumors had been removed. It was thought best to wait two or three weeks before attempting any other procedure.

One month later another examination was made, and there was little change, except that he was breathing fairly well through his left nostril. He was placed in the Wesley Memorial Hospital, a general anaesthetic (ether) was administered, and the entire pharyngeal wall cleaned of this neoplasm, first by a rough dissection with a pair of curved scissors, then using an adenoid curet, the smaller parts were entirely removed. The bleeding was profuse, and the shock profound, and it was not until late in the night that the patient was entirely out of danger. It was really the suddenness of the shock, or the bleeding into his own vessels that arrested the hemorrhage. I did not find it necessary to use a post-nasal plug.

After five days of absolute rest in bed, he was allowed to return home, in very good condition, with perfect nasal breathing.

One year later I examined him, and while his nasal breathing was still perfect, and the patient had gained greatly in health and strength, there was a recurrence of the growth in the right side of his naso-pharynx. I saw no indication at that time to interfere, and so advised his father. He is to report again within one year.

CASE 2. Mrs. G. R., age, thirty, a farmer's wife, came to the clinic of the college of physicians and surgeons, complaining for fifteen years of difficulty in swallowing, and of a choking sensation whenever she laid down. She had, herself, looked into her mouth five years ago with a looking-glass, and had discovered a tumor-like body in the region of her left tonsil. There was nothing in her family or past history to indicate malignancy. The woman was well nourished and had always been healthy.

The examination showed a large granular tumor attached to the lateral wall of the pharynx, posteriorly to a moderately hypertrophied left tonsil, extending almost as high as the soft palate, and as low down as the epiglottis, and toward the median line of the pharynx for about one-half inch. The base of the tongue was in contact with the growth, and it was evidently this contact that caused the difficulty in swallowing, and the irritation about the epiglottis, especially in the reclining position that caused the choking sensation.

A small piece was excised for microscopical examination which proved to be a lymphoma, according to the report of Dr. Claude Smith of this city. There was much bleeding from this small operation.

An operation was advised and the patient was placed in the Wesley Memorial Hospital. Dr. W. P. Nicolson was consulted as to the advisability of an external carotid ligation, and it was his opinion that it should be performed.

The left external carotid was easily ligated, and the proper neck dressing applied. Immediately following, a mouth gag was inserted and the tumor grasped with a large pair of Volsella forceps and snared in three sections with a Farlow snare. There was practically no bleeding, and the size of the three pieces removed was about that of a small hen egg.

The left tonsil was slightly hypertrophied and buried, and I thought it best at that time to remove it also. I went about it in my usual way, and removed it with a snare, when to my surprise, after the patient had been turned on her right side, face downward, I discovered blood gushing from her mouth. Upon examination, the hemorrhage was found to come from the operated tonsil. A gauze sponge held over the raw surface of the tonsil arrested the hemorrhage, but as soon as removed, the spurting recurred. A large abdominal clamp was used to catch up the tissues between the

pillows, which stopped this spurting, but the oozing was rather profuse. After a few moments deliberation, the tonsillar hemostat applied, and the patient returned to her ward in excellent condition. That night I kept the patient under the influence of an opiate, and the next morning the hemostat was removed. The following day, the clamp holding the bleeding vessel was also removed.

The case made a rapid recovery, and in ten days left the hospital. I have heard from the patient often, and there has been no recurrence so far as she knows up to this time, which is nine months after the operation.

My purpose in presenting these two cases is to illustrate the importance of carotid ligation in the removal of large tumors from the naso-pharynx. The procedure is a simple one, and rarely attended with risk.

In case one, that of the fibroid tumor, a double ligation of the external carotid would undoubtedly have caused considerable less bleeding, no shock and the chances for a recurrence of the tumor would have been very much less. My reason for not ligating the carotids is that the father seriously objected, and was willing for the patient to assume all risk.

Two similar cases operated upon in this city in years past by colleagues, with fatal results from hemorrhage, only substantiates my belief that a ligation is imperative. The removal of the tumor in case two, in which the carotid was tied, the lymphoma was attended with practically no hemorrhage, and the excessive bleeding from the tonsillar operation can only be explained by an anomalous tonsillar artery, a branch of the internal carotid, over supplied with blood from an external carotid ligation.

Candler Building.