

tion of the stomach may occur in syphilitic persons with the same frequency as in those without the constitutional taint.

It is said that the late Hunter McGuire stated on one occasion that much of his success was due to the fact that in obscure manifestations of disease, he treated the patient for syphilis. This might apply with satisfaction to some of our long-suffering dyspeptics, who have run the therapeutic gamut without relief, who have become pessimistic invalids, burdensome to both themselves, their physicians, and the community at large.

922 Candler Building.

RADIUM IN THE TREATMENT OF SYNOVIAL LESIONS OF THE SKIN

RICHARD L. SUTTON, M.D.

KANSAS CITY, MO.

It is probable that the true nature of synovial lesions of the skin was first discovered by Sidney Jones and G. H. Makins¹ of London, but it is to the late James Nevins Hyde² that the general profession is indebted

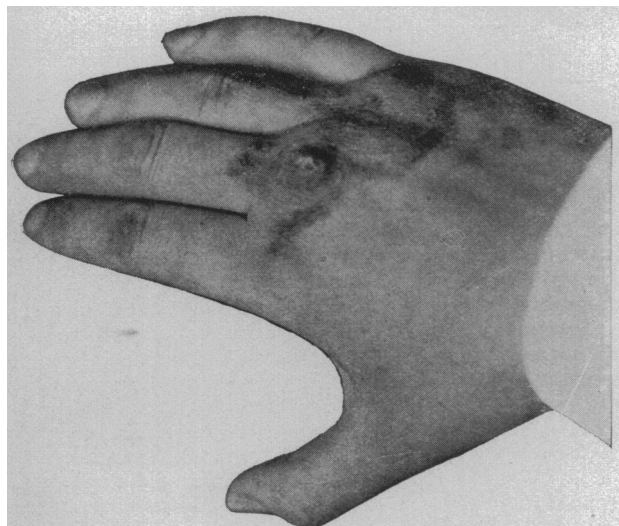


Fig. 1 (Case 1).—Synovial lesion of the skin of eighteen months' duration.

for a classical description of the disorder. In the first edition of his treatise on diseases of the skin, he states that lesions of this type

Occur in the form of wart-like projections from the skin, pseudovesicles, and bullae, always over the sites of bursae connected with tendons, traversing the small articulations of the hand and foot. They are seen over the metatarsophalangeal articulations; and in the hand most frequently over the dorsal face of the articulation between the distal and adjacent phalanges of the index finger and thumb. The first form is that of a roundish, corneous, pea-sized wart with a yellowish center, of long duration, usually insensitive unless roughly handled. When punctured there exudes a syrupy, yellowish, or grumous fluid, which continues to form after repeated puncture. Split-pea-sized vesicles, and bullae as large as a 50-cent piece, often exceedingly painful, are also seen, especially on the feet, with simply an epidermic roof wall. Each lesion contains the same yellowish or whitish fluid, occasionally mingled with masses like sago grains. In every case the contents of the lesions are supplied

by a synovial bursa beneath the skin, with which the lesion is either directly connected, or in communication by a short sinus.

More recently Lingenfelter³ has described a typical example of the affection occurring on the dorsal aspect of the third phalangeal articulation of the second digit of the right hand, in a woman aged 51. The lesion had

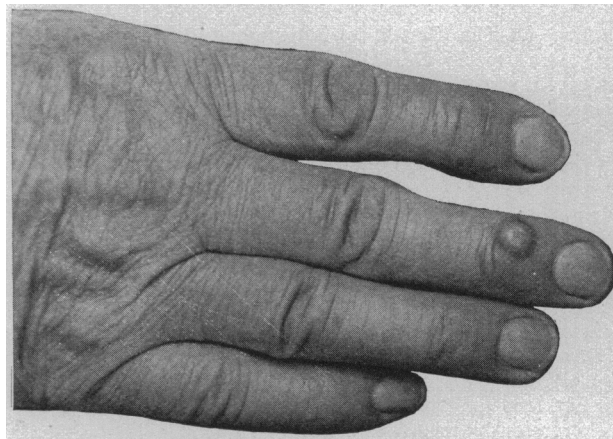


Fig. 2 (Case 2).—Synovial lesion of the skin of five months' duration. The inflammatory areola is due to the use of caustics.

been present for fourteen months. Pain of a sharp, stabbing character, radiating in all directions, was present at rather frequent intervals, and was usually succeeded by a throbbing ache. In a discussion of Lingenfelter's communication, Ormsby⁴ called attention to Hyde's earlier investigations and report, and, in addition, described four cases which had come under his observation during the past eight years. Three of his patients were women, between the ages of 46 and 50, the other being a man, aged 66. The cause of the disorder is unknown. The microscopic and cultural findings were negative in Ormsby's cases. He says that an arthritic diathesis is strongly suggested.

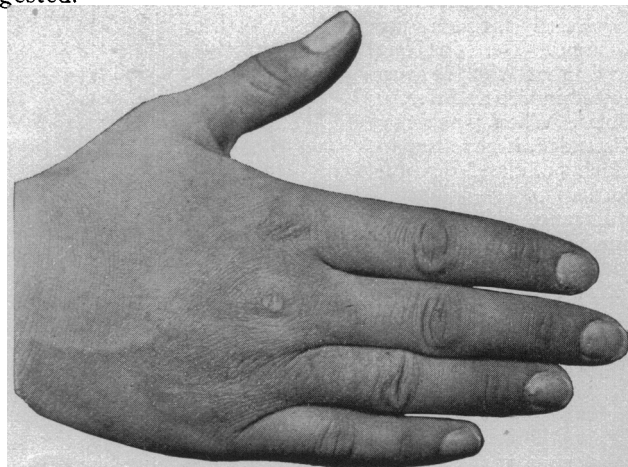


Fig. 3 (Case 1).—Showing the condition of the hand four months after treatment with radium was discontinued.

The lesions are extremely resistant to treatment. Hyde recommended complete excision or destruction of the secreting cyst wall. Lingenfelter employed the Roentgen ray with success. Ormsby also found the use of this agent curative in two instances, although

1. Jones, Sidney, and Makins, G. H.: Cited by Hyde, *Diseases of the Skin* (Footnote 2).

2. Hyde: *A Practical Treatise on Diseases of the Skin*, Philadelphia, 1883, p. 444.

3. Lingenfelter: *Jour. Cutan. Dis.*, 1913, p. 647.

4. Ormsby: *Jour. Cutan. Dis.*, 1913, p. 943; *Diseases of the Skin*, Philadelphia, 1915, p. 515.

he was compelled to resort to supplemental electrolysis in a third instance. On account of the patient's inability to remain in the city, energetic treatment was given with electrolysis, with apparent success, in his fourth case.

REPORT OF CASES

During the past year I have encountered two examples of the disorder.

CASE 1.—The first was in a married woman, aged 58, referred to me by Dr. C. F. Menninger of Topeka, Kan. The lesion, a smooth, rounded, pea-sized, fluctuant tumor, was located over the distal phalanx of the right index finger, and had been present eighteen months. It had been incised and drained on two different occasions, but each time the cyst had refilled, with syrupy, straw-colored fluid, as soon as the wound healed. There was intermittent pain, of a sharp, lancinating character. Treatment by electrolysis was refused because of the attendant discomfort, and as the patient could remain in the city for only a few hours, frequent applications of tincture of iodine, with compression by means of a small pad and bandage, were advised.

In a recent letter, the patient says that the lesion is much reduced in size, and that the pain has disappeared. It is probable, however, that permanent relief will be secured only by the adoption of more radical remedial measures.

CASE 2.—The second case occurred in a graduate nurse, aged 26, referred to me by Dr. J. Park Neal of this city. The lesion was located over the metacarpophalangeal joint of the index finger, and had been present five months. Clinically, it corresponded to the first form described by Hyde—a roundish, pea-sized, fluctuant nodule, having a depressed, yellowish center. Owing to frequent and repeated cauterization, and the use of picric acid and similar agents, the surrounding skin was inflamed and eczematous. Following puncture, considerable amounts of gelatinous, grumous fluid could be expressed through the opening. The patient said that the lesion varied in size at different times. When greatly distended, it gave rise to much pain and discomfort.

Because of the encouraging reports of Lingenfelter and Ormsby following Roentgen-ray therapy, it was decided to try only radium in this case. The fractional dose method was used, a one-fourth strength applicator, unscreened, being applied for one-half hour on eight successive days. Following the subsidence of the reaction, it was found that the lesion, with the exception of a small central cicatrix, had entirely disappeared. At this time, five months having elapsed, there is no sign of recurrence. The surrounding area of dermatitis responded readily to frequent applications of calamine lotion and zinc oil.

Lathrop Building.

Requisites of Conversation.—The first ingredient in conversation is truth, the next, good sense, the third, good humor, and the fourth, wit.—Sir William Temple.

FIBROLIPOMA OF THE LARYNX *

GORDON B. NEW, M.D. (TOR.)

ROCHESTER, MINN.

After a careful review of literature I have been able to collect reports of only twenty-three cases of lipoma or fibrolipoma of the larynx. In 1899, Garel¹ presented a case before the Société française de laryngologie, and he had at that time collected reports of thirteen other cases from literature. In 1901 Garel presented "un cas d'aversion ventriculaire" before the same society. His patient died of pernicious anemia, and at necropsy the fibrolipoma was found. In 1908 the same author reported another case of a large lipoma of the larynx. He had collected reports of six additional cases of Calamida, De Santi, Goebel, Ingals, Meyjes and Laurens. In 1909, Goldstein,² presented a case of his own with a detailed summary of eleven other cases and a thorough discussion of the etiology and pathology of the condition. As far as I know, these, including the one presented in this paper, make twenty-four reported cases of lipoma of the larynx.

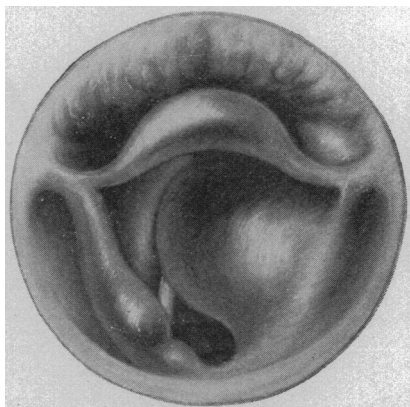


Fig. 1.—Tumor, left side of larynx, above true cord, apparently distending the aryteno-epiglottidean fold.

REPORT OF CASE

History.—Mrs. W. C. (Case 133172), aged 29, examined June 15, 1915, with unimportant previous history, complained chiefly of hoarseness which had lasted for eight years. She took cold eight years ago, lost her voice entirely for one week, and never fully recovered. A physician had been consulted at the time and had prescribed throat sprays and gargles, but did not make a definite diagnosis. Five years ago a physician was again consulted because of the hoarseness, and she was treated for bronchial trouble. One year ago her larynx was examined and she was told she

had enlarged glands of the neck and catarrh of the head which was the cause of the hoarseness, and electric massage of the back of the neck was given. Seventeen months ago the patient noted a thickening of the left side of the neck, but it had not increased. While ill with measles three months ago she had spasms of the throat and great difficulty in breathing. When examined she had slight dyspnea on exertion, but felt perfectly well; there was no

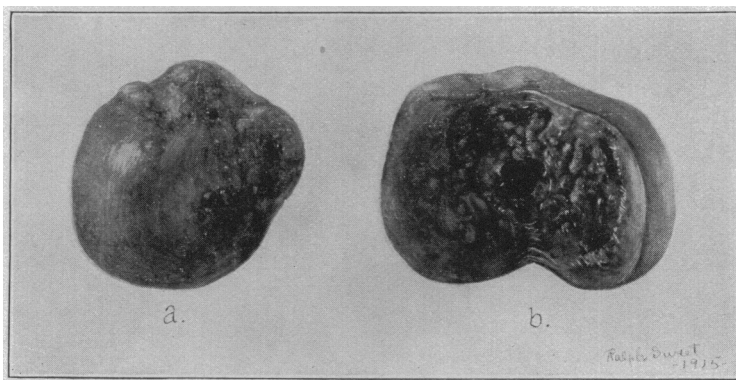


Fig. 2.—Gross specimen, actual size: (a) intact; (b) on section.

cough, no expectoration, no loss of weight. Blood pressure was 120 and 180. The urine and the Wassermann test were negative.

The nose and throat were negative, except for the laryngeal findings; there was a tumor in the left side of the larynx covered with normal-looking mucous membrane, apparently bulging the aryteno-epiglottidean fold. The left cord was not visible, and only the posterior third of the right cord could be seen. The tumor did not change its position during

* From the Mayo Clinic.

1. Garel, J.: Enorme lipome du larynx d'origine ventriculaire. *Bull. de laryngol., otol. et rhinol.*, 1908, xi, 1. Calamida, De Santi, Goebel, Ingals, Meyjes, Laurens and Hunt are quoted by Garel.

2. Goldstein, M. A.: Lipoma of the Larynx, *Laryngoscope*, 1909, xix, 641.