ble with the effect of stopping my breath. Recently, any violent exercise, which rapidly increases respiration, causes the growth to swell. The same is true of any nervous excitement."

Examination of the throat was rendered difficult by the large size of the patient's tongue, which, when protruded, occupied almost entirely the buccal cavity and prevented the satisfactory introduction of the laryngeal mirror. Laryngoscopy was therefore undertaken with the tongue depressed, as much as possible, by means of a spatula. Only the right half of the larynx could be seen, the left being covered by a large smooth, globular, bright-red mass which extended from a point a little to the left of the median line to the right lateral wall of the pharynx, filling the corresponding pyriform sinus, from which cavity it apparently sprang. The growth was distinctly movable both on manipulation and phonation. It could just be reached with the finger and communicated to the touch the sensation of a soft elastic, semi-solid body, with here and there small areas of a harder substance. By exciting retching, the upper surface of the tumor appeared above the upper edge of the epiglottis.

On May 5, I operated as follows: Having provoked retching, the growth was caught with a pair of laryngeal forceps in its ascent and drawn as far upward as possible toward the base of the tongue. The handles of the forceps were then entrusted to my friend, Dr. S. Johnston, who was kindly present, and upon the forceps as a guide, the strong silver wire of an *écraseur* was threaded and carried to the base of the growth, which was then rapidly severed, the whole operation taking only two or three moments. The patient expectorated no blood after the extirpation of the growth.

Laryngoscopic examination immediately after the operation discovered in the centre of the floor of the right pyriform sinus a small raw, slightly bleeding surface which marked the site of the tumor's base. The patient thought that, during the night, some hæmorrhage took place from the wound, the blood entering the stomach, but on the following morning, a firmly organized clot occupied the seat of operation and the patient was allowed to return to his home in Virginia.

The growth was about the size and shape of a testis, was soft and elastic to the touch and gave a distinct sense of fluctuation. On section, it appeared to be made up of a soft elastic tissue in which innumerable tolerably hard whitish points were seen. Microscopical examination undertaken by Professor Councilman, of the Johns Hopkins University, disclosed the following: The growth was covered over with epidermis which showed in several places slightly rough elevations. Under the microscope, were found "externally, well-formed mucous epithelium, while the body of the tumor was composed of areolar connective tissue in which there were small areas of small cells

similar to the lymphoid corpuscles. Immediately beneath the epidermis, this lymphoid tissue was most abundant. There was no glandular tissue in the growth nor any glands opening on its surface. The small cell areas could well belong to the follicular tissue so common in the pharynx."

In other words, the tumor was composed of the lymphoid pharynx tissue so graphically described in recent years by Waldeyer and his pupils, and I have therefore used the term "lymphoid" as best expressive of its true nature.

The origin of the growth was doubtless due to some form of local irritation—possibly in the case before us to a neglected localized inflammation of the pyriform sinus.

Outgrowths, generally fibrous in nature, are occasionally met with in the glosso-epiglottic fossæ, or projecting from the tonsils and lateral pharyngeal walls, but primary growths of the pyriform sinus are excessively rare. As the above case is probably unique, I have thought it worthy of record.

Over four years have elapsed since the removal of the growth without any signs of its recurrence.

DR. J. SOLIS-COHEN remarked that it was rather curious that this unique growth originated in the position from which some few cases of lipoma had taken origin.

IMPAIRED VISION AS THE RESULT OF SUNSTROKE.

Read in the Section of Ophthalmology at the Fortieth Annual Meeting of the American Medical Association, Newport, R. I., June, 1889.

BY A. R. BAKER, M.D.,
OF CLEVELAND, O.

My attention was called to this subject a few years since by the commissioner of pensions, who referred a number of cases to me for expert examination for alleged impaired vision as the result of sunstroke while in the service. Upon referring to works upon the eye and special articles treating the subject of sunstroke, I found little of value bearing upon this point. Most articles discussing the etiology of atrophy of the optic nerve mentioned sunstroke as one of the causes; and treats upon the sequela of sunstroke mentioned blindness as one of them. But as to any information as to the frequency of atrophy of the optic nerve as the result of sunstroke, or as to the pathological conditions, the symptoms, diagnosis or treatment, these works make no mention; and the only report of cases that proved of any value in my researches was that of Dr. Hotz, in a paper entitled "Notes of Intra-ocular Lesions Produced by Sunstroke" (*American Journal of Medical Sciences*, July, 1879). In this paper Dr. Hotz reported a number of cases in which an ophthalmoscopic examination shortly after the sunstroke revealed an optic neuritis. In

none of these cases was the swelling of the optic nerve excessive, and all recovered with vision little, if any, impaired, and a very slight, if any, atrophy. In the *Medical Record* of April 28, 1888, there appeared a paper by Dr. Thos. A. Spaulding, of Portland, Me., on the subject, a part of which was read at the preceding meeting of the American Ophthalmological Society. In this paper it is stated that "no member present had ever heard of the sight being affected by sunstroke." As this statement appeared to be somewhat remarkable I addressed letters to a number of physicians who, owing to long experience in military and civil practice, I thought would have met such cases; but all the physicians to whom I addressed these letters answered that they had never met a case of blindness or impaired vision as the result of sunstroke.

Among 13 cases referred to me for expert examination with impaired vision, alleged as the result of sunstroke, I met three cases of simple hypermetropia, two of senile cataract, one of progressive myopia, one of detachment of the retina, and one of disseminated choroiditis, probably of syphilitic origin. Judging from these cases, and from the almost entire absence of references to this subject in medical literature, I am not surprised that many observers are inclined to doubt the existence of impaired vision as the result of insolation. I wish to put on record the following cases, which, to my mind at least, present conclusive evidence that vision is sometimes impaired as the result of sunstroke; and it is to be hoped that in the future the fundus of the eye will be carefully examined in all recent cases so that the frequency of optic neuritis as the result of this cause may be determined.

Case 1.—Mr. H. M., aged 39, examined April 25, 1887. Had sunstroke while in the service July, 1864. Has had neuralgia and pain in the head almost continuously ever since; this is especially severe when exposed to heat. He followed his usual occupation as a miner for some years after returning from the army, but gradually became unfit for work and now has partial paralysis of upper extremities. He has complained of impaired vision ever since he came out of the army, his sight being poor especially at night. Never associated the loss of sight with sunstroke. No other cause for neuralgia, paralysis, loss of sight and other nervous affections can be discovered. Partial white atrophy of optic disc; field of vision very much contracted; vision, left eye, $\frac{2}{30}$ (Snellen); right eye, $\frac{2}{30}$; refraction normal. A record taken five years previously showed no appreciable change in his field of vision.

Case 2.—Mr. A. J. W., farmer, aged 65; examined August 1, 1887. Had sunstroke in June, 1864. Has suffered from constant headache confined to right side of head. This side of the head is always more or less tender on pressure. Mind

not very clear; prematurely old; slight paralysis of left side of body; dragging of left foot in walking; cannot bear heat of sun; always carries an umbrella when sun shines. Has fallen to the ground frequently during hot weather, and only resuscitated by cold water affusions. Complete white atrophy of outer half of optic disc of left eye, and inner half of right optic disc; left lateral hæminopsia; vision, left eye, $\frac{2}{30}$; right eye, $\frac{2}{30}$ (Snellen). I examined the eyes with the ophthalmoscope before taking field of vision, and was able to say, from the atrophic condition of the outer half of one optic disc and the inner half of the other, that the patient was suffering from hæminopsia.

Case 3.—Mr. J. T., aged 45; examined November 5, 1888. Had sunstroke in summer of 1864. Has been a constant sufferer from neuralgia, photophobia and other nervous affections since date of sunstroke. Has never been able to engage in any business or occupation. Does not venture outside of the house on days when the sun is shining. He requires the same constant care and attention as a child six or eight years of age. There is complete white atrophy of the optic nerve of left eye. Veins are large and arteries very small. The blood-vessels about the disc are very tortuous, showing previous intense neuritis. Partial white atrophy of right optic disc. Blood-vessels somewhat tortuous, but not so much so as in the other eye. Vision left eye, slight perception of light; right eye, $\frac{2}{30}$ (Snellen).

Case 4.—Dr. T., aged 57; examined April 15, 1889. In June, 1863, while in charge of a picket line as medical officer, he became insensible from sunstroke. He was totally blind for three days. His sight gradually returned, but with the field of vision extremely limited. He describes it as looking through two small gimlet holes. The brightest day appears to him as mere twilight, and at night he is almost completely blind. He has lost all color perception. Although he has had to avoid walking on the streets on hot days, and his general health has not been robust, he has proven himself a man of indomitable will, and, notwithstanding his impaired vision, he has been a successful practitioner of medicine, and still continues to do an office practice. He has white atrophy of both optic nerves of such a high degree that it seems remarkable that he can see at all. The field of vision is only about two inches in diameter at a distance of 12 inches. Vision right eye, $\frac{2}{30}$, with 2 D. C. axis $90=\frac{2}{30}$ (Snellen); vision left eye, $\frac{2}{30}$, with 2 D. C. axis $90=\frac{2}{30}$.

In addition to these cases, all of which occurred in old soldiers, I wish to report the following case, which very closely resembles those reported by Dr. Hotz:

Mr. H. B., aged 45, merchant. Had sunstroke on July 4, 1886. First examined on August 5th

of the same year. Patient suffering from headache, dizziness, nausea, occasional diplopia and dimness of sight. Ophthalmoscopic examination revealed an optic neuritis of both eyes; outlines of the disc could not be distinguished. Veins large, arteries small. Vision, right eye, $\frac{2}{40}$; left eye, $\frac{3}{40}$ (Snellen). Refraction normal. Have had the case under observation most of the time since the above date. At present there is no appreciable atrophy of optic nerve. There is a slight tortuosity of blood-vessels. Vision $\frac{2}{40}$ in either eye. Health good. No nervous disturbances except that the patient seems to be afraid that there is something serious going to happen, and makes the life of his medical adviser a burden by constant inquiries after this or that insignificant symptom.

In view of these cases, notwithstanding the fact that out of thirteen cases of alleged impaired vision as the result of sunstroke nine were found to be suffering from affections that could have no possible connection with this cause, I am led to believe that impaired vision does result from sunstroke in a large number of cases. We would expect this from an affection which produces such a profound impression upon the cerebral centres.

It is not necessary for me, before such an audience as this, to enter into a detailed account of the intimate relation existing between the optic nerve and the brain and its meninges. I wish simply to emphasize the importance of making an ophthalmoscopic examination of the *fundus oculi* in all cases of *coup de soleil*. This examination should be made immediately after the attack, at a somewhat more remote period, and in all cases where there is alleged impaired vision as the result of sunstroke, no matter if it be at a period many years afterward.

RELAXATION AND MANAGEMENT OF THE PERINEUM DURING PARTURITION.

Read before the Golden Belt District Medical Society of Kansas, July 4, 1889.

BY WILLIAM B. DEWEES, A.M., M.D.,
OF SALINA, KAN.

Mr. President and Fellows of the Golden Belt District Medical Society of Kansas:—In performing the duty assigned me on this occasion, I have chosen to briefly consider the *relaxation and management of the perineum during parturition*.

Great rigidity of the tissues at the pelvic outlet, as a cause of lacerations and other serious complications in labor, is—as we are all fully aware—an old topic, and almost worn threadbare from discussions *pro* and *con* as how the better to overcome this abnormal condition; nevertheless the little triangular, pyramidal or wedge-like body, known

as the perineum, often meets with a serious lesion, occurring as an accident to parturition.

Believing that immunity from perineal injuries is due to a better knowledge of preventive means, we offer no apology in presenting the subject for your consideration.

Prof. H. Lenox Hodge,¹ writing on this subject, says: "There are few complications which demand the more sedulous attention, and the best exercise of the judgment and skill of the accoucheur."

Prof. Wm. P. Dewees² observes: "There is no more frequent complication of labor, or one more productive of dangerous consequences to the mother and child."

The very great variety of opinion, by those who write and teach, as to the best mode of caring for the perineum, sets forth the necessity for a closer study and fuller discussions of the subject. One of the most delicate as well as most responsible tasks which devolve upon the accoucheur is the regulation of the exit of the child's head and consequent management of the mother's perineum. He who preserves the integrity of a perineum which is in peril, shows more skill and consummates higher art than he who successfully repairs a perineum which has been *torn*.

The method of universal success has not been found, nor can it be confidently hoped for. However, better methods with better results may be expected. Under any method of management yet devised, injury occurs in a considerable number of cases. The history of accidental parturient wounds of the perineum proves that they occur in the experience of every practitioner of obstetrics, however skilful he may be. But, it cannot be denied that they occur most frequently in the hands of the unskilful; that a large percentage of such cases are avoidable, and that many others, by prompt and well directed assistance, may be limited in their extent.

The question of the proper management of the perineum during labor is no longer dwelt upon in our schools as formerly; indeed, in some it is not taught at all, the direction being "if the head be delayed, place the forceps, and pull it through; a few stitches will make it all right." How different this, from the instructions imparted in my *Alma Mater*;³ how well do I remember that venerable teacher, Prof. R. A. F. Penrose, folding a napkin to a soft smooth surface, and placing it upon the distended perineum of a manikin, assuming a position to support against the advancing head. "Gentlemen," said he, his face reflecting the conscious responsibility and anxious interest which should be felt by every one who assumes to aid the physiological act of parturition, at the moment when the future happiness and

¹ Hodges' System of Obstetrics, p. 423.

² Dewees' System of Midwifery, p. 358.

³ University of Pennsylvania, Med. Dept., at Philadelphia.