Should one undertake the removal of such a tonsil with the snare or the tonsillotome it would at best result in the removal of only a small portion of the gland (tonsillotomy); and should one attempt the dissection with the finger or any other blunt dissector so much force would be necessary that damage would be done to the surrounding parts; the operation would be slow and tedious, and finally the ragged condition of the wound must needs be trimmed to smoothness with some form of scissor-punch.

Therefore, with the majority of throat specialists, the choice of instruments lies between the knife and the scissors, with preference for the knife. While the knife and scissors are dangerous instruments in the hands of an unskilled surgeon in the blood-obscured field of the throat, both these are quite safe in the hands of a skilled throat surgeon, and are the only instruments, within my knowledge, with which a classical tonsillectomy can be done under any and all conditions.

HOW TO USE THE KNIFE

Grasp the tonsil with a small tenaculum forceps (not a large one that will distort the gland) and apply slight traction in the direction which will put moderate tension on the tissue where the cutting is to begin; then, with the knife, cut through the mucous membrane that covers the free surface of the gland. This membrane, which is continuous over the pillars, is tough and yielding, and to divide it with a light touch the knife should be keenly sharp. The first incision through this membrane is usually made between the tonsil and the anterior

Tonsil and nasal septum knife.

pillar, or between the tonsil and the posterior pillar, about midway between the upper and the lower extremities of the gland. With a light cut the blade of the knife passes through the membrane and in between the tonsil and the pillar, when it is carried slightly upward and allowed to cut its way out. Practically all the cutting, after the first incision, is done by cutting from within the tissues outward. This is the chief virtue of this knife, making it very safe.

The tonsil may be entirely circumcised if desired, in this manner, after which straight but gentle inward traction may be exerted on the tenaculum, when a few light sweeping or pulling strokes with the knife will divide whatever adhesions remain between the tonsil and its bed.

In this final stage of the operation care should be taken to follow closely the deep contour of the tonsil, which is not always easy when the deep capsule is obliterated. Severe hemorrhage will almost never occur unless the surgeon cuts into the superior pharyngeal constrictor muscle. The tonsil may be entirely removed at once with the knife, in this manner, if desired. But owing to the difficulty of dissecting out the lower portion of a tonsil with any form of knife or scissors without injuring the base of the pillars or the styloglossus muscle, it is better, after the tonsil has been separated two-thirds the way down, to slip a small wire snare over the tenaculum and finish the dissection with the snare, which makes a very clean and a very safe operation, and one as expeditious as need be. Practically the same procedure is carried out under local as under general anesthesia.

A summary of the virtues of this knife might include: its universal applicability; the small size and thinness of its blade, which enables it to cut easily and in any direction; its circular blade, which renders it less dangerous in the blood-obscured field of the throat; and the particular angle and convexity of the blade on the back, which enables the surgeon to follow more closely the outline of the deep contour of the tonsil.

501 Old National Bank Building.

ENDOTHELIOMA OF THE LYMPH-NODES OF THE NECK*

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Endothelioma of the lymph-nodes of the neck is perhaps uncommon. In reviewing the literature I found only one reported case. MacLaurin¹ reported a very interesting case in which the nodes of both sides of the neck were involved and the disease had extended into the chest. MacLaurin considered the case inoperable. Fioravanti² reports a case of fibrochondromyxosarcoma-endothelioma of the parotid gland. Jackson³ cites a case of endothelioma of the larynx in which he did a laryngectomy under the assumption that it was a malignant tumor. Bolognesi⁴ reports a case of endothelioma of the right submaxillary gland in a patient 39 years of age. The tumor was the size of a hen's egg. There were no adhesions and no other glands involved.

Endothelioma takes origin from the endothelium of the lymph-nodes or blood-vessels, or may arise from serous cavities, e. g., in the omentum. The parotid gland and carotid-body are sometimes the site of growth. The structure of an endothelioma consists of clumps of endothelial cells supported by a stroma, which in slowly growing cases becomes widely altered showing hyaline or mucoid degeneration. In the rapidly growing tumors the stroma is ill-marked; the endothelium invades the connective tissue, occasionally making abortive attempts at the formation of cell-nests. Extreme malignancy is seldom seen in endothelioma. Metastases rarely occur. The glands are seldom involved unless by direct growth of the tumor (MacLaurin). Endotheliomas have been regarded as sarcoma.

CASE REPORT

Patient.—W. B., aged 60, white, male, laborer, was admitted to my service at the City Hospital, Jan. 2, 1912, with a provisional diagnosis of inoperable sarcoma. Thirty years previously patient had noticed a small nodule on the right side of his neck about 8 mm. in diameter, a little median and below the angle of the lower jaw. The nodule was freely movable beneath the skin and did not increase in size for five or six years; then it became gradually larger and in the spring of 1911 it was as large as a hen's egg (4.5 by 4.5 cm.); it was irregular and movable. Shortly thereafter a second nodule appeared lower down. These nodules were not painful. During the latter part of 1911 the growths increased rapidly in size and the patient became hoarse and could scarcely speak above a whisper. There had not been any appreciable loss of weight.

Examination.—Patient was well developed and cheerful. Just below the right parotid was a large, firm nodular mass which caused patient to incline his head toward the left. Below this large mass were several smaller masses which

* From the City Hospital, St. Louis.

1. MacLaurin: Australian Med. Gaz., 1909, xxix, 138.

2. Fioravanti: Clin. mod., Florence, 1905, xl, 337.

3. Jackson: Pennsylvania Med. Jour., 1909, x, 662.

4. Bolognesi: Arch. f. klin. Chir., 1910, xciii, 33.

were irregular and of firm consistence. All masses were slightly movable, and palpation did not cause pain. The upper growth did not involve the inferior maxilla. The lowest palpable growth was just above the sternoclavicular articulation. The skin was freely movable over the growths and was of normal color. Pupils were equal and reacted normally. Examination of larynx showed involvement of right recurrent laryngeal. A specimen was removed by Dr. Kinsella and the pathologic department reported the growth to be an endothelioma. Removal was advised.

Operation.—Under ether anesthesia preceded by morphin and atropin, the vessels were exposed just above the sternoclavicular juncture; a Crile clamp was placed on both artery and vein. The usual Z incision was made, the flaps were dissected up and the growths including the sternomastoid muscle, the internal jugular vein and the submaxillary gland were removed *en bloc*. The carotid artery and pneumogastric nerve were more or less adherent to the mass and infiltrated, but owing to the pathologist's report that the growth was not malignant and in consideration of the patient's age, it was deemed advisable not to excise these structures. A small rubber tissue drain was placed in a stab-wound at the lower part of the operative field. The flaps were approximated with catgut.

Postoperative History.—Patient was placed in a sitting posture. On the fourth day he was up and about the ward. The wound had practically healed within a week and the patient was feeling fine, although the hoarseness had not disappeared.

NOTE.—While correcting the proof sheet, I learned that the patient had two lymph-nodes removed from the left side of neck shortly after the first operation, and had developed erysipelas, from which he recovered.

4826 Delmar Avenue.

A NEW CASE OF DUODENAL STENOSIS

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Patient.—Mrs. S. B., aged 56, was admitted to the Medico-Chirurgical Hospital on Jan. 5, 1912, complaining of pain in the right hypochondrium and vomiting. Her family history was negative, excepting death of father from rheumatism. The patient had been in good health prior to four years ago, but since then had had several attacks of illness, which were diagnosticated acute gastritis. Her habits were good, although she had used tea freely. Dec. 21, 1911, following a severe headache and a feeling of weakness, the patient was seized with severe pain in the right hypochondrium, which lasted about three minutes. This pain was not referred, but recurred three or four times daily, apparently without relation to the time of the ingestion of food, until date of admission to the hospital, and was somewhat relieved by vomiting. Following the first attack of pain, jaundice was noticed. After coming to the hospital, her condition showed marked improvement for a time, the attacks of pain and vomiting ceased, and the jaundice diminished considerably.

Examination.—There was some tenderness in the right hypochondrium and a small mass was palpable, which did not move with respiration. An x-ray examination did not reveal gall-stones, but showed the pylorus to be in relation with the gall-bladder region, suggesting adhesions. An examination of the urine revealed a trace of albumin, a small amount of bile, a trace of indican and a few narrow hyaline casts. Cammidge reaction was negative. A blood-count Jan. 6, 1912, showed erythrocytes, 3,860,000; hemoglobin, 80 per cent., and leukocytes, 11,600. Repeated examinations of the feces gave negative results. Jan. 17, 1912, an examination of the gastric contents extracted one hour after a test-breakfast, gave the following result: Reaction, acid; total acidity, 60; free hydrochloric acid, 0.1 per cent.; lactic acid, negative; pepsin, present; starch digestion, stage of erythrodestrin; occult blood, negative; bile, negative; mucus, a small amount.

Up to this time, the patient's condition had been improving, but now vomiting recurred. There was no recurrence of the

pain over the gall-bladder region, but the patient vomited frequently large quantities of bile-stained fluid. January 23, there occurred a severe chill, and the pulse became more rapid and feeble. The temperature pursued a very irregular course, varying from a subnormal level to 101.6 F. An examination of the blood at this time showed a leukocytosis of 25,200; the differential leukocyte count resulted as follows: Polymorphonuclear cells, 81 per cent.; small lymphocytes, 7 per cent.; large lymphocytes, 11 per cent., and eosinophils, 1 per cent.

Operation.—January 26, Dr. Ernest Laplace operated and found the duodenum markedly adherent to the under surface of the liver, and kinked at the site of adhesions. Situated between the duodenum and the liver was the much-shriveled gall-bladder. It was necessary to tear away the liver tissue in breaking up the adhesions, leaving an excavation in the liver, considerable hemorrhage resulting. The gall-bladder could not be liberated from the duodenum, and owing to the patient's weakened condition, it was deemed advisable to desist before the operation was completed.

The patient died three days later, and necropsy was refused.

The stenosis of the duodenum in this case was due partly to the constricting cicatrix of an old ulcer and partly to the kinking occasioned by the adhesions. Among other points of interest presented by this case are compression of the gall-bladder and common duct, apparently due to the adhesions either old or recent, accompanied by jaundice, and indications of a secondary acute inflammatory process obviously occasioned by perforation of the duodenum at the site of an old ulcer.

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SUPERNUMERARY AXILLARY MAMMARY GLANDS

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I have been treating an unusual case for the last three or four weeks. The patient, Mrs. T., was confined May 17, 1912. She was the mother of four children. On the second or third day she complained of severe pain in each axilla and said that she had the same abscess that she had had in previous confinements. As she was having no fever I thought it would be well to make a thorough examination. I found under the right and left axillae three secreting mammary glands and from each of these I was able to obtain milk. There was no apparent nipple on any of the six glands excepting a minute indentation. The milk, however, flowed very freely from all six of them on pressure. I used the old method of massage with camphorated oil and in about two or three weeks the glands lost their fulness and ceased to cause any trouble. Of course, this represents eight mammary glands, three under each axilla and two in their normal position. I would like very much to know if any other case of this kind has been reported.

[COMMENT.—Several reports of similar cases have been published in THE JOURNAL, for example, March 16, 1912, p. 747 (by Dr. J. D. Cantwell); and May 11, 1912, p. 1443 (by Dr. Frank J. Hirschboeck).—Ed.]

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Therapeutics

HEMATURIA

Hematuria means hemorrhage from urethra, bladder, ureter or kidney. It is to be distinguished from urinary conditions due to the presence of blood-pigments in the urine, such as hemoglobinuria, including methemoglobinuria and hematoporphyrinuria. This last condition is of slight clinical significance. Traces of the iron-free blood-pigment, hematoporphyrin, are found in normal