XXVII.

REPORT OF A CASE OF BILATERAL ABSCESS OF THE SEPTUM, WITH WELL MARKED SYMPTOMS OF SEPTICEMIA;

AND

REPORT OF A CASE OF EPIGLOTTIC ABSCESS, WITH SECONDARY INVOLVEMENT OF THE CERVICAL GLANDS.*

BY WILLIAM LEDLIE CULBERT, M. D.

NEW YORK.

The writer has thought it might be of interest to report the following cases, not only on account of their comparative rarity, but also because of certain peculiar clinical features which they presented.

In a somewhat hurried review of the literature of these two subjects I find quite a few cases of abscess of the septum reported, but only eight cases of abscess of the epiglottis during the past dozen years.

ABSCESS OF THE NASAL SEPTUM.

CASE 1.—Mr. A., 31 years old, broker, a steady cigarette smoker and moderate drinker; no specific history; catches cold readily. Came to the office on August 30th last, with the history that five days previously he had contracted a severe cold. The following day he felt so sick he had gone to bed, and since then had been suffering with chills, fever, sweats, severe pains in his back, limbs and joints, becoming steadily worse. On the fifth day he came to the office; he had a temperature of 104 F. and a pulse of 132; his skin was

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clammy; he was very weak, looked very sick, and altogether he presented a picture of marked septicemia. There were, in addition, all the local symptoms of abscess of the septum. The pain was intense and throbbing. Both nostrils were completely occluded, the nose was large and the alae bulging on both sides. The mucous membrane was loose, the tumor boggy to the feel, and fluctuation was easily made out. As he came from quite a distance, and was so very weak, I sent him to a hospital near by. The infected area was cocaineized, and although there was no doubt of the existence of free communication between the abscesses on either side, yet, to make sure of thorough evacuation and free drainage, both sides were incised by a nearly horizontal cut about $1\frac{1}{2}$ inches long, and a vertical cut $\frac{1}{2}$ inch, as far back as possible. The abscess cavity was then irrigated with peroxide of hydrogen, and subsequently with a warm carbolic solution, 1-80. A strip of iodoform gauze was inserted in either side and pushed upward and backward for a considerable distance, where the abscess had dissected up and separated the mucous membrane from the bone. Relief from the pain in the head and other local symptoms was immediate. By the next day the temperature had fallen to normal and all septic symptoms had disappeared. One strip of gauze was removed, and the following day the other strip was taken out. Prompt healing took place, and there was no return of any of the symptoms. The patient left the hospital on the third day and was instructed to observe the discharge from the nose. Five days after the operation he returned to the office. The septum appeared normal. He brought with him a small quadrangular piece of bone with necrosed edges and resembling one of the plates of an ethmoid cell. I have recently tried to communicate with this patient, but learn that (unfortunately, for my satisfaction) he is abroad.

The feature of this case to which I desire to call particular attention, is the occurrence of marked symptoms of septicemia. This is not usual, I believe. The etiology is not clear in this case, no explanation being found beyond an antecedent coryza. Septal abscess is most often the result of trauma, with or without the formation of hematoma.

Ballenger * reports a case following the removal of a septal spur. Freeman † reported six cases of hematoma, three of which became purulent. In all of these cases there was a free communication between the collections on both sides of the septum. In a paper read before the Laryngological Section of the New York Academy of Medicine in February, 1899, Waterman reports three cases, one of which was bilateral with no communication between the two sides. A number of cases are reported by Labinski, ‡ Wagner, § Delevan, § and others. From these it appears that the exciting cause is often obscure—traumatism, infectious fevers, and metastases from other neighboring pus foci having been brought forward as the most likely cause. In the case just reported, the question arises as to whether, in view of the discharge of a plate of bone resembling the ethmoid in structure, the infection did not start in this region. It is also stated that in most cases the abscess is unilateral and confined to the cartilaginous septum. In this case it was bilateral, and both cartilaginous and bony septum were involved.

ABSCESS OF THE EPIGLOTTIS.

CASE 2.—The patient, Mr. H., aged 34 years, merchant, came to me on August 11, 1902, complaining of pain on deglutition, difficulty in breathing, thick and difficult speech, and a sense of swelling in the throat. He is a smoker, drinks moderately; no specific history. He is a gouty subject, and has suffered from repeated attacks of quinsy. His statement, when he presented himself, to use his own words, was, "I think I have another attack of quinsy, but it seems to be displaced downward." These symptoms had lasted for two days before seeking medical aid. The only etiological factor besides gout was a slight coryza. Examination showed the anterior chain of cervical glands on both sides of the neck swollen and tender, more so on the left, corresponding to the position of the abscess. He had a temperature of 100.5

* *Memphis Lancet*, March, 1899.

† *Laryngoscope*, October, 1901.

‡ *Deutsche Med. Wochenschrift*, Sept. 9, 1901.

§ *Archives of Laryngology*, Vol. I, No. 1.

§ *Archives of Laryngology*, Vol. IV.

F. and a pulse of 90. The laryngoscope revealed a mass at the base of the epiglottis filling up most of the glosso-epiglottic fossa, pointing upward and originating apparently at the base of the anterior surface of the epiglottis a little to the left of the medial line. The epiglottis was displaced backward and pushed somewhat toward the opposite side. The mass was about the size of a small walnut. The epiglottis was injected and slightly swollen, the edge, however, being fairly sharp. There was considerable inflammation of the surrounding tissues, but no edema and no involvement of the larynx. Operation was performed without delay and without an anesthetic. An attempt was first made to incise the abscess with a straight knife, but it was found impossible to puncture it low enough down to secure a thorough evacuation and drainage by this means. A sharp, curved aneurysm needle was then tried. With the guidance of the laryngeal mirror, the needle was thrust into the base of the swelling on the left side and then withdrawn with an upward motion, thus tearing the tissues a little. Through the opening thus made, the pus found free exit. Relief was instantaneous. Subsequent treatment consisted of a hot gargle at frequent intervals and in the application of ice to the glands. The patient left the hospital two days afterward, and by the 18th all swelling in the glands had disappeared. A recent examination which was made showed an absolutely normal condition, without any evidences of his former trouble.

The interesting feature of this case I take to be the extensive involvement of the cervical lymphatic glands. This, so far as I have been able to learn, is not usually attendant upon epiglottic abscess. As to the precise point of origin of epiglottic abscess, writers differ. Zublinski* and Caz† report cases of phlegmonous inflammation of the glosso-epiglottic fossa, and appear to think that abscess of this region originates in the loose connective tissue on the floor of the fossa. Howe‡ reports a case in which the abscess developed on the interior surface of the epiglottis. Abscess of the lingual

* Deutsche Med. Wochenschrift, Feb. 23, 1899.

† Archiv. für Laryngology, Band VIII, Heft 2, 1898.

‡ N. Y. Med. Jour., 1889, p. 628.

tonsil, according to Swain, Saminsky and others, is not so uncommon, and the epiglottis, from its relation to the lingual tonsil, is prone to partake of inflammatory processes of this tissue. Chamberlain * reported a unique case of cold abscess, in which the whole membranous covering of the epiglottis was undermined. In the writer's case, the origin is believed to have been at the base of the epiglottis. As to etiological factors in general, typhoid fever, hot fluids, foreign bodies, and extension from neighboring parts are mentioned. In one reported case only, that of Fredet,† there was an extensive edema of the glottis with a fatal result. As a rule, however, comparatively slight laryngeal involvement is noted.

54 East Thirty-fourth Street.

* Medical Record, 1891, p. 427.

† Union Medicale. 1885, p. 1068.