CHICAGO LARYNGOLOGICAL AND OTOLOGICAL SOCIETY.

Meeting of March 3, 1919.

THE PRESIDENT, DR. ELMER L. KENYON, PRESIDING.

Syphilis of the Throat.

DR. N. SCHOOLMAN presented a lady, twenty-four years of age, who had been married for nine years. She had one child, who died at the age of three months of convulsions. Subsequently she had a miscarriage at four months. She stated that she was well until about six months ago, except for an injury to her leg which occurred in childhood. At the time of presentation there was quite a marked pathologic condition in her throat. The soft palate was almost adherent to the posterior wall of the pharynx, and she was entirely unable to breathe through her nose. The Wassermann reaction was positive.

DISCUSSION.

DR. L. W. DEAN asked if anyone had ever had even fairly satisfactory results in operating on these cases after the stage of cicatrization had been reached?

DR. H. L. POLLOCK said they had had three or four similar cases in the last three or four years. They did not operate on any of them until they got a negative Wassermann test on the blood and spinal fluid. They operated on them in different ways, turning a flap backwards into the nose and trying to make an adhesion with the flap they separated from the posterior pharyngeal wall and suturing it through. In the first, two catheters were used into the nose for several weeks, and they gradually grew together. In the other two they used an obturator. Every one of the four cases went right back into the same condition they were in before operation. He

had seen several operated previously and every one of them gave an nil result.

In one case they used the tonsil from either side and thought if they could get the mucous membrane over, that would keep it open.

DR. A. M. CORWIN remembered a case which he tried to remedy with the cooperation of the late Dr. Hugh Ferguson. The lad fortunately had his tonsils, for at that time these organs were not being slaughtered as they are today. They turned one of these tonsils partly out and attempted to sew it in place posteriorly in the wound, hoping that it would become adherent in the palatopharyngeal angle, to block the scar retraction as an island of new epithelialization. They thought for a time this was going to be successful, but it sloughed out and the condition was quite as bad as before. He thought, however, that it could be done with very great care and good technic.

LT. COL. WISHART (Toronto) had not had any better luck with his cases. He said the thought passed through his mind that in the facial work being done in London at Sidcup they had been using a stout dental preparation to implant in the face which, covered with skin graft, allows new epithelial surfaces to form. They had been accomplishing a great deal with that. He wondered whether something of this kind could not be used in these cases. Of course, there was the great difficulty of keeping it in place, but that could be overcome and it would probably prevent shrinking. It occurred to him that something of that kind could be attempted.

Sarcoma of the Tonsils.

DR. L. W. DEAN said that for a number of months he had had in mind reporting this case of sarcoma of the tonsil. He felt justified in reporting any case of sarcoma of the tonsil because of its extreme rarity. It was the only case of sarcoma of the tonsil which he had had. He doubted that anyone would see in a lifetime more than two or three such cases, as up to the present time only about eighty cases of sarcoma of the tonsil had been reported. In this series of cases the one early symptom had been the feeling of a foreign body in

the throat and of some obstruction. Those cases that had been observed after involvement of the extratonsillar tissue had complained of pain. His case was particularly interesting because the patient was under observation for three years without any apparent metastases, dying at the end of that time from a pneumonia which followed influenza. There was no postmortem, so he may have had metastatic growths which were not suspected.

The patient was a man, seventy years of age, and most irritable. He was well nourished for a man of that age. He came in simply complaining of a mass in his throat. The first examination showed several egg shaped, perfectly smooth, light colored masses about an inch in length, growing from the right tonsil. He would not come into the hospital at any time. All that was done for him while he was under observation was to remove these masses as they appeared. The microscopic examination was first made by the pathologist in the University Hospital and confirmed by Albert from the Department of Pathology. Since then different pieces had been examined by two other competent pathologists, and all made the diagnosis of sarcoma. This man in the course of six months or so developed the same type of growth on the left side. They did something they did not very often do. They enucleated his tonsils, using the ordinary procedure without having him stay in the hospital, but they did have him in the immediate neighborhood of the hospital. After removal of the faucial tonsils there was no recurrence in the fossæ of the tonsils. The recurrence began on each side of the lingual tonsil adjacent to the faucial tonsil and extended to the midline. The patient was under their observation for three years. The last time Dr. Dean saw him he came into the clinic, and some one of the assistants removed another crop of these growths. A specimen exhibited was only about one-third of the tumors which were removed during the three years.

In a review of the eighty cases reported he found that those cases which were operated early with enucleation of the tonsils had given a good prognosis. He had always felt that if we could have induced this man to come in and have proper dis-

section of the lingual and faucial tonsils, at least early in the course of his disease, that the whole condition might have been obliterated.

DISCUSSION.

DR. A. M. CORWIN said that a number of years ago he reported offhand to this society a most remarkable case, which Bergeron might remember, as he was associated in the same suite. A strapping big Westerner came to Chicago with terrible griping colic referred to the pit of his stomach. At the time Dr. Corwin saw him he was anasarous. He had definite kidney findings, indicating active destructive processes. There was no syphilitic history in the case—it was before the days of the Wassermann reaction. He had a growth, melanotic in character, in his left tonsil, which extended down to the side of his tongue and over onto the base, involving the lingual tonsil, where a round tumor interfered considerably with his swallowing. It was a round, firm affair, as big as a small hen's egg, which bled freely. He had difficulty in eating, difficulty in swallowing, and was anasarous. His heart was dilated and revealed a valvular leak.

There was nothing to do but to remove the growth at the base of the tongue. By injecting with adrenalin and cocain, and following that with alcohol, they were able to remove it without hemorrhage. The whole lingual tonsil was affected with these melanotic sarcomatous growths, which proved to be a round cell sarcoma. They painted it with strong silver nitrate every day with the hope of keeping down the secondary infection. There was already a large glandular involvement at the angle of the jaw, evidently an acute infection. At that time Wright of England had been using amylopsins and trypsin on sarcoma, and the patient was given hypodermics of amylopsins and trypsins, and they were also given internally, though this was not recommended. The patient decided to go to Kansas on his way home to die. Because of his tremendously unfavorable condition, there was not a doubt in Dr. Corwin's mind but that he would die. Dr. Billings also made an unfavorable prognosis, with the diagnosis of probable sarcoma of the small intestine and of sarcoma of the base of the tongue. Dr. Corwin corresponded with the pa-

tient's physician after he went home to Montana, and some time later received a long letter saying that the patient had passed a large mass per rectum, following which the urine cleared up, the tongue and tonsil condition cleared up and there was not a remnant of the growth left. He had gained weight and was back at work, evidently in fine shape, as healthy and strong as he had ever been.

DR. CHAS. H. LONG related in connection with this report a case he had some years ago. A young boy, eleven or twelve years old, was brought to a hospital to have tonsils and adenoids removed, which was done. He intended leaving the hospital within a couple of days, but owing to postoperative hemorrhage he was there six weeks. The tonsil and adenoid tissues were examined by Dr. Zeit of Northwestern Medical School, who reported sarcoma. Because of the unfavorable prognosis, Dr. Long advised roentgenotherapy. His associate, Dr. W. F. Coleman, who specialized in electrotherapeutics, suggested the use of a small X-ray tube specially designed for directing the rays into the throat. They gave several exposures, but every treatment seemed to increase the hemorrhage and cause headaches, and the mother decided to terminate treatments and allow the disease to continue its course. He saw the boy occasionally during the year, and, as the growth increased in size, he gradually grew worse with a total nasal obstruction. The tumor, commencing in the adenoid region, continued forward, pressing the contents of the orbit and the antral wall before it, so that the left eye was very much projected, and the nasal septum was forced to the opposite side.

The speaker was called to the house very early one morning—as the boy had experienced a severe attack of coughing and choking and an extra tongue seemed to have made its appearance. Looking into the mouth he noticed that there was a long, dark colored piece of flesh about the size of the little finger lying to the outer side of the tongue. Examination proved it to be one of the branches of the nasopharyngeal tumor. He got permission to remove a portion of this and had Dr. Zeit examine it, and his report was that it was a fibroma. When he was certain that it was a simple growth and not a sarcoma, he decided to remove it. The body part

of the growth was so large that it was impossible to take it out in any way except through the mouth. An incision was made in the median line through the soft and hard palate, after a preliminary tracheotomy had been performed, and a growth the size of a man's fist was removed.

It was very difficult to get around the pedicle. The roots seemed to extend in many directions, into the pterygoid fossa, mouth and antrum. He took a snare and broke the mucous membrane around the tumor, and then was able to remove it by the aid of curette and fingers.

A very successful result was obtained. The boy was now nearly sixteen years of age; he still saw him occasionally and everything was going nicely. He conferred with Dr. Zeit regarding the difference in the two reports of specimens of tissue examined by him and was informed that in the early stages of these growths it was impossible to differentiate round celled sarcomas from round celled fibromas, therefore, when this boy's tonsils and adenoids were removed, it was impossible to distinguish between sarcoma and fibroma.

DR. N. SCHOOLMAN thought it would be of interest to report a case that attracted considerable attention at the Infirmary recently. A man came to the hospital complaining of very severe headaches and presented a paralysis of the muscles of the right eye. He first came to the Ear Department and was referred to the Eye Department, and while under observation there developed over the right frontal sinus a large, painful, fluctuating swelling, with extensive edema of the right eyelid, entirely closing the eye. There was some tenderness over the left frontal sinus and some slight edema of the left eyelid. His nose on the right side was fairly free; on the left side it was occluded by a mass which would bleed on the slightest examination. The right frontal sinus was opened by a Killian incision, and it was found that the anterior wall of the sinus was necrotic and discharging considerable pus; the intersinus septum was necrotic and pus flowing from the left to the right sinus, so the septum was taken out and both sinuses converted into one large one. A large catheter was passed through the right sinus into the nose. A remarkable thing about this case was that the sinus would almost fill up over night with soft bleeding granulations and the catheter in the nose would be-

come anchored. The pathologic report by Dr. Lane was that it was a rapidly growing carcinoma.

DR. H. W. LOEB (St. Louis) had seen two cases of sarcoma of the tonsil. In one the diagnosis was not confirmed, because the patient refused any sort of operation. The second case was a woman about sixty years of age, who stated that the mass had been growing for three or four years, and within the previous two months there had been considerable swelling in the anterior cervical glands. A small portion was taken off for diagnosis and the pathologist reported a fibrosarcoma. In view of the fact that the growth was so large it was found necessary to make an incision across the cheek from the upper angle of the mouth. This made it quite easy to remove the growth. After this the cervical glands were removed. The case remained under observation for three years without recurrence, which of course was a surprise, in view of the fact that the glands were involved at the time of operation.

He was particularly interested in Dr. Dean's case.

DR. OTTO STEIN reported a case that came under his observation about twelve or fourteen years ago, in which he dissected out a tumor mass in the case of a boy ten years of age. He apparently had a sarcoma in both tonsils. Dr. Stein's diagnosis before any section was made was sarcoma of the tonsils. He was not doing very good dissecting operations at that time and dissected this one under local anesthesia with a great deal of difficulty. He thought he did it very poorly at the time, but it evidently was a very good method. Sections showed the growth to be a round celled sarcoma. He dissected the entire mass, which was about the size of a walnut, from the left tonsil. When he got through with the left tonsil he was tired out and did not care to tackle the right one. There was no particular bleeding at the time. He kept track of this boy through his physician for several years. He had no recurrence on the operated side, and the side not operated cleared up spontaneously.

DR. DEAN (closing) thought from the discussions one important factor could be deduced, namely, that in so-called sarcoma of the tonsil, the prognosis was good, or least fair, if operated early.

*Paper: A Case of Chronic Bilateral Abductor Paralysis of the Vocal Cords (Cricotrytenoidus Posticus) Result of Goiter Operation.

A. M. CORWIN, M. D.

DISCUSSION.

DR. L. W. DEAN stated that the case which he had was almost identical with this case. He remembered the history very vividly, though it must have been some five or six years since the patient was under his observation. What impressed him most with the case was that the patient was a young lady, about twenty-eight years of age, well educated, a school teacher, with otherwise perfect health, a girl one would dislike to lose in any community. This young lady was operated on for a goiter, and immediately following the operation had a bilateral abductor paralysis. It was about three months after the operation that he saw her. She came to him particularly because of attacks of dyspnea. This patient did not have the good voice which Dr. Corwin's case had; nevertheless she had a fair voice. Examination of the larynx showed an absence of abduction on each side. During deep inspiration there was only the slightest change in the glottis. She had also some expiratory dyspnea. She had attacks of spasm of the adductor.

Dr. Dean was inclined to view the case as one where there was a paralysis of the abductors in accordance with Semon's law. He felt also, because experimental stimulation of the central end of the pneumogastric would cause a spasm of the adductors on the opposite side, that possibly it was not only a paralysis of the recurrent laryngeal but also an irritation of the pneumogastric. At any rate, that was the only satisfactory explanation that they could give for the spasms of the adductors which accompanied the paralysis of the abductors.

After studying her for several weeks and keeping her in the hospital and observing these attacks of dyspnea, they advised a punch operation on the cords. He thought to obliterate sufficient tissue to give her a good breathing space would result in the permanent loss of voice. The operation was refused. His advice then was that in case she had the slightest

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*See page 781.

dyspnea she should immediately go into a hospital. This she did, but unfortunately the hospital was not prepared to do a rapid tracheotomy and she died from the dyspnea, the result of laryngeal obstruction. So far as he was concerned, he felt that Dr. Corwin was justified in advising the destruction of one cord, even with the resulting loss of voice.

LT. COL. WISHART had been exceedingly interested in Dr. Corwin's case, because at the present moment they had in the military wards in his own city a case of similar nature, but which apparently differed considerably in the symptoms. The patient was a boy of about twenty-one. Dr. Wishart did not know anything about the previous condition of his thyroid gland, but he knew the patient was operated upon and that the thyroid was removed and subsequently he had lost his voice. He appeared also to have had some chest condition, supposedly tubercular, and was invalided back to Canada without any treatment of his throat, presumably to be treated for tuberculosis, the idea being that he probably would not live very long. His breathing got rapidly worse and he suddenly developed so great an amount of difficulty that a hurried tracheotomy was required. So much scar tissue had formed that now the larynx was twisted, and it was impossible to do more than get a fleeting glimpse of his vocal cords during examination. They could not get any view at all of the larynx with the suspension apparatus. After the patient wore the tracheotomy tube for some time they took it out and tried intubation and then were obliged to do the tracheotomy again. As soon as the intubation tube was taken out he began stertorous breathing. They then split the larynx and dissected out one vocal cord. For some six weeks after that operation he had marked relief in his breathing, and they hoped that everything was going to be satisfactory, but the difficulty reappeared and they have had to put in a tracheotomy tube again. They were in profound difficulty in regard to this young man. He was afraid to leave the hospital because he feared he would get into circumstances at home where he could not be helped, and they really did not know what to do with him, how to give him permanent relief and make him a decent member of society. His chest had markedly improved and he was no longer confronted with immediate dissolution because of a

tuberculosis. Therefore, this case of Dr. Corwin's was exceedingly interesting to the speaker, and he hoped to hear how somebody could relieve this condition.

DR. CORWIN asked why the boy had a return of the dyspnea after the operation.

LT. COL. WISHART said probably on account of the scar. They got only a very small view of the larynx at any time. He thought that probably one would not succeed in seeing it under three or four examinations. It was so much twisted that one could not get a view.

DR. ROBERT GOOD said in regard to Dr. Wishart's case, since the pathology in this case was scar tissue and contradiction, he thought one ought to concentrate one's thought on the scar tissue. In a case like this if the scar tissue was resected on one side only under local anesthesia in an effort to relieve the pressure on the nerve, it would be at least worth trying before resorting to such a procedure as resecting the vocal cord. An anastomosis with the hypoglossal might be possible.

DR. WISHART said that they did that prior to resection of the cord. They cut down through the scar tissue on the left side, but it was so dense that they could not see where the nerve was.

DR. E. L. KENYON supported Dr. Good's suggestion. Since the interior of the larynx was anatomically unimpaired, would it not be possible to produce intentionally a complete paralysis of one cord by a reoperation on the neck? This would serve to throw one cord outwards into the cadaveric position, thus supplying sufficient breathing space, providing the cord on the opposite side did not persistently overadduct beyond the median line. If the condition produced by completely paralyzing one cord persisted, the voice would eventually become normal and remain so. If, however, the overadducting cord, by overlapping the median line, should still prevent free breathing, that cord could by operation on the neck be caused to become completely paralytic, and so take the cadaveric position also. Thus the breathing space would be rendered sufficient, but the voice destroyed. This manner of procedure would seem to present more hope of preserving the voice, as well as providing breathing space, than operation in the larynx, with its danger of scar tissue retractions and its necessary loss of voice.

DR. WISHART said, in answer to Dr. Kenyon's question, that he thought the twisting of the larynx had a great deal to do with the condition.

DR. SONNENSCHNEIN mentioned a case he recently saw which had been operated at the County Hospital by Dr. Boot. The patient was a young woman who had had a goiter operation followed by a complete bilateral abductor paralysis. A tracheotomy had to be done. Dr. Boot very carefully cauterized with the galvanic cautery the upper surface of the cords, relying on the scar to draw the cords from the median line. The result was that there was a very small slit between the cords. She still had the dyspnea, but she was up and about, and the tracheotomy wound had healed.

DR. CORWIN, closing, said it was gratifying to have the various expressions coming out of the experiences of the other members, especially that from Dr. Good. This was not a case to be taken lightly or handled under snap judgment. The future comfort and usefulness of this patient depend on a very slight variation of procedure and certain refinements of technic. He saw no reason why cutting the cord in two in the middle and allowing the ends to retract, would be objectionable as far as future scarring was concerned. One doctor told him that the dissection of the cord was submucous. In that case there ought to be a minimum of scar tissue. He expected in the future to have something to say about this case. As to the dissection of the recurrent nerve and its anastomosis with the superior laryngeal, he did not know whether it had ever been done or attempted. From the small size he should consider such a procedure impracticable. The idea of dissecting out the nerves from the mass of scar tissue in which they were both imbedded was hardly to be considered seriously. The high position of the scar and its extent also contraindicates the attempt to cut down on one or both recurrent nerves to sever them completely in order to bring about a cadaveric position of the cords under complete paralysis. This would seem to be desirable since at the present time the cords were under complete adduction, showing that this function of the recurrent was still in force. The abductor function was usually the first to be destroyed under pressure influences upon the nerve.

*Paper: A Study of One Hundred Cases of Suspected Chronic Nasal Accessory Sinus Disease with Report of the X-Ray Findings.

H. C. BALLENGER, M. D.,

CHICAGO.

DISCUSSION.

LT. COL. WISHART asked if Dr. Ballenger said that one case of polyp of the antrum showed a shadow where the pedicle entered the antrum. His experience with these cases was that there was no shadow in the antrum. He was referring to those cases where there was a pedicle arising from the outer wall of the antrum and passing into the nasal fossa without any nasal involvement or considerable involvement of the antrum wall. In those cases he had not found a shadow.

DR. H. W. LOEB said that he got the impression that the essayist could read a radiogram for diagnostic purposes much better than he could. From a very considerable experience with radiograms the speaker found there was very little to be achieved except by anterior views. In the anterior view the plate comes nearer to the sinus in question than in any other way. He had not been able to detect a difference in the shadows made by abnormal and normal sphenoids by an anterior view. Some years ago, when working with Dr. Carman on some experimental work, he suggested that the sphenoid was nearer to the palate than any other part of the head. Therefore, if a picture could be taken from the palate side it might show differences. He also mentioned this to another radiographer. However, it was only about two years ago that he succeeded in getting one who would take enough interest to experiment with it. In the meantime he thought someone else was doing the same thing. They succeeded in getting a thick celluloid film, which was placed in the mouth and held against the palate by the tongue, and that showed the succession of sinuses very well. They did not have a pathologic case that showed anything until about six months ago. In that case they succeeded in getting a fairly good view of the

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*See page 894.

infected sphenoid. He hoped some other members would try this method and thought it would show not only pus in the sphenoid but in the ethmoid. As far as he was concerned, he did not believe that it was possible to detect anything by any lateral view, and considered an anterior view of the sphenoid without any value as far as such differentiation was concerned.

DR. ELMER L. KENYON said that such beautiful X-ray work was done in respect to the teeth that it had been a question in his mind whether for the ethmoid cells a small film might not be introduced into the middle meatus and the ray passed in through the orbit. There seemed to be nothing impossible about this, and it would give a true picture of the ethmoid region.

DR. A. M. CORWIN asked Dr. Ballenger whether he had checked up these plates with the ordinary method of transillumination. Both of these methods had been unsatisfactory at critical times in his experience, and he wondered what Dr. Ballenger's experience had been in following both procedures in this series.

DR. ROBERT GOOD said regarding the cases that were filled with mucous or polyps in the sinus where the radiograph was negative, if transillumination was used a positive result would be obtained. He thought transillumination was of more value than the X-ray in many of these cases.

DR. BALLENGER, referring to the case of polyp in the antrum, said he could not prove it came from the antrum, but the pedicle had to what he assumed was the nasoantrum opening. It might have come from the ethmoid.

He had nothing else to say except in reading a series of plates there was frequently an element of doubt. Usually with exposures at various angles one could arrive at a fairly definite conclusion.

In answer to Dr. Good, he stated that transillumination had not been made as a routine method in these cases. He had not a great deal of faith in transillumination, except when negative, unless the transillumination revealed a dark antrum on one side and the visual examination revealed pus emerging from beneath the anterior portion of the middle turbinate on the dark side. Barring that, he believed little value was attached to the procedure.