

DR. CARTER inquired whether the thymus is not frequently enlarged in lymphatic leucemia.

DR. MUNDAY, replying to Dr. Carter's inquiry about the thymus, said that he had been looking up that question and that it did not seem to be given as one of the diagnostic points.

In regard to Dr. Cocks' question about Vincent's angina and the stomatitis, Dr. Munday said that had occurred only recently and did not exist at the beginning of the trouble. An examination has not yet been made to determine whether or not it is a case of Vincent's angina.

Laryngectomy Combined with Gastrostomy. DR. FRANK TOBEK.

The feeding of a patient who has been subjected to an extensive laryngectomy, especially if complicated by a partial resection of the pharynx, is attended by difficulties and dangers. If a permanent tube is introduced through the nose into the esophagus its constant presence not only causes the patient much inconvenience but also interferes with the healing of the wound through the fact that the tube, which cannot be kept aseptic, rests against the suture of the pharynx. This suture becomes infected and gives way, and not rarely necrosis results. The infection spreads downward, and the tracheal stump which had been sutured to the skin, may separate from it here and there. It may then happen that even after the patient has successfully rallied from the operation as such, he will aspirate secretions and succumb to a pneumonia.

If, on the other hand, the stomach-tube is introduced every time the patient is to be fed, the conditions are, if anything, still worse, for the introduction of the tube, done at least occasionally, by the nurses, may easily result in perforation of the suture line. I have experienced such a case in which the tube had been pushed through the suture line of the pharynx, and the accident was not noticed until the fluid food that was poured into the tube ran through the dressings into the patient's lap.

In the case here presented I overcame these difficulties in a very simple way. When the laryngectomy had been completed I performed a gastrostomy according to Witzel's method in order to administer the food through the gastric fistula. The case was a far advanced one, in which not only the whole larynx and epiglottis had to be removed, but also the anterior wall of the pharynx had to be resected to the extent of three or four centimeters and a portion of the base of the tongue likewise had to be excised. Under these circumstances the conditions for suturing the pharynx were, of course, very unfavorable. Nevertheless, although on the sixth day the presence of mucus in the wound gave proof that a portion of the wound had given way, the after-treatment, particularly as regards the change of dressings, was so simple that the difference between this case and former ones was marked.

The healing of the wound progressed without any disturbance. The pharynx fistula closed after $4\frac{1}{2}$ weeks and the patient could again swallow both fluid and solid food. At the same time the gastrostomy tube was removed and the gastric fistula closed promptly, without leaking a drop.

The addition of a gastrostomy to an extirpation of the larynx does not add very materially to the severity of the operation; for the laryngectomy is done, as I have lately always performed it, under local anesthesia. In

such advanced cases the severe dyspnea forbids operating under general anesthesia, unless one has chosen to perform a preliminary tracheotomy. This, however, one will prefer to avoid in the interest of asepsis. For local anesthesia I employ a $\frac{1}{2}$ per cent solution of novocain with supracricoid deep injections being made to anesthetize the trachea and larynx, and superficial ones for the overlying soft parts. The deep injections are four in number on each side. The first, to block the superior laryngeal nerve, is made between the hyoid bone and thyroid cartilage into the thyro-hyoid membrane two centimeters from the median line. The incisure of the larynx serves as a guide to the median line. The other three injections are made at points farther down to reach the posterior part of the larynx and trachea. For these a curved needle is of advantage. One of these is made behind the cricoid cartilage, another below the isthmus, and the lowest one in the region of the jugular notch. At least 5 ccm. of the solution is injected at each site, the injection beginning at the deepest spot and being continued as the needle is drawn forward. Then superficial injections are made corresponding to the lines of incision. I employed a T-shaped incision. The operation itself is made according to Gluck's well known method, with transverse division of the trachea and suture of the tracheal stump to the skin in the jugular.

When the laryngectomy has been completed, the patient, who now breathes again with perfect ease, can readily take an inhalation narcosis through the tracheal opening for his gastrostomy. Of course it is also possible to perform the gastrostomy under local anesthesia.

This little addition to the technic of laryngectomy, I feel sure, will prove to be of good service in many difficult and extensive cases.

DISCUSSION.

DR. FREUDENTHAL said that he saw the patient early in the spring. At that time there was a mass of tissue which was not absolutely characteristic of malignant growth, and it did not appear very large. He advised removal of a piece for examination and explained what would be the result if it proved to be malignant. A piece was removed under suspension laryngoscopy, and during this procedure he saw how large the mass really was. Large pieces were removed, as the patient had asked that the whole mass be taken out, if possible. The tissue was examined and reported to be non-malignant. However, it grew very rapidly, and within a few weeks the same procedure was repeated. Again the report was that it did not show any malignancy, although it seemed clear to him that the condition was malignant, or it would not have returned so quickly. About that time he left for Europe, and on his return in the fall the patient showed up again suffering from a severe dyspnea, and asked whether he could go to Dr. Torek for an operation. Dr. Freudenthal said that he assented to this, and was present at the operation, and had been impressed by the large amount of novocain used by Dr. Torek,—150 to 180 of a half per cent solution,—and also by the gastrostomy which Dr. Torek performed, which was an entirely new point in such a condition. If it proves as beneficial in other cases as in this one it should be more generally applied.

(To be continued).