

done, because it makes the patient his own prescriber, often to his own detriment, as no two patients or diseases are alike. It is a dangerous practice, and should be abolished by a mutual agreement with the pharmacists. This practice is often resorted to by designing persons for mercenary purposes. I will briefly recite a case to illustrate:

I once prescribed a mild but efficient cough mixture. What was my amazement when I ascertained that the formula had been printed and sold to many acquaintances for twenty-five cents a copy. Let, then, physicians and pharmacists live in perfect harmony, following their useful and noble professions, each respecting and protecting the other.

RETRO-PHARYNGEAL ABSCESS—WITH REPORT OF CASE.

BY REVERE H. HERROLD, M.D.

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Miss T; age, 22; native of Sweden; occupation, clerk; left the land of her nativity in August, 1893, in good health as far as can be discovered. August 29 I saw her for the first time, and received a history of previous good health, except that a week before, she was seized with choking and pharyngeal spasms. These symptoms passed away and none appeared again until the day of my visit, when I found the spasms and choking present, with cyanosis, greatly increased during the pharyngeal spasms. Examination of the throat with the finger revealed no pathologic condition, leaving thus a doubt as to what caused the spasms and choking. Anti-spasmodics were administered, which only partially relieved. The patient having stated that no passage from the bowels had occurred for several days, a cathartic was prescribed and the patient left for a time. In less than an hour I was again called, and found that the cathartic, which was a powder, was being expelled from the mouth by what at first appeared to be mucus but later was found to be pus. The attempt to swallow the powder caused the rupture of abscess, which was located very low. The patient became unconscious and remained so to the time of her death. Continuous symptoms were manifest here for about thirty-five hours. The symptoms a week previous were of such short duration that no physician was called.

There is a feature of this case which deserves mentioning. The deceased left her native land to meet and marry her lover. Having no means of her own, the lover paid for her physician and saw that she received a respectable burying.

In making a brief review of this subject it may be said that a retro-pharyngeal abscess is the result of a suppurating cellulitis in the areolar tissue between the pharynx and the vertebræ, and frequently not in the median line. It is primary or secondary according to its previous pathologic state. The cause, if primary, is atmospheric or due to some irritating substance lodged in the pharynx. The secondary form may occur after measles and scarlet fever. The inflammation of the pharynx common in those diseases extends to the subjacent connective tissue and becomes suppurative. Caries of the cervical vertebræ is, however, the most frequent cause of the secondary form. When it originates in this manner it is similar to a lumbar abscess except that its proximity to the air passages renders the symptoms more urgent and dangerous. Erysipelas, syphilis, inflammation of the inferior maxilla, cerebritis and scrofula have been followed by a retro-pharyngeal abscess. Small lymphatic glands which lie in the connective tissue external to the pharynx, are undoubtedly the original seat of suppuration in a majority of cases. Often the abscess may be seen or fluctuation felt by

the finger, but when, as in the case reported, the abscess is low, it can not be positively diagnosed. It may be said, however, that when it is due to caries it is preceded by deep-seated pain, greatly increased by movements of the head. The symptoms usually described are those of restlessness, mouth dry and hot, deglutition more or less difficult, the tongue furred. After suppuration there may be alternations of rigors and fever. The tissues chiefly involved are the submucous, and the degree of redness of the mucous surface is less than where the mucous membrane is chiefly involved. Chilliness and convulsions occasionally occur, but embarrassment of respiration is the chief cause of danger, frequently beginning early, and becoming more and more prominent as the abscess increases. Dysphagia is present, and is sometimes so great that solid foods are refused, and drinks taken with difficulty.

The disease may be mistaken for protracted laryngitis owing to the resemblance in the respiratory symptoms; the voice is feeble or indistinct from the pressure of the tumor, and the respiration sometimes whistling and impeded. Dyspnea increases as the abscess enlarges, and imperfect oxygenation of the blood follows unless the abscess is opened or it ruptures spontaneously. Paroxysms of dyspnea may occur so as to threaten suffocation. The pulse is frequent and rapid, the head is thrown back, the tongue protruded, and the patient is forced to remain in a semi-erect posture. The limbs become cool, livid. Finally death results from dyspnea. Even if the abscess ruptures, life may not be saved in all cases, as the case herewith submitted illustrates. If the trachea and bronchial tubes are deluged by the purulent discharge, suffocation follows. Another example of this is found in the records of the Bellevue Hospital. In May, 1871, a boy, age two and a half years, having symptoms of an abscess for three months, was brought before the Hospital class. The patient's head was carried sidewise, and rotation of the head caused pain. A laryngeal râle accompanied respiration. In this case the upper part of the tumor could be detected by the finger, but its location was so low that it could not be opened with a bistoury. Dyspnea came on and death being imminent, the class physician, Dr. Swezey, broke the abscess with his finger and pus was ejected, but death occurred almost immediately. Most of the cases reported are of infants and children. The case submitted by me occurred in a lady 22 years old. It can not be precisely ascertained when an abscess begins to form, nor can its duration be foretold. The duration will depend upon the rapidity of growth, and the direction in which it points; a lateral or downward extension not being so immediately dangerous to life as an anterior.

We should not lose sight of the fact that the thickness and the density of the wall of the abscess varies greatly. Thus Dr. W. C. Worthington reported a case in 1842 in the *Provincial Medical and Surgical Journal*, in which the case occurred from exposure to cold. The patient was a child and was treated for croup. It died from suffocation. In this case the anterior wall of the abscess was very thin. On the other hand, Dr. E. O. Hocken relates a case in the same journal and the same year, where the abscess seems to have been present from birth, the infant dying at the age of 9 weeks. It had always thrown back its head as if suffocating when taking the breast

The walls of the abscess were thick, firm, almost cartilaginous.

The treatment of retro-pharyngeal abscess needs no comment. It must be opened early. Where it has ruptured spontaneously speedy recovery has followed by the use of codliver oil and the syrup of the iodid of iron. Spontaneous ruptures, however, do not always mean a speedy recovery.

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OBLITERATION OF CONGENITAL PIGMENTATIONS.

Read in the Section on Dermatology and Syphilography at the Forty-fourth Annual Meeting of the American Medical Association.

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Abnormal pigmentations of the human skin have always existed and are always more or less objectionable, especially where they occur upon the exposed parts of the body. I say always objectionable, meaning the congenital ones, and I might say the artificial ones sooner or later are objectionable.

In order that we may be able to more thoroughly understand the character of the various pigmentations, I have made the following classification, which I have found to be very convenient, and which I believe answers ordinary purposes. It is as follows:

1. Elevated pigmented surfaces.
2. Non-elevated pigmented surfaces.
3. Red, elevated or non-elevated, pigmented surfaces.
4. Brown, elevated or non-elevated, pigmented surfaces.

In the elevated pigmentations, I have found obliteration much easier than in any of the other three I have mentioned. Those that are non-elevated and have a brown color, are the hardest to obliterate, and require a greater length of time for treatment, and the results are not so good.

On the other hand, the red ones, elevated or non-elevated, are removed with greater ease, especially if elevated. I believe that this classification answers every purpose in the treatment of congenital pigmentations. As to the acquired ones, I do not care at present to have anything to say. When we consider how little progress has been made in the successful treatment of these lesions, and the great number of persons possessing them together with the demands which association brings, we can not help but look with regret upon the present status of treatment. It is with horror that I look upon these deformities, and with great chagrin that we stand handicapped in giving relief to those who so often approach us with so many regrets. I believe it is the duty of every person to rid himself, so far as possible, of every characteristic that may be objectionable to his associates—warts, moles, cicatrices, tumors of various kinds, superfluous hairs, deformed nails, fingers, ears, lips, eye-lids and nose, are all of equal importance. The dentist prides himself in giving to his patient a set of teeth that is not only useful, but possessed of great beauty; the barber becomes noted in applying his artistic skill to the hair of both the head and face. With all these standing out in bold relief, we must admit our shortcomings. Possibly the remedy lies in the extirpation of these pigmentations, followed by skin-graft-

ing, as suggested by Thiersch. It may be that it is something less severe, but who is to present it? I firmly believe that where the pigmentations are large and can not be excised, and the edges brought together without deformity, that the Thiersch method offers the best results. Surely the grafts, together with the attending cicatrices, would be less objectionable than the discolored or elevated surfaces, and I am thoroughly convinced that I, myself, would resort to them, taking my chances, in preference to carrying one of these birth-marks.

If the lesion is supplied with a great amount of blood, there is but little difficulty in destroying the vessels with electrolysis. This is the treatment which I offer as the best means, so far discovered, in destroying the elevated or non-elevated red pigmentations, also where the elevations are brown, unless it be by the Thiersch method. But, where the surface is brown, so far I have been unable to lessen the deformity to any great degree by electrolysis. Thinking, perhaps, that I might be able to obliterate this discoloration, I selected a few upon myself and various patients for experiment. I decided to use finely powdered feldspar and flint. These are ground for fifty hours and used extensively in the manufacture of fine pottery. I selected needles as fine as could be had, and with great care tattooed several lesions as carefully as I could, some with flint and some with feldspar. The result was an inflammatory process, which destroyed not only the color, but also the epithelium and part of the papillary layers. In each case there was a fine white cicatrix remaining, which was smooth and a little lighter than the surrounding skin. I am not sure that either the feldspar or flint was the least beneficial. I make the statement to show what *could not* be done with them. Where the lesions are small I have had better results with electrolysis and excision than by any other procedure. If excision is to be resorted to, it should be with the greatest care, the sharpest knife, and aseptically. I have not found it necessary to use but the lightest sutures, silk worm gut being the best; often these are not used unless there is great tension to be overcome, usually having found rubber adhesive straps sufficient to keep the walls of the wound together until primary union could take place.

I have tattooed with all remedies so far suggested, and I am free to confess that not one of them is satisfactory in my hands. Possibly the fault lies within myself, more perhaps in the application than in the prolonged treatment, for I have been faithful in their application.

There is one procedure that I value above all others in cases where any congenital pigmentation, whether elevated or non-elevated, red or brown, involves any great amount of surface. It is in the use of Thiersch's skin grafts. The great trouble is in overcoming the fear of both the operator and the patient that the grafts are not always certain. This is a very great desideratum, but one which must not be overlooked. If the operator is fearless, clean and skilful, there is no reasonable doubt but that the skin will become adherent and that the surface will become smooth and lose the objectionable deformity. Even though the grafts should not become adherent, the resulting cicatrix is far less objectionable than the condition for which the operation was made. My own experience has taught me that these lesions