

## ABSCESS OF WHARTON'S DUCT: ACUTE RANULA.

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*History.*—In December, 1907, Mrs. C. M. consulted me for severe lancinating pain in the mouth and tongue. She had not been able to sleep for two nights. Speech was thick and she talked with the greatest effort. For several months she had had from time to time a swelling under the angle of the lower jaw which would cause some pain for a few days and then disappear. The present attack was the worst she had experienced.

*Examination.*—The mouth was opened only with the greatest difficulty and the tongue could scarcely be protruded between the lips. On raising the tongue a soft, rounded mass presented itself at the opening of Wharton's duct. The submaxillary gland was swollen and painful. There could be no doubt that the swelling was an abscess of the duct and the inference was that somewhere in the duct a stone had formed.

*Treatment and Result.*—After applying cocain, the abscess was opened by a deep, long incision. There was a gush of pus, followed by the ejection of a semisolid mass. Relief was almost instantaneous. The ejected mass proved to be a small stone surrounded by a soft substance having the appearance and consistency of cooked macaroni. The stone had probably formed some time before and caused the frequent swellings of the submaxillary gland by obstructing the duct. The escape of the stone was fortunate, since its removal is usually attended with some difficulty on account of its tendency to adhere to the walls of the duct.

Salivary calculi are made up of phosphate and carbonate of lime and some organic matter. They are usually spindle-shaped and vary in size. In Puzy's case the calculus was  $1\frac{1}{2} \times 1 \times \frac{1}{2}$  inches and the weight was 7.6 gm. When the duct is entirely obstructed a ranula forms and this may suppurate as in the above case. The patient in this case was well in a few days and has had no return of the trouble.

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## ESOPHAGEAL STENOSIS:

A NEW METHOD FOR THE DIAGNOSIS AND MANAGEMENT OF CERTAIN FORMS.

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Some years ago I made a brief reference to a method for overcoming spasmodic stenosis of the cardia. Since then I have had opportunity of employing and demonstrating this procedure where other methods were not available. So far as I know this method has not been previously described.

After esophageal stenosis has been determined by the introduction of sounds of proper size, it depends on the aspects of each individual case what further instrumentation is permissible. The object of passing a sound through a constricted, or partly obstructed, portion of the esophagus is either to dilate the passage, or to reach the stomach, as with the stomach-tube. The passage of a sound may in itself give information as to the nature of the obstruction.

Complete and most persistent obstruction to the passage of food, and especially to the sound, may be caused by purely spasmodic contraction. This may occur at any place in the esophagus, but perhaps most frequently at the cardia. It is considered that cardiospasm may be

so unyielding as to give rise to diverticula of the esophagus.

Frequently such spasmodic strictures will relax when continued, firm, even pressure is made with the sound, but this is not always true. Such procedure, on the other hand, is very likely to give rise to abrasions of the mucous membrane of the esophagus which, especially at the cardia, may in itself give rise to continued spasm.

There is also constant danger of perforating the esophagus, as in the unsuspected presence of carcinoma or an aneurism, or of opening of esophageal varices.

The following method is, probably, the safest and simplest for overcoming esophageal stenoses that may be overcome. It substitutes a water column for the solid sound. It is contraindicated in all cases where the simple introduction of a sound or stomach-tube is contraindicated.

Having located the site of the obstruction with the olive-tipped bougie, a stomach-tube of proper size is passed to the obstruction. The tube has an opening only at its lower end and no lateral fenestræ. At its middle is inserted a bulb. The tube is now filled with water, raised, and its upper end compressed with the fingers. Firm, even, continued pressure is now made on the bulb by the operator. A column of water is thus pressed against the obstructing tissue. If the obstruction is purely spasmodic, it will suddenly relax and the water is felt to pass from the tube, which follows instantly and easily.

If the obstruction is organic and incomplete, the water will gradually pass, by this method, through the obstructed portion, but the tube does not follow. A similar result will follow if the obstruction is partial from organic cause but is made complete by a spasm.

The safety of this procedure lies in that before the esophagus can be injured or ruptured in the presence of an unyielding obstruction, the water will return along the side of the tube. In compression from an unsuspected aneurism the danger of perforation will also be lessened.

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## IODIN IN TREATMENT OF ULCERS.

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About two years ago I began using iodine for ulcers by painting the skin up to the edge of the ulcer. This produced such good results that I ventured to use it on the surface of the ulcer itself. The effect has been excellent. I have found this application of iodine a very efficient means of converting a septic ulcer into a clean, granulating wound which heals readily. I use it in a concentrated form or a saturated solution in alcohol and apply it every day or as often as is required until the slough separates, when an ordinary dusting powder and gauze may be applied. The iodine should then be discontinued, but if any unhealthy or superfluous granulations appear, it should be again applied. It quickly changes a phagedenic ulceration into a healthy condition. I have used it in many forms of mouth and throat troubles by painting it over the surface. It will arrest and cure pyorrhea alveolaris. I would suggest the free use of it in cancerum oris. The application is usually painless. It is extremely serviceable in infected wounds.