

The author summarizes his opinion regarding these operations as follows: the section of the affected muscles produces not only a palliation, but also a cure of torticollis, susceptible of producing favorable results in all cases that are treated individually and persistently, and is incontestably a marked step in advance in the surgical treatment of spasmodic torticollis.

DISEASES OF THE LARYNX AND CONTIGUOUS STRUCTURES.

UNDER THE CHARGE OF
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Illumination.—DR. WALTER F. CHAPPELL (*New York Medical Journal*, 1896, No. 938) has devised a shade for the Welsboch light for use without a condenser. "It consists of a section of iron or aluminum tubing, nickel-plated on both sides, and of sufficient diameter to fit over an ordinary (one-piece) mica chimney or standard. A rim is turned up on the lower end of the shade and rests on the supports which carry the chimney. The opening in the shade corresponds in size and shape to the mouth of the Welsboch light, and admits of direct, steady light without any side-glare or reflections."

Amygdalotomy.—DR. J. HOMER COULTER, of Chicago (*New York Medical Journal*, 1896, No. 938), recommends dissecting the palatine folds half-way off from the tonsil with a small electric cautery; then drawing the tonsil forward and dissecting it out thoroughly to about one-half its extent, cutting this portion off, and treating the surface with a strong solution of silver nitrate. The other portion of the tonsil is to be removed in the same manner a week or ten days later.

Hypertrophies of the Turbinates.—DR. NORVAL H. PIERCE, of Chicago (*New York Medical Journal*, 1896, No. 938), practises submucous linear cauterization in the following manner: a small incision is made in the hypertrophied membrane through which a blunt, flat probe is introduced, and the membrane carefully separated from the erectile tissue beneath. Then a few crystals of chromic acid are fused upon the cup-shaped end of a sound and this is inserted into the track previously made by the probe, so as to cauterize the tissue.

Papillomatous Vegetations in an Infant of Two and One-half Years.—DR. DELIE reports (*Revue Heb. de Laryngologie, d'Otologie, et de Rhinologie*, 1896, No. 42) a case in which a well-nourished and well-colored child had no other symptoms of disorder except painful and prolonged respiration, sonorous and active in both phases. The dyspnoea was worse at night and interfered with sleep.

On inspection of the mouth the entire isthmus was seen to be occupied by papillomatous vegetations from one-half millimetre to one millimetre in thickness, and from two to three millimetres in length. They were fleshy, slightly rose-tinted, glistening, and covered with epithelium, and they were firm to the touch, which did not provoke pain or bleeding. These compact villousities occupied the entire anterior face of the soft palate, and extended for a centimetre upon the mucous membrane of the hard palate. They occupied the anterior palatine folds as well as the posterior palatine folds, a portion of the tonsils, and the lateral walls of the pharynx. The rhinopharynx was free, as well as the superior face of the soft palate. Laryngoscopy revealed similar neoplasms descending laterally toward the pharynx. The epiglottis was free, but the ventricular bands were affected with the pathological process, where the vegetations were smaller, finer, and softer, less compact, less elevated, and larger than those of the throat, entirely masked the entrance into the larynx, and produced the constriction which was the cause of the respiratory stridor. No ulceration was seen anywhere. Numerous ganglions occupied the maxillary and the hyoid regions. The infant presented no other phases of disease whatever. It had had a tenacious coryza at the age of three months, and had been querulous, pale, anæmic, and feeble up to the age of fifteen months.

Before this child had been born the mother had given birth to a stillborn infant at seven months, but she could not recall having ever been ill herself. Her eldest son, however, sixteen years of age, had some syphilitic vegetations of the anus.

The diagnosis was syphilitic vegetations. The treatment was iodized wine in progressively massive doses. Amelioration became manifest on the fifteenth day, and progressed to complete cure at the end of four months. During the regression of the vegetations it was found that the interarytenoid fold and the laryngeal face of the arytenoids had participated in part in the syphilitic neoplasia.

Laryngeal Tuberculosis.—At a meeting of the Laryngological Society of London, December 9, 1897 (*Journ. of Lar., Rhin., and Otol.*, February, 1897), microscopic specimens of a pedunculated tuberculous growth of the vocal cords were shown by DR. ADOLPH BRONNER.

"The larynx was in other respects apparently normal. The patient had been suffering from pulmonary phthisis for over two years, and had been hoarse for a few months. There was a small red, regular, pedunculated growth on the edge of the left vocal cord. This was removed with forceps. The patient died about a year later. There was no further history of hoarseness, and the larynx apparently remained normal up to death."

The Clinical Research Association reported as follows:

"The growth is composed of vascular connective tissue, like granulation-tissue, in which are imbedded the acini of mucous glands. There are one or two giant-cells beneath the mucous membrane, which are probably indicative of the tuberculous nature of the affection."

Dr. McBride referred to the German literature, where such growths were mentioned by Avellis and others as tuberculous tumors simulating fibromata and papillomata.

Recurrent Fatty Tumor of Epiglottis.—DR. P. MCBRIDE reported this case to the Laryngological Society of London (*Journ. of Lar., Rhin., and Otol.*, February, 1897). It occurred in a man, forty-one years of age, who for some six months had noticed a peculiar sound in breathing. This became troublesome on lying down. There was also some difficulty in swallowing, which required a distinct effort and was accompanied by sound. A pale pink, rounded tumor, seen behind the tongue and found to be attached to the epiglottis, was removed in part with scissors and in part with incandescent snare. Eighteen months later recurrence had taken place to the full size of the growth removed. This was removed with the incandescent snare during traction with forceps, thus enucleating the mass.

Immunity for eight years followed, and then there was recurrence again, the growth becoming so large in six or eight months as to obscure the larynx.

This growth was removed with the use of the incandescent snare, aided by traction with the vulsellum. The heated wire cut through the capsule and the deeper portion came away by enucleation. Hence Dr. McBride concludes that traction should always be exercised in these fatty tumors during the time the capsule is being burned through with the incandescent snare.

Photography of the Larynx and Posterior Nares.—DR. THOMAS R. FRENCH, of Brooklyn, describes (*New York Medical Journal*, 1897, No. 947) his present method of laryngeal and post-nasal photography with the aid of the are light, and illustrates his article with cuts of the apparatus and of various images.

While these results might fail to elicit the artistic appreciation of the novice, they are exceedingly valuable to the real student by reason of their accuracy in depicting the things as they appear from the various restricted points of observation.

Diseases of the Ethmoid.—DR. JOHN NOLAND MACKENZIE, of Baltimore, presents (*New York Medical Journal*, 1897, No. 947) a contribution to the pathological anatomy of ethmoid disease, which is illustrated with a series of microscopic drawings illustrating some of the special points to which he calls attention. This article appears, likewise, in abstract in the *Journal of Laryngology* for February, 1897.

Fatal Rapid Destruction of Nose and Face.—DR. MCBRIDE reports (*Journ. of Lar., Rhin., and Otol.*, February, 1897) this case in a house-painter, twenty-eight years of age; the lesion having begun with a scratch inside the nose. Syphilis, tuberculosis, glanders, and anoma were excluded from the diagnosis, which remains undetermined.

Papilloma of the Larynx; Cancerous Degeneration; Laryngectomy; Death.—In the *Boston Medical and Surgical Journal*, 1897, No. 3, Dr. J. L. GOODALE reports this case as one of cancerous degeneration of a laryngeal papilloma following operation.

To sum up: a male, aged sixty-four years, with negative clinical history, complained in March, 1894, of a hoarseness of several months' duration.

This was shown to be due to "a pea-sized, sessile, papillomatous growth, situated on the free margin of the left vocal cord at the junction of the anterior and middle thirds." The tumor was removed by Dr. J. Payson Clark and pronounced by the Massachusetts Hospital pathologist to be a benign growth, being "a small, vascular, and fibrous mass covered by flat epithelial cells."

After the operation the patient escaped observation until April 22, 1895, when he returned to the clinic and stated that his hoarseness had persisted more or less, but had not become marked until February, 1895, since which time it had increased rapidly. Examination showed the left cord and ventricular band transformed into a prominent, somewhat oval, reddened, roughly granular, rigid mass, encroaching on the lumen of the glottis and moving slightly on phonation. Right cord replaced by bright red granulations.

The larynx was excised *in toto* by Dr. RICHARDSON. When laid open it showed no extension of the disease below the cords or above the ventricular bands. Report of the pathologist, epidermoid cancer. The patient died a week later from pneumonia.

[In view of the result of the collective investigation of Dr. Semon, of London, in which the mass of testimony negated the opinion that these transformations occur, it is a pity that this case could not have been better studied. It is quite possible that the papilloma originally removed started upon a cancerous basis, especially as the hoarseness of which the patient complained was not relieved by the initial operation.]

The compiler has seen instances in which malignant disease of a vocal band progressing inferiorly has been complicated and in part marked by papilloma upon the same side, and has thus thoroughly deceived the physicians first called to the case.]

Extirpation of the Larynx.—At a meeting of the Laryngological Society of London, December 9, 1897 (*Journ. of Lar., Rhin., and Otol.*, February, 1897), several cases were reported.

1. An excision of the larynx and upper two rings of the trachea, for perichondral sarcoma of the cricoid cartilage, by Mr. W. G. SPENCER.

2. Total extirpation of the larynx for squamous-celled epithelioma; patient and specimen shown by Mr. LAMBERT LACK.

3. Total extirpation of the larynx, with part of anterior wall of pharynx, of posterior of tongue, and glands in neck, for squamous-celled epithelioma, by Mr. LAMBERT LACK.

Mr. Lack's operations were performed without preliminary tracheotomy, and the trachea was stitched to the lower transverse incision of the skin, so as to shut off all communication with the wound before the larynx was removed. These cases have done remarkably well. One is quite well; can whisper distinctly and is able to dispense with the tracheotomy-tube. The other one is in good health and has put on a good deal of flesh. He had previously been refused operation in three hospitals.

Mr. Spencer's patient had recovered good general health, could swallow easily, and could hold conversation with the nurses and patients in the hospital. The operation had not been performed with any other view than that of palliation.

OTOLOGY.

UNDER THE CHARGE OF
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Endothelioma of the Outer Ear.—MANASSE reports a case of the above-named disease (*Archiv für Ohrenh.*, vol. xli. p. 6). The tumor in this instance had existed for ten years in the form of a teat attached to the upper part of the auricle of an old woman; latterly ulceration took place in it. It was supposed that the growth had its origin in the lymphatics.

Epithelial Cancer of the Auditory Canal.—MANASSE also reports the occurrence of epithelial cancer in the auditory canal (*Ibid.*). The tumor was removed and permanent cicatrization took place. The typical cells in this case were cylindrical and cubical, whereas usually the cells of epithelial cancer are flat.

Endothelioma of the Middle Ear.—LEUTERT observed an endothelioma of the middle ear, originating in the lower front part of the drum-cavity. This was first considered to be a polypus, but the excessive hemorrhage induced by manipulation led to the diagnosis of endothelioma. The same observer also records his finding in the pedicle of an otherwise benign nasal polypus a nest of cancer-cells.—*Archiv f. Ohrenh.*, vol. xli. p. 64.

Sarcoma of the Middle Ear.—KUHN reports two cases of sarcoma of the middle ear (*Archiv f. Ohrenh.*, vol. xli. pp. 66-69). In the first case, a man aged thirty-three years, both ears were affected. In the course of two years, beginning with profuse suppuration and the development of malignant growths in each ear, the mouth became inflamed, the teeth dropped out, both eyes exhibited choked disks, the patient broke both legs, apparently from the acquired brittleness of the bones, and finally, with a polyuria, polydipsia, and phosphoric diathesis, death occurred.

In the second case, that of a woman aged forty-three years, it was stated that for two years the patient had suffered from tinnitus aurium, and in her left ear, for this some period, a bluish tumor had been noted. During a year before her examination by Kuhn an otorrhea had existed in this ear. A small piece of the tumor in the ear was examined, and it was found to be a melanosisarcoma. Operation was declined, and the woman withdrew from further observation.

JOEL (*Ibid.*) reports a primary sarcoma of the mastoid in a child two years old.

KÜMMEL (*loc. cit.*) claims that the diagnosis of a tumor in the region of the ear may become difficult if the growth suppurates, as the disease then resembles a simple suppuration of the middle ear or mastoid process.

BERTHOLD (*Ibid.*) claims that a choked disk is of diagnostic value only when it is permanent, in cases like that referred to by Kuhn.