

## A CASE OF SO-CALLED RECURRENT OR CHRONIC ABSCESS OF THE SOFT PALATE.

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M. P., thirty-eight years of age, is a man of large frame and robust constitution; gives no history of hereditary tendency to gout or tuberculosis, and no personal history or objective evidence of syphilitic infection or other constitutional disease, and is not addicted to the use of tobacco or to alcoholism. Six years ago, according to patient's statement, he had a severe tonsillar inflammation, which subsided after several days by a discharge of pus. Does not remember upon which side the trouble was located at that time.

After the subsidence of this attack he enjoyed a freedom from any throat trouble until the month of August, 1897, when he suffered another seizure of intense sore throat, similar in nature, he says, to the attack six years before. For ten days he endured the severest pains on swallowing, salivation, stiffness of the jaws, fever and other phenomenas, associated with abscess formation in the tonsillar region, and finally he consulted his family physician, who advised incision into the inflamed parts. Subsequently an incision was made into the soft palate above the tonsil, on the right side, where the seat of inflammation was located, but no pus was evacuated. Three or four days later relief came, as the result of the spontaneous rupture of the abscess and discharge of a considerable quantity of pus. The acute symptoms rapidly subsided, but there remained a constant annoying sensation in the throat, which the patient described as being not exactly pain, but rather a feeling of discomfort, which led to frequent expectorations and attempts to clear the throat. Occasionally he experienced a slight access of soreness, referred to the right side of the throat, accompanied by the discharge of a very small quantity of pus that he noticed in his expectoration.

At the time of his entrance into the clinic, October 7, about two months after his acute attack, examination revealed some hyperæmia of fauces and soft palate, especially on right side, with very slight enlargement of the tonsils, which appeared otherwise healthy. Near the middle of the anterior pillar, on right side, was seen the orifice of a small fistulous tract, and when probed this tract was found to extend to the depth of a half-inch upward and backward to the supratonsil-

lar space, and into the substance of the velum near the juncture of the two pillars. There was no cicatricial tissue induration, thickening or ulceration about the parts, or any adhesions of the tonsil to the faucial pillars. The opposite side appeared normal, and, apparently, had not participated in the recent acute inflammation of the right side. There was no fluctuation about the inflamed parts, and no pus escaped upon the introduction of the probe into the fistula. An application of chromic acid was made to the tract and the patient given an alkaline sedative gargle and told to report at the clinic within a few days.

Eight days after having been cauterized a second time the patient returned, complaining of having suffered considerably with his throat. The fauces and palate on the affected side were quite inflamed, and upon the introduction of a probe into the still existant fistula a quantity of whitish caseous pus exuded, coming, apparently, from the supratonsillar space, or substance of the soft palate itself.

It was then decided to apply the galvano-cautery; so at a subsequent visit, two days later, the parts were cocaineized and the entire tract laid open by means of a cautery knife and biting forceps. In the course of a few days the parts had healed and the patient felt relieved of his sore throat and disagreeable sensation.

The above described case, which I had occasion to observe in the laryngological clinic of Professor Moure, of Bordeaux, impressed me as being particularly worthy of note, from the fact that it is so typical an example of that class of cases so recently brought into notice by Cartaz, of Paris, communication made to the *Société Française de Laryngologie*, May, 1897, and consigned to a separate category among the affections of the soft palate. In a thorough research among the literature I have failed, as did Cartaz, to find any previous description of these cases, except a few cases reported by Ripault and Ruault, which, though described in the consideration of the subject of chronic peritonsillar abscesses, differ only in a certain degree from the case under consideration.

The nature of these cases must not be confounded with that of chronic tonsillar abscess, of which much has been written in recent years, and which, also, are often associated with fistulas, traversing one of the faucial pillars, and accompanied by very similar subjective sensations. It will be seen that in such cases the tonsil itself is the seat of the inflammatory process, and that there is either a collection of pus inclosed in one of its crypts, or that an existing fistulous tract leads to the seat of inflammation and gives exit to a discharge of pus, the velum palati being in no wise concerned in the pathological pro-

cess. In the cases described by Cartaz, in two of Ruault's cases, and in the one which I have been fortunate enough to observe with Dr. Moure, the tonsils were not the seat of suppuration, which resulted rather from an independent process, localized within the substance of the soft palate, or in the small cellular area formed by the juncture of the two pillars above the tonsil, and known as the supra-tonsillar space. No clearer idea can be given of the affection than is conveyed by the following descriptive lines, taken from Cartaz's original memoirs on the subject: "They are, in fact, chronic fistulous abscesses in the tissues of the soft palate at the level of the juncture of the two pillars. Fistula, rather than abscess, for the trouble provoked by that lesion is of little importance. It is a form of chronic abscess of the supra-tonsillar fossa, with extension into the velum palati, whether or not there may exist a fistula of congenital origin, a kind of small diverticulum, containing more or less high toward the base of the uvula, or, on the contrary, a true fistula, remaining as the last trace of an acute suppurative inflammation." Thus, it may be observed that it is especially from a pathological point of view that these cases appeal to our interest, and as no occasion has yet been offered wherein a thorough investigation could be made into the true pathology of the affection, we must base our theories upon our knowledge of the anatomical disposition of the affected parts and upon the facts obtained by clinical observation. It has been demonstrated by the anatomical researches of Merkel, and of others, that not rarely there exists in the structure of the soft palate a kind of diverticulum, as it were, of the supra-tonsillar space, extending upward between the two converging faucial pillars toward the base of the uvula.

It is also noted that the supra-tonsillar space, though presenting no anomaly as to its extent, may be partly or completely divided by a membranous partition into cellular spaces. Whether or not these anomalies are the remains of one of the pharyngeal fissures, as has been suggested, or what is their true origin, it is useless to theorize upon in this connection. Their existence, however, gives us some insight into the probable history and the behavior of the lesion under consideration. When we admit, as is also stated, that these diverticula, and often the supratonsillar fossa alone, contain not only cellular tissue but also lymphatic follicles in more or less quantity, being as it were an upward prolongation of the tonsillar tissue, it becomes clear that these parts may be subject to the same inflammations, both chronic and acute, to which the tonsil itself is subject. Propagation of an inflammation from the tonsillar or peritonsillar tissues may readily occur, or the disease process may originate in the glandular tissue included

in the deeper structure of the velum palati. The usual history of the case is that of a chronic or a subacute intermittent inflammation in the soft palate, following an acute peri-tonsillar abscess, which, having ruptured, left a fistulous tract in the palate, through which a more or less constant discharge of pus or caseous matter takes place. The existence of these fistulæ are most constant, and is usually the means which affords a recognition of the disease. Even in those cases where no history of former suppurative inflammation of the parts can be learned these fistulæ are present, and in these cases are, in all likelihood, of congenital origin. As in cases reported by Landgraft, Gard and others fistulæ of the soft palate are seen, not associated with any supuration, but it will be remarked that, in the majority of such cases, the lesion is bilateral and, according to the last mentioned author, can be recognized with little difficulty as being a congenital defect.

They are nearly always found opening on the anterior surface of the soft palate, near the point of junction of the two faucial pillars, and by a slit like orifice, which may only be observed by a close scouting of the region and the use of the probe, but which, when explored, will prove to be the exit of a tract leading to considerable depth toward the supratonsillar space, or upward in the direction of the base of the uvula. When this chronic abscess condition exists there issues from the fistula either a small quantity of stringy pus, or often a kind of characteristic whitish caseous matter, as is seen in chronic follicular tonsillitis. The discharge may be observed to continue more or less constant, but usually occurs at intervals of five or six days, associated with spells of slight inflammatory hyperæmia of the surrounding mucous membrane and an uncomfortable pricking sensation in the throat, which leads the patient to repeated attempts to obtain relief by expectorating or swallowing. The tonsils may be somewhat hypertrophied, and adhesions may exist between the glands and the faucial pillars; more often, however, only a chronic follicular inflammation is present, or the tonsils have a healthy appearance. It is most probable that the cases of apparent idiopathic origin are due, in reality, to primary involvement of the tonsillar tissue, even though the tonsils may have a normal aspect at the time when our attention is directed to the inflammation in the soft palate. On the other hand, the same causative factors producing tonsillar inflammation may influence at the same time, or by preference, this lymphoid tissue in the supratonsillar fossa or the soft palate, and also, when there is a pre-existing fistula infection, may be conveyed by particles of food or other septic agents, gaining entrance from the oral cavity. Whatever may be the form of the chronic abscess of the soft palate from

the point of view of their etiology, whether following in the wake of an acute phlegmonous peritonsillitis or associated with a pre-existing fistula and developing in the course of a chronic tonsillitis, or, independently, the symptoms are much the same, and of slight prominence, and may be overlooked or referred to other causes. It may lead to more serious inflammation and therefore should be radically suppressed. The indication is to lay bare the fistulous tract and the seat of suppuration throughout its entire extent. This is best accomplished by means of the galvano-cautery, using a small knife heated to red heat, after which, with the aid of an antiseptic gargle, the parts heal within the course of a few days, and no further attention is usually necessary.

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#### **Submucous Injections of Guaiacol in Laryngeal Tuberculosis.**

A brief description of treatment in a series of seven cases of laryngeal tuberculosis by submucous injections of guaiacol, with an illustration of a new modification of syringe, is recorded by Dr. James Dónelan (*The Lancet*, December 25, 1897).

The author considers guaiacol superior to other forms of therapy applied, and reports very successful results in the cases which he has had under his care.

The instrument used is made entirely of steel, and can be completely sterilized; consists of a long steel tube with rectangular laryngeal curve, arranged to carry different sized nozzles, armed with short hypodermic needles. The special feature of the syringe is the application of a graduated solid steel plunge, instead of a piston rod and leather washers, thus preventing contamination of the pure guaiacol used. The needles used are short, and inserted into a nozzle with a rounded shoulder, preventing the needle from penetrating too far.

It is in the speedy relief of the dysphagia accompanying these cases that the results of the submucous injection of guaiacol has been most manifest, and it is claimed that in this respect guaiacol is far superior to lactic acid, which, especially when associated with the curette, usually aggravates this distressing symptom.

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