

all instruments after cleansing thoroughly were steeped the previous night in a carbolic solution (one in forty). After injection the cannula was retained *in situ*, and plugged with carbolised tow, and a support to the collapsed tumour given by strapping (broad strips) placed transversely half-way across the neck.—18th: Temperature 99°4'; respiration 24; pulse 84. She is languid, feverish, and complains of constriction of the strapping; on being loosened, instant relief followed, although anterior bulging of the tumour (now tender) shows that inflammatory swelling has set in. Support by means of a soft handkerchief and a stimulating draught ordered, also a compound senna draught. The same evening a rigor, followed by sweating, occurred. Temperature 102°; respiration 36; pulse 120; effusion, pain, and swelling increasing.—19th: Temperature 103°; respiration 36; pulse 120. To have compound citrate of potash draught, and diffusible stimulants.—20th: Temperature 104°; respiration 44; pulse 132. Early rigor (6 30 A.M.); pulse small; tongue foul; face flushed; skin hot, pungent; conscious. Ordered fifteen grains of salicylic acid every two hours; removal of cannula, substitution of a rubber drainage-tube, and a poultice to bring on early suppuration. Evening temperature 99°2'; respiration 24; pulse 116; free sweating (clammy); respiration tranquil; face still flushed; escape of fetid fluid from the drainage-tube; neck suppurating.—21st: Rigor (6 45 A.M.); temperature 99°8'; respiration 24; pulse 120; bowels open twice. To continue the salicylic draught every four hours, and to take champagne.—Evening temperature 99°; respiration 20; pulse 104. Escape of half a teacupful of fetid serum and relief; face still flushed; clammy sweat. To anticipate rigor to take a full dose of salicylic draught in the morning.—22nd: Temperature 100°4'; respiration 30; pulse 104, full, regular. Complains of noises in the head (draught) and cramps in the leg; conscious; no rigor. Evening temperature 101°; respiration 30; pulse 112. Semi-conscious; discharge from neck, though less; tongue foul; has gastro-umbilical pain (solar plexus). To have an enema.—23rd: Temperature 105°; respiration 32; pulse 132. Sighing, high-pitched respiration; muttering, restless delirium since early morning; *alæ nasi* working; pallor of face; extremities cold, left leg especially, but *dorsalis pedis* found pulsating; pupils contracted, insensible. Some rhonchus on the right side; tumour tense, much enlarged, pungently hot, and dusky; orifice of wound choked with coagulum; right lobe filled and fluctuating; left lobe tense, tender, and fluctuating in upper, dull and solid in the lower, meridian. Treatment: Removal of clots; renewal of fomentation; to continue salicylic draught and champagne; hot bottles to the feet. 4 P.M.: Continuation of delirium. Death from coma. Shortly after death the cyst ruptured, discharging per ora half a pint of fetid pus; tumour extending from chin to sternum; gangrenous. No post-mortem allowed.

Remarks.—The coma was induced by the compression of the large cervical vessels, the previously high temperature being unattended with unconsciousness. A rigor thirty-one hours after the operation foretold the onset of the traumatic state; the departure of the temperature, of which a chart is annexed, from the normal is explained by the salicylate treatment, which brought it down five degrees on the third day; the morning rise on the fifth was recorded after a rigor; of these three were marked, and a fourth (unnoticed) preceded the rise to 105° in my opinion. The mechanism of effusion in this case was interesting. Twenty-four hours after the operation by either method the tumour had enlarged to within 1½ in. of the transverse and 1 in. of the vertical measurement, giving roughly an average of half an ounce secreted per hour, not allowing for that absorbed; after this, compression of effused contents allowed but little if any further secretion. The early enlargement of the cyst is due evidently to the power of effusion the lining membrane possesses, its stationary character to the process of absorption in the absence of a serous membrane being at zero. Had the one kept pace with the other, putrefaction would not have occurred; there would have been a limit to the tension. The question now arises, Did the cause of the high inflammatory action set up rest in the introduction from without of invisible germs that rendered the fluid infective? It is admitted that the exudation of serum is not infective as alike are organisms without; could then a chemical change in the exudation products leading to genuine suppuration take place as readily with antiseptics as without? Could it occur at all without the presence of micro-organisms. Occurring in an isolated country cottage,

a model of cleanliness, it would seem that there was not sufficient chance of the air containing septic matter even in a diffused form to prove effective in blood serum to make it necessary to raise the question at all. Again, if as an irritant the injection of iron, as in rodents (Wegner), is always infective, and the exudation products are thereby septic, and if the aim of our treatment, suppuration, is invariably attended with the presence of septic organisms, it seems to me that antiseptics are not indicated; if, on the other hand, the inflammatory changes that accompany the use of antiseptics are of limited extent and duration (Sanderson), our course is obvious. Yet my treatment is counselled by a great authority. The presence of septic organisms generated from without in common with the bacilli of tubercle (Baumgarten) must first be proved by some well-known and simple test before the danger signal is upheld against our surgical resources divested of an antiseptic element; if, on the other hand, we are to be guided by Professor Hueter, we must invariably use antiseptics in our practice, taking our sprays suspended to our pack-saddles, even into remote country districts, in carrying out the theory that "organisms exist everywhere, ready, whenever access is offered to them, to enter the body and to fulfil their morbid function."

Ealing.

SUCCESSFUL EXTIRPATION OF THE LARYNX.

BY WALTER WHITEHEAD, F.R.C.S.E., F.R.S. EDIN.,
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LARYNGEAL SURGERY has of late attracted considerable attention, and as the profession is somewhat divided in opinion on the respective merits of extra- and intra-laryngeal operations in dealing with laryngeal growths, I wish to place on record the particulars of a case favourable to the former procedure.

W. G.—, aged forty-six, blacksmith, was admitted into the Manchester Royal Infirmary on April 28th, 1882, on the recommendation of a medical friend, who suggested the desirability of removing a growth which he had discovered attached to the right vocal cord. The patient had suffered from extreme hoarseness, difficulty in breathing, distressing cough, and occasional paroxysms of dyspnoea, for three months before coming under observation. Laryngoscopic examination afforded a conjectural diagnosis that the growth, which overspread the right vocal cord, was of an epitheliomatous nature. The disease could only be inferred to extend beyond the range of vision by the knowledge that malignant neoplasms in that locality usually extend below the cords. Tracheotomy was performed as a preliminary measure on April 30th, the operation giving immediate, but only temporary, relief to the more pressing symptoms. A recurrence of ominous dyspnoea, which was afterwards discovered to have been produced by the imperfect manner in which the cannula had been reintroduced after having been removed for cleaning, hastened the decision to remove the disease.

On May 27th the thyroid cartilage was slit from below upwards, and the two halves held apart, when it was seen that the new formation not only implicated the vocal cord, but extended, as was conjectured, downwards, and involved the upper part of the trachea. Before proceeding to excise the diseased structures, Trendelenburg's tampon was substituted for the tracheotomy cannula, and the insufficient protective influence of the tampon against blood finding its way down the air-passages was guarded against by packing the trachea above with a small sponge. The whole of the disease, the thyroid and cricoid cartilages, and the two upper rings of the trachea, were then removed by means of scissors. The epiglottis was left intact. The skin was brought together by a few silk sutures, and the wound dressed with dry lint.

On the following day Trendelenburg's tampon was replaced by a soft rubber tube which still remains *in situ*. A microscopic examination of the growth confirmed the diagnosis as to its being an epithelioma. The patient's voice was not immediately lost; for several weeks after the operation he could express himself in monotone and could be distinctly heard at a distance of six feet; gradually the sound faded and eventually disappeared altogether. It can still be demonstrated, by means of a flame in front of the mouth,

that air finds a channel in the track of the original air passages. The patient now breathes quite freely, takes his food without inconvenience, and enjoys life as fairly as can be expected under the circumstances. The absence of any local glandular enlargement or evidence of any recurrence of the disease affords a reasonable prospect that the patient may derive prolonged benefit from the operation. The idea of introducing the artificial vocal apparatus of either Gussenbauer or Foulis was entertained, but abandoned on the grounds that no real advantage had yet been established in favour of these instruments. The preference for thyrotomy was based on the opportunity it affords for a complete inspection of the entire larynx, and the facility it gives for extending or restricting the extent of the operation to any limit necessitated by the amount of the disease. The only difficulty met with during the operation was the separation of the deeper attachments.

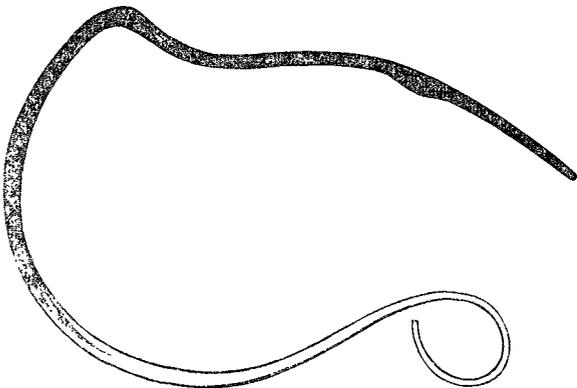
Manchester.

CASE OF PARASITIC AFFECTION OF THE MOUSTACHE.

By GEORGE THIN, M.D.

THE following interesting case which occurred in my practice is worthy of record for several reasons.

In April, 1876, a gentleman, aged about thirty, consulted me on account of loss of hair in one part of the moustache, a little to the right of the nose. He had recently returned from residence abroad, but was in good health, and very careful of his person. His strong black and handsome moustache was disfigured by a bald strip about a quarter of an inch broad, which passed from its upper to its lower border. The hairs on both sides of the bald strip were split at the ends, and were bent and withered-looking. On examining these altered hairs under the microscope, they were found to contain spores similar in size and appearance to those of *trichophyton tonsurans*. The disease of the hairs had



Hair from moustache affected with fungus growth (conidia), macerated in solution of potash, and mounted in glycerine. The dark part shows the portion of the hair in which the spores were present. Magnified five diameters.

existed, he told me, for five months. I directed him to brush his moustache twice daily with the following preparation:—Carbolic acid, one drachm; olive oil, two ounces and a half; lavender oil, six drops. In less than a month the disease had disappeared, and the bald part became again covered with healthy hairs. But the singular part of the history is to come. The disease was first observed in November, 1875. It reappeared in November, 1876, and every succeeding November until 1880 inclusive. Last November, for the first time since it commenced, it did not reappear. During the successive outbreaks the nature of the disease was verified by microscopic observation. In the attacks subsequent to the first the carbolic oil was used four times stronger than I originally prescribed it, and always with the speedy cessation of the loss of hair. The skin from which the hairs fell off remained healthy in appearance, showing no redness or scaling, or any signs characteristic of *tinea circinata* or *tonsurans* or of parasitic sycosis.

The two points that have led me to consider the case as remarkable are, first, the position of the fungus in the hair;

and, secondly, the reappearance of the disease in November for five successive years. In regard to the position of the fungus, the direction of the growth is different from that which I have observed in *tinea tonsurans*. In that disease the fungus grows into the hair-follicle between the hair-shaft and the internal root sheath, enters the shaft near the papilla, and grows outwards in the centre of the shaft. In this case the fungus attacked the free extremity of the hair, and grew downwards towards the skin. This is shown in the accompanying woodcut, which represents a drawing of an affected hair slightly magnified. In the woodcut the dark end is the free extremity of the hair, and represents the portion of the shaft affected with the fungus. The tapering extremity of the dark band in the centre of the hair accurately represents the manner in which the growth is found penetrating the shaft. Why this disease should have recurred each successive November can only be guessed. We must, I imagine, assume that some spores remained from each year to the following year, and that in November they found the conditions of growth. The parts of the hairs in which they grew were completely removed from the fluids of the body. Did they find in November the conditions of temperature and moisture suitable to their growth? The patient during these years enjoyed good health, lived in London, and led an active professional life.

Queen Anne-street, W.

A NEW INTRA-UTERINE STEM, COMBINED WITH AN INSTRUMENT FOR KEEPING SEPARATE THE LIPS OF THE CERVIX AFTER INCISION.

By J. BERESFORD RYLEY, M.D.

It will, I think, be admitted without question that dysmenorrhœa and its wide-spreading effects solicit the attention of the profession more frequently than all the other diseases of the uterus put together. Any new mechanism therefore that has for its object the further alleviation of a malady so distressing, on account of its physical, physiological, and psychological consequences, will, I feel sure, be received with that consideration which its importance deserves. The idea of making the cervix uteri the *point d'appui* or fulcrum for an intra-uterine stem,



instead of the vagina or a point outside the body as has hitherto been the case, had been present to my mind in an indefinite shape for a long time, and is only the extension of another which had for its object a contrivance for keeping separate the lips of the cervix after incision. Those who have been called upon to perform this operation and all who have written on the subject are aware and assert that a successful issue depends altogether upon the tedious after-treatment and is but little affected by the mode of operating. Dr. Atthill of Dublin, than whom no one has written more practically upon this point, says in his "Diseases of Women," "Passing the uterine sound daily for at least two or three weeks subsequent to the operation and at intervals for some time longer, I find to be usually sufficient to prevent the divided surfaces from uniting." If one will but pause for a moment to consider the almost unbearable distress to the patient and the humiliating tedium to the practitioner involved in such a proceeding, it will not be wondered at that so many should have pronounced this operation to be most unsatisfactory. I have examined the cervix uteri after operation by most of the well-known gynecologists in London and elsewhere, and have usually found that after a time its canal and outlet had contracted back to their originally abnormal conditions, and that the history of the majority of the patients was that they had had more or less relief for a few months after operation, but that the pre-existing symptoms had returned as severely as ever. Again, those who have had any experience in the application of the various forms of uterine pessaries must very often have