

**Report of a Case of Papilloma of Cord. DR. GEORGE E. DAVIS.**

Papillomata and fibromata are more frequently met with than other benign tumors in the larynx; however, even these, are comparatively rare. Occasionally, these growths may be present for greater or less periods without subjective symptoms; therefore may not be discovered unless by accident.

Sir St. Clair Thomson reports two cases of this nature. Moreover, the clinical manifestations that are present in cases of laryngeal neoplasm are more or less individual on account of the relations to the delicate voice-organs and respiratory function.

In view of the above data and the fact that this man passed through the hands of one specialist and a hospital clinic without a diagnosis, I was prompted to report his case with observations as to method of technic of anesthesia and treatment.

Mr. L. O., age 38, furrier, was seen first on Saturday, February 13. Patient gave a history of hoarseness since June, 1914. No pain, and coughed only occasionally. No dyspnea as the papilloma was sub-glottic. Examination by indirect method revealed a pinkish, globular, pedunculated tumor about 6 mm. in diameter, attached by a pedicle about 3 mm. long and 2 mm. in diameter to a median and under-surface of the left vocal cord, 2 or 3 mm. from the anterior commissure. The tumor remained sub-glottic save on forced expiration.

Treatment: The pharynx was first sprayed with a small amount of cocain solution—4 per cent and 1 to 10000 adrenalin chlor. Then the larynx was anesthetized with the most concentrated cocain solution that could be made by dissolving cocain crystals in 1-1000 adren. chlor. This solution was applied by means of a cotton wound-applicator and repeated until the anesthesia was absolute and all laryngeal reflex abolished.

As the tumor was small, situated well forward and below the glottis on the left cord—four factors rendering removal by the indirect method much more difficult according to the experience of Sir St. Clair Thomson, I was pleased when, with a single pass, I succeeded in removing the tumor in about five seconds by means of a narrow-bladed, spoon-cupped, biting stylett-forceps, operated through a canula with Schrötter handle.

Sir St. Clair Thomson makes the claim that the Mackenzie forceps enable the operator to make the best use of his tactile sensations both in seizing and removing the growth. However, I disagree with this opinion on two accounts. First: The Mackenzie forceps are clumsy and heavy in comparison with the stylett-canula forceps; and in the second place we can bend the stylett-canula forceps and so adjust the angle of curvature to each individual case to render the operative field accessible wherever the tumor may be located. Obviously this is impossible with the Mackenzie forceps.

Most authorities advise the introduction of the forceps closed, but I believe, since we are using but one eye and consequently distances and relations are harder to estimate, the tactile sensations, particularly in the technic of *seizing*, are better conserved by introducing the forceps open, as the procedure of grasping the tumor is confined to the single mechanism of closing the forceps instead of the double mechanism of opening and closing.