

of the origin and history of the symptoms. The cure is effected by so-called "suggestive methods" during the hypnotic state, the hypnoidal state and by various other "associative methods" which I shall discuss elsewhere. It is ridiculous to ascribe healing effects to psycho-analysis, which has no more therapeutic virtue than the taking of cultures or the records of pulse and temperature possess the power of curing diphtheria, typhoid fever or tuberculosis. I may also add that Freud's sexual theory of his "Angstneurosen" and of hysteria is grotesque, while his Talmudic ingenuity of "Traumdeutung" and of so-called "psychopathology of daily life" is arbitrary, fanciful and reminds one of ancient oneirology and astrology.

From this lengthy digression we may return to the hypnoidal state. How is the hypnoidal state induced? The hypnoidal state is induced by what I term the method of hypnoidization. The term is unfortunately awkward and is apt to give rise to misunderstandings, as it may convey the wrong idea of induction of hypnoidal states, by which are meant hysterical and allied conditions. This, however, is not what I intend to indicate by the term "hypnoidization." By hypnoidization I mean the induction of the hypnoidal state, which is by no means an hysterical state. Recently, Dr. Morton Prince suggested the term "hypnoidilization," which would clearly indicate the induction of the hypnoidal state. Unfortunately, the term "hypnoidization" was coined by me some fourteen years ago. The term has since passed into literature and is more often used by writers in its correct denotation and connotation, although occasionally it is apt to give rise to misunderstandings. It is, therefore, best to leave the term unchanged. There is nothing rigid about the method of hypnoidization. In fact, the method is quite elastic, it admits of many modifications. The principal object consists of bringing about the conditions of monotony and limitation of voluntary movements as well as the other conditions which I have found requisite for normal and abnormal suggestibility.

The procedure of hypnoidization is quite simple and may be described as follows: The patient is told to close his eyes and keep very quiet. He is then asked to attend to some monotonous stimulus, such as the beats of a metronome, or listen to a continuous note produced by a tuning fork, or to smell some pleasant odor, or simply to submit himself to a gentle massage in which touch and pressure are of uniform intensity. This should be carried out in a room where it is dark and quiet. Fatigue, physical and mental, especially emotional, is a favorable condition. A prolonged warm bath with relaxation is favorable. A predisposition to sleep is helpful. It is, therefore, best to make the first attempts at hypnoidization late at night, when the patient is both tired and sleepy. In most cases, darkness, quietness, repose, fixation on a bright point and listening to the monotonous buzzing of an inductorium are conditions favorable to the induction of the hypnoidal state, even at the very first attempt.

Dr. John Donley gives the following account of the method of hypnoidization:

"Hypnoidization has two things to recommend it — facility of induction and successful results. The technic is simple, — there need be no mention of hypnosis and hence no stirring up of apprehension in the mind of even the most timorous patient, — while the effects produced are comparable, in many respects at least, with those of hypnosis. It is not and perhaps cannot be maintained that in hypnoidization we possess a complete substitute for hypnosis; but so far as a limited experience (some thirty cases) allows of our drawing any conclusion, we feel that hypnoidization is quite worthy of more attention and study than it has hitherto received.

"Many variations of the particular procedure (as described above) are, of course, possible, and the one which the writer has found generally useful is the following: The patient is first placed at ease by a few minutes' conversation, during which he is instructed regarding what is about to be done. He is then requested to lie upon a couch, the head of which has been placed close to a faradic wall plate. With his eyes closed, he is directed to listen to the monotonous vibration of the ribbon rheotome and to concentrate attention either upon nothing at all or upon the particular idea or group of ideas and images suggested to him by the physician. At the beginning of the experiment, the patient may be somewhat tense and ill at ease, but a few minutes suffice to render him relaxed and to place him in the mental state to which Sidis has given the name 'hypnoidal.' It is during the continuance of this state that one may obtain information valuable for diagnosis and give suggestions useful for therapeutics."<sup>8</sup>

Once the hypnoidal state is induced by any of the various methods of hypnoidization, we can either attempt to follow up the history and the development of the malady, or we may chiefly work for the therapeutic effect and treat the present symptoms. It is, however, advisable from a purely practical therapeutic purpose to combine the two procedures, as the cure is then far more effective and far more stable. In cases when the history of the origin and development of the disease could not be traced, on account of the age or unintelligence of the patient, the therapeutic effects alone of the hypnoidal states have been utilized. The results are not as satisfactory as far as scientific information is concerned, but they are nevertheless of great benefit to the patient.

(To be continued.)

## STENOSIS OF THE LARYNX.

BY RICHARD H. JOHNSTON, M.D., BALTIMORE, MD.,

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E. McC. was brought to the Presbyterian Hospital March 15, 1908, with the following history: The latter part of December, 1907, she had laryngeal diphtheria which required intubation. She was intubated with a metal tube which she wore thirteen days. Jan. 10, 1908, the tube was removed to be cleaned, and before

it could be replaced the child ceased to breathe, so that a rapid tracheotomy had to be done. From this time on the parents noticed that breathing through the larynx gradually became worse. On her entrance into the hospital, obstruction of the tracheal canal caused immediate cyanosis, which showed that she was getting no air through the larynx. March 16, under chloroform anesthesia, the larynx was examined by direct laryngoscopy in the extended position. When the epiglottis was lifted, we saw at once that the larynx was completely closed by new formed tissue between the vocal cords. Careful examination with a small probe revealed a tiny opening in the most anterior part of the larynx which was not sufficient to admit air. Since the patient had an opening in the trachea, we decided to attempt dilatation with urethral sounds from below upwards. We soon found that there was danger of making a false passage because the new tissue above the tracheal wound was thick and dense. A few days later, the patient was again anesthetized, the direct laryngoscope was introduced, and with Jackson's long laryngeal knife an incision was made between the cords and through the subglottic space to the tracheal canula. A tupelo tent was then inserted to assist in the dilatation. This little operation was followed by prompt and decided reaction; the temperature went to 104° and the breathing suggested pneumonia. We were forced to abandon treatment for a few days. When the little patient was again in good shape, the same treatment was repeated, with the result that the smallest intubation tube passed into the larynx. A very short tracheal canula was left in the tracheal wound as a safety valve in case the intubation tube should be coughed out. The temperature promptly went up again and fell to normal when the tube was removed. Several weeks passed before the patient could tolerate the tube. Alum-vaseline applied to the intubation tube seemed to have a favorable effect on the tissues. Every two weeks the child was extubated and the tube cleaned and re-introduced. At each extubation the short tracheal canula was removed and a long one put into the trachea; granulation tissue was always found at the inner end of the short canula, so that usually some force had to be used to push the long canula through into the trachea. When the intubation tube was removed, the patient became dyspneic and cyanotic, so that rapid work was necessary. After a time, the two-year hard rubber tube was introduced and worn comfortably. The patient left the city for her home in South Carolina the latter part of August, at which time she was still wearing the two-year tube and the short canula. In four and a half months the larynx, from a condition of complete stenosis, had been successfully opened and an intubation tube introduced. The physical condition of the child was good, and we confidently expected ultimate recovery from retained intubation tubes. At her home, treatment was continued by her uncle. In October, the short tracheal canula was removed and the wound allowed to heal. Early in November, against my advice, the patient was extubated and the tube left out eighteen hours. Dyspnea then became urgent and the surgeon succeeded in passing the smallest intubation tube only after several attempts. The stenosis was dilated gradually until a three-year tube was worn in comfort. The patient made favorable progress; when the tube was removed, breathing through the larynx was quiet, but the experiment of leaving the tube out for any length of time was not repeated. In March, 1909, it was noticed that the patient was not well; she seemed out of sorts and disinclined to play. Removal of the tube revealed nothing abnormal in the throat. Examination of the blood showed malarial organisms and quin-

ine was administered. Despite prompt treatment, pernicious malarial fever developed with a fatal termination two or three days later.

H. S., six years old, was brought to the Presbyterian Hospital early in January, 1909, by Dr. Twigg, of Cumberland. She was referred to me by Dr. H. Harlan. In September, 1908, the mother noticed that the child's breathing was slightly forced, especially after taking active exercise. She grew gradually worse and late in November she was intubated by Dr. Twigg for supposed diphtheria, though she had no other symptoms. When the tube was removed, the dyspnea promptly returned. When she came to the city, she was refused admittance to one of our general hospitals because of probable recent diphtheritic infection. Dr. Dunott sent her to Dr. Harlan, who, in turn, referred her to me. When I saw her, dyspnea was marked, all the muscles of the neck and chest being involved in the respiratory act. Since the child had had indefinite symptoms since September, it was impossible to say with any degree of certainty what the cause of the trouble was. Examination of the larynx was made in the flexed position without anesthesia. The patient was placed on the table, her feet, hands and head firmly held, the direct laryngoscope introduced and the larynx satisfactorily inspected. We saw at once a web of tissue stretching between the true cords anteriorly, which flapped like a sail before the wind when the patient cried or struggled for air. Posteriorly, there was a small opening through which she was breathing. We succeeded in passing a four-year intubation tube by exercising slight force, and the dyspnea immediately disappeared. Twelve hours later, the patient coughed the tube out. Dr. Ellingwood then introduced a five-year tube. When I reached the hospital that afternoon, I was informed that the larger tube had come up a few minutes before and that the patient was breathing badly. I decided to intubate carefully with a six-year tube, which showed no disposition to become displaced. The mother was allowed to take the child home with instructions to return in a month. She remained away five weeks and then hurried back because breathing was so difficult. When the tube was removed, it was filled with thick, dried secretion. With the tube out, the patient breathed much better. The tube covered with alum-vaseline was re-introduced. The mother was instructed to report every two weeks, which she did until April 15, on which date the tube was removed for the last time. The child breathed so well, I decided not to intubate again, but to keep her in the hospital and watch her a few days. Examination with the mirror showed the larynx well open. The voice, which before had been a whisper, returned, and the little patient played about the hospital with no signs of dyspnea. She was sent home apparently cured; the mother was told to bring her back at once should any shortness of breath develop. Since she has not returned, we must assume that there has been no further trouble.

In December, 1908, I examined a Bohemian child, fourteen months old, at the Garrett Hospital at the instance of Drs. J. Staige Davis and John Rührhah. The patient had been intubated three months previously for laryngeal diphtheria, from which she made a good recovery. A few weeks before I saw her, she developed dyspnea, which had gradually grown worse. Examination of the larynx was made in the flexed position without anesthesia. The vocal cords moved normally. In the subglottic space we saw a dark-gray mass apparently springing from the anterior wall of the larynx. Behind, there was a small opening through which the patient breathed. We thought it possible to pass a small intubation tube, but before this could be

done, the mother, who was ignorant, took the child from the hospital and did not return.

Complete stenosis of the larynx is one of the most difficult conditions the laryngologist encounters. All such patients wear tracheal canulæ and it seems as if the easiest treatment is dilatation from below upwards. Personally I am afraid of this method of procedure, for, if the tissue is hard and unyielding, there is great danger of making a false passage. If there is an opening in the larynx, however small, the sound will probably find it and pass through without damage. This method of treatment is not strictly scientific, for we are working in the dark. In my opinion this treatment should not be resorted to until a careful examination is made under direct laryngoscopy, which will give us valuable information as to the location and character of the pathological lesion and the size of the opening if there be one. With this knowledge we may be able to resort at once to intubation, which is the logical method of treating incomplete stenosis. In complete obstruction we may succeed in establishing an opening through the direct laryngoscope which must be kept open by intubation. After months of treatment we may remove the tube and find to our disappointment that the patient is not cured. Rogers, who has perhaps had more experience with such cases than any one else in this country, believes that practically every case can eventually be cured by retained intubation tubes. One of his patients wore a tube five years and recovered with a singing voice. He is opposed to any form of external operation and dispenses with the tracheal canula as soon as possible, on account of the probability of tracheal stenosis from the prolonged wearing of the canula.

It will be noted that two of the three cases cited above followed diphtheria; such sequelæ have been seen many times following intubation, but they are not always the fault of the operator. We cannot say that a stenosis was caused by intubation, since such cases were observed in diphtheria before the introduction of this method of treatment. Statistics, however, seem to indicate that pressure necrosis is responsible for many stenoses following diphtheria. If a tube too large for the child be introduced, as sometimes happens, it is easy to understand that pressure on the true cords will cause necrosis and the subsequent formation of granulation tissue which might give rise to stenosis. It is probable that metal tubes exercise more pressure than the hard rubber ones. In the treatment of obstruction the hard rubber tubes are preferable to metal because they exert the same amount of pressure and possess a certain power of absorbing the pathological tissue. In subglottic stenosis following diphtheria, autopsies show ulceration on the anterior cricoid wall where the intubation tube comes in contact with it. The formation of new tissue is directly connected with the ulcers. Galatti thus describes the autopsy findings: The larynx was of normal size. The mucous membrane was pale; on both false cords were shallow, depressed

scars; 1 cm. below the true cords corresponding to the cricoid cartilage the lumen of the larynx was greatly narrowed and the mucous membrane changed into scar tissue. The perichondrium of the cricoid cartilage at this point was thickened with scar tissue and adherent to the mucous membrane. Bokay, in his exhaustive treatise, "Die Lehre von der Intubation," describes four personal autopsies in which the stenosis was in the subglottic region corresponding to the cricoid cartilage. He makes the statement that laryngoscopy in this class of cases has no practical value because the children are so unruly it is scarcely or not at all possible to see the larynx. He refers to Hagenbach in this wise: "One who has had a large experience in examining the larynges of young children will occasionally succeed in making a diagnosis." Bokay then says that in his experience Kirstein's autoscope is not a diagnostic help; he believes that Killian's direct laryngoscope will give no practical results on account of the difficulties in using it. Since his book was published, in 1908, it is evident that the simplicity of direct laryngoscopy in the flexed position is unknown to him. Dillon Brown estimates that stenosis following intubation occurs in one case out of every seventy-five to one hundred. If these figures are correct, it behooves the laryngologist to learn how to examine for the condition and to treat it successfully. That many such cases have been treated by the general surgeon in the past is a reproach to laryngology. Now that we have simple methods of examining these little patients, we have no excuse for turning them over to the surgeon. If we can impress the profession generally with the fact that, in the early stage, when the difficulty in breathing appears, it is of paramount importance to have the larynx examined to find out the cause of the trouble, we will be able to cure a certain number of patients before complete stenosis occurs. After complete closure of the larynx, the difficulties are increased and the treatment prolonged months or even years. In direct laryngoscopy in the flexed position we have a safe, easy and simple method of diagnosis which, of course, leads the way to successful treatment; it has made the examination of the larynx in children simplicity itself. The progressive laryngologist of the future must assume the responsibility of these cases; he must know how to manage them and be ready to perform certain neck operations which are liable to arise at any time in the course of treatment, especially in the complete stenoses.

### Clinical Department.

#### A TUBAL ABSCESS OF UNUSUAL POSITION ACCOMPANIED BY A BACTERIURIA OF RENAL ORIGIN.

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THE following case which came under my care in November, 1906, is of interest not only because of the very unusual position of a tubal abscess,