

epidemic form, but the cases are too acute and short-lived to belong to this group.

Some Japanese authors have written of forms of polymyositis occurring in Japan, but from the literature obtainable I do not find the cases of the subacute type. Ito and Konaka's²⁵ ten cases of myositis apparently arose from direct infection through the skin or tonsils and caused local suppuration, necessitating operative procedure. Hnátěk,²⁶ among others, has described a case more typical of polymyositis hemorrhagica.

In conclusion I wish to express my indebtedness to the several physicians for referring to me these cases, and especially to Dr. Ernest L. Hunt, assistant pathologist of the Worcester City Hospital, to whom all credit is due for the pathologic and photographic work in Case 3.

A MIXED TUMOR OF THE PAROTID GLAND.

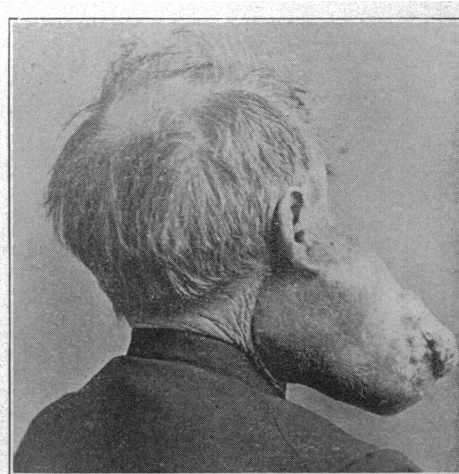
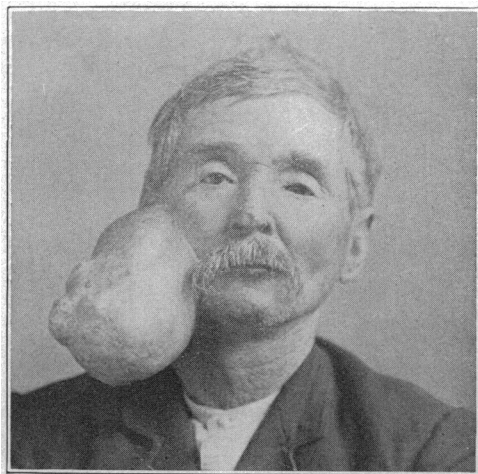
A. H. CORDIER, M.D.,

KANSAS CITY, MO.

History.—X. Y., aged 45, consulted me Sept. 1, 1906, with reference to a growth in the region of the parotid gland. His family history was negative. Eight years previously he first noticed a slight enlargement over the parotid gland on right

in a healthy condition and was saved to be used to cover the wound after the growth was removed. An incision on the facial side of the growth was made meeting the line of the first. The filaments of the seventh nerve were easily recognized and pulled aside, the capsule of the gland and tumor was left intact during its removal, the dissection was made mostly from the lower side of the growth, the vessels were ligated as soon as cut and very little blood was lost during operation. The facial side of the dissection was made early as the seventh nerve could thus best be discovered and protected. A careful search failed to find any accessory gland structure. The incision was closed with a small drainage inserted at the angle of the jaw. The line of the closure was made to correspond with the natural curve beneath the jaw, thus avoiding an unsightly scar. Recovery followed and now, one year later, there has been no return.

No one characteristic feature of a growth of this kind is of much value in making a macroscopic diagnosis; however, in this case there existed so many traits of a mixed tumor that I felt warranted in diagnosing it as such. Its location (the parotid), its slow primary development, with later more rapid growth, freedom from tenderness or pain, the fact that it was freely movable and that there was no glandular involvement nor constitutional effects, the rarity of other forms of neoplasms in this locality and the contour, consistency and



Figs. 1 and 2.—Front and side views of patient with mixed tumor of the parotid.

side, this grew slowly for two years until it attained the size of an egg. About this time a physician removed it. A year later the growth made its reappearance and enlarged slowly up to two months ago, then it enlarged rapidly.

Examination.—It was, when seen, about the size of a large cocoon (Figs. 1 and 2). No tenderness on pressure nor pain at other times had been noticed. The principal disturbances had been from the size of the growth and the consciousness of its presence. There had been no marked increase in the parotid secretions. The seventh nerve had not been involved as there was no paralysis; the hearing was good. The growth was freely movable over the ramus of the jaw and had a nodular appearance with numerous erythematous patches over it. Numerous large veins ran in tortuous courses over the growth. Many nodules were firm while others were semi-fluctuating. At several points the growth presented superficial ulcerated spots the size of a finger nail. In general appearance it resembled an inflamed lipoma or a multinodular uterine fibroid.

Operation.—In operating in this case I made the incision from in front of the ear downward and forward along the angle and lower border of the inferior maxilla. The integument at the base of the tumor along this line was seemingly

surface markings of the tumor all pointed to its being a growth of that class designated by Bergmann and others as a "mixed tumor."

Growths appearing in the parotid gland as a rule assume the atypical forms, some consisting only of hyaline cartilage and connective tissue. The cartilage frequently undergoes mucoid changes, giving rise to soft spaces in the tumor. These growths of the parotid gland are not very prone to dissemination. In the mixed tumors considerable connective tissue is developed. If slow there may be much connective tissue; if there is rapid cell proliferation the stroma may be choked out. Sarcoma and endotheliomata may both exist in the same tumor. Endotheliomatous elements are usually found in all rapid growing sarcomata. If on serous membrane they are usually multiple. The nature of these growths is not fully settled, as they seem to have both a connective tissue and epithelial elements.

On cutting into this growth after its removal it presented to the eye the character of many growths, one spot looking like a sarcoma, another resembled an enchondroma, again there seemed to be a carcinomatous focus, while scattered through the growth were mucoid

25. Juntendo Iji Kenkin Kwai Zasshi., Tokyo, 1903, 883; also translation in Deutsche Ztschr. f. Chir., Leipzig, 1903, lxi, 302.

26. Case of Polymyositis with Hemorrhages, translation in Wien. med. Presse, 1905, xlii, 917.

or colloid masses. It was connected to the gland by a broad base on its facial aspect.

Valkmann, Nasse and others maintain that the endothelial cells present resemble the epithelial cells very much, but are true endothelial cells, taking their origin from proliferated cartilage cells.

While other pathologists maintain that both epithelial and connective tissue cells may enter into the formation of these mixed tumors of the parotid, von Bergmann pins his faith to the germinal displacement theory and mentions the presence of osseous and cartilage tissue in the parotid as being decidedly foreign.

These tumors may develop at any age from infancy to old age. The theories as to their etiology are purely speculative in the face of the disputed classification of these growths. Neither sex, age, occupation, heredity nor traumatism have been traced as a cause in a sufficient number of cases to be of much value from an etiologic standpoint. These growths may grow to be very large, as the accompanying illustrations show.

These growths are not painful on pressure. There is a peculiar cartilaginous hardness of the nodules between which are soft semi-fluctuating areas; these tumors are freely movable. In the typical mixed tumors of the parotid the diagnosis is usually easy; however, a lipoma

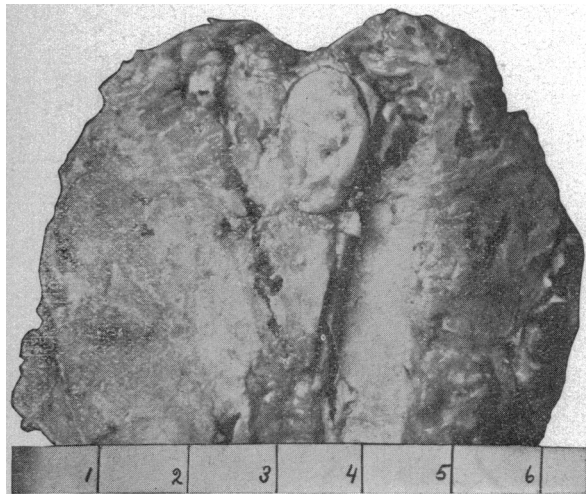


Fig. 3.—Parotid gland tumor of the mixed type, after removal, showing size in inches.

or a lymphoma may lead to an error in diagnosis. The prognosis for a patient with a mixed tumor is, if seen early, a favorable one. Many growths of its benign character, however, may by time or injury be changed into one of the most virulent types of sarcomata. The presence of an accessory parotid with a minute growth in its substance or the incomplete extirpation of the original growth may explain why these tumors often reappear and maintain their benign character.

Early extirpation of these growths should be carried out; by this course the greatest percentage of cures will be attained. All precautions should be used in safeguarding the seventh nerve and as thorough, clean extirpation as possible should be practiced.

These growths, like all neoplasms, should be removed thoroughly and early, as only by this method of dealing with them can we expect to save surrounding structures and their functions and prevent widespread dissemination and recurrence. The removal of these parotid gland tumors is often quite difficult owing to their close proximity to the seventh nerve and their deep vascular supply.

A CASE OF SYSTEMIC BLASTOMYCOSIS.*

R. A. KROST, M.D., M. J. MOES, M.D.

Resident Physicians Cook County Hospital.

AND

A. M. STOBBER, M.D.

Resident Pathologist, Cook County Hospital.

CHICAGO.

The subject of blastomycosis is rapidly gaining the attention of the medical profession, and recognized cases of cutaneous infection are now comparatively common. Greater attention is now being given to the more rare systemic forms of the disease and the varied clinical and pathologic manifestations.

The following case adds not only to our general knowledge, but presents a few additional features of unusual interest:

Patient.—M. L., aged 42, married, native of Poland, laborer by occupation, had lived in United States four years. He was admitted to the Cook County Hospital April 8, 1907, and assigned to the service of Dr. Loeb as a case of acute articular rheumatism. No history having been obtained at that time, this diagnosis was made by the examining physicians because of the obvious swelling of the hand and foot.

History.—After admittance to the ward, the following history was obtained with the aid of an interpreter: About four months before admission patient was taken with a severe cold, associated with cough and expectoration. This interfered but little with his general health. He next noticed a pain in the back, which, at first, was felt only on motion, later when lying on the back. A month later a swelling appeared at this painful area in the dorsal region, at the left of the median line. The cough, which persisted from the onset, became more marked, with abundant expectoration. His appetite began to fail and he noticed that he was losing in weight. About four weeks before admission blood was present in the sputum for several days. It had been present but once since that time. General weakness became so pronounced that he was compelled to stop work six weeks after the onset. Two months before admission painful swellings developed successively on the back of the left hand and foot, and in the chest wall on the left side over the eleventh rib. The next lesion appeared three weeks before admission as a small papule on the right ala of the nose. This was quite painful, and developed slowly into a warty growth. A week later enlargement of the submaxillary glands on both sides of the neck was noticed. He complained of cough, profuse expectoration, night sweats, marked general weakness, and pain in the affected parts. The patient denied previous illness of either a general or specific nature. The family history was negative, except that his first wife died of tuberculosis. Three children borne by his second wife are healthy. The patient had been a coal heaver the past four years, and his habits were moderate in every respect.

General Examination.—The patient was a middle-aged man, considerably emaciated, and very anemic. He lay on the right side and suffered much pain on even slight movements involving the affected parts. The skin was moist, the perspiration being especially profuse on the forehead and in the axillæ. The respirations were free and rapid, averaging thirty per minute. The pulse was full and regular. The temperature was 99.8 F. The scalp was normal, the face drawn, the cheeks sunken, and the eyes were partly closed. The pupils were dilated, equal, and reacted to light and accommodation. There was no nystagmus nor evidence of ocular paralysis. In the middle of the forehead was a small papillomatous growth covered with a thin yellow crust. On removal of this crust a small quantity of pus appeared. The margin was indurated, red and sharply demarcated from the surrounding skin. At the margin of the right ala of the nose was another larger growth, which measured 1.5 cm. in length. The papillomatous character was more distinct, and it extended into the nostril for a distance of 0.5 cm., being associated with considerable swelling of the adjacent tissues. The left ala of the nose was

*A part of the article is omitted from THE JOURNAL for lack of space. The complete article appears in authors' reprints.