CRITICAL REVIEWS.

THE PRESENT POSITION IN REGARD TO TREATMENT AND PROGNOSIS IN TUBERCULOSIS OF THE LARYNX.

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It was formerly held by physicians that a patient with tuberculosis of the larynx was doomed to an early and distressing end. Later, when the question of local treatment came to be discussed, laryngologists were divided into two camps. The former, having diagnosed the condition, held that treatment was of little avail, and contented themselves with local application of lactic acid and sprays or insufflations, to attempt to alleviate the more distressing symptoms. The latter attacked the larynx vigorously by surgical measures, convinced that removal of the diseased parts was the efficient and proper treatment, and afforded a chance at any rate of the cure. There was a tendency, however, to neglect the necessity of considering the patient's chest condition and his resisting power in deciding on the measures to be adopted. Ill-advised surgical measures on patients unsuited to them gave bad results, and for a time brought local treatment into disfavour. We know now that tuberculous laryngitis is nearly always secondary to pulmonary tuberculosis, and that as the eyes are said to be the mirror of the soul, so do the laryngoscopic appearances give a very good idea as to the hold which the tubercle bacillus has on the patient, and how great or how small is his resisting power. It may be laid down as a general statement that if the chest condition is capable of being arrested, no patient ought to be allowed to die from tuberculous laryngitis, but, on the other hand, the chest condition will tend to relapse and the infection obtain the upper hand unless the larynx is efficiently treated. The modern tendency is to insist on the necessity of co-operation between the physician and the laryngologist in the diagnosis and treatment of these cases.

In my clinic at Mount Vernon Hospital, where all cases admitted for phthisis have the larynx examined as a routine, it is not uncommon to find that there is a laryngeal lesion which has produced no symptoms.

The converse is also true, that doubtful cases coming to the laryngologist for hoarseness frequently have the diagnosis confirmed by the physician who finds a hitherto unsuspected pulmonary lesion.

A recent work[1] gives an excellent account of the diagnosis, treatment, and prognosis of tuberculous laryngeal lesions. Sir St. Clair Thomson's book on diseases of the nose and throat[2] has a chapter on the subject which is well worth reading.[3]

At the meeting of the British Medical Association at Birmingham in 1911, the treatment of tuberculous laryngitis formed one of the subjects for discussion at the Laryngological Section.[4] Opening papers were read by Dr. Dundas Grant, Dr. Watson Williams, and Mr. G. Seccombe Hett. These papers, with the ensuing discussion, furnish a statement of the most recent opinions of experts upon the subject. Treatment by tuberculin has been reported on favourably,[5] and in my own experience has certainly seemed to give good results. It has, however, been used in conjunction with a sanatorium life, and local treatment where the latter seemed necessary.

Very slight laryngeal lesions in an advanced and rapidly progressive case give a bad prognosis; they are frequently sub-terminal infections. In other cases, where there is an extensive lesion of the larynx in a person with normal temperature and a chronic type of pulmonary lesion, surgical procedures of a radical type, such as removal of the epiglottis or arytenoids, can often be done with impunity, and achieve excellent results. Lesions of the vocal cords can frequently be arrested by absolute vocal rest for six months, if the chest condition be favourable. Tracheotomy is not now resorted to for insuring vocal rest, but only if asphyxia is feared. Enlarged arytenoids can often be reduced by deep puncture with the galvano-cautery, and should this fail, I have had excellent results by punching them out, and have never seen failure of healing of the wound.

Infiltrations without ulceration of the ventricular bands are best treated by successive deep-cautery puncture at intervals of ten days. Watson Williams finds submucous injections of service for infiltrative lesions. Superficial ulcerations of the vocal cords should be touched with the cautery. Curetting should be limited to large ulcers, and should be employed with caution so as to avoid providing a larger breach of surface than already exists. Where a tuberculous lesion is confined to the epiglottis, I have been much impressed by the results of removal of the body by punch forceps; and as in the case of the arytenoids, I have

[1] Lockard: "Tuberculosis of the Upper Respiratory Tract."
[2] Thomson, Sir St. Clair: "Diseases of the Nose and Throat." London: Cassell and Co. 1911.
[3] References in both of the above works to current literature are very complete.
[4] See *British Medical Journal* and the *Journal of Laryngology, Rhinology, and Otology*, 1911.
[5] Wilkinson, Camac: *British Medical Journal*, November 26, 1910.

never seen the stump fail to heal where this was employed in suitable cases. Even in desperate cases the extreme dysphagia produced by the infiltrated and sloughing epiglottis has been at once relieved.

The accumulation of secretion in the larynx can be prevented by the use of an alkaline laryngeal spray, and this simple treatment often makes the patient much more comfortable and better able to cope with his trouble. Unnecessary coughing should be prevented, and where this is caused by irritation in the larynx, dry inhalations of creasote, carbolic, and chloroform, applied by means of a Burney Yeo's mask, worn for some hours at a time, is very efficacious. Equal parts of orthoform and anæsthesin, insufflated half an hour before meals, is recommended for the relief of dysphagia. It may be necessary to use a 10 per cent. cocaine spray for the same purpose. Injections of alcohol into the superior laryngeal nerve are useful to relieve pain in the larynx.[1] To show that the prognosis is not always desperate, even in severe cases of tuberculous laryngitis, I may perhaps be permitted to end by quoting the following case: A strong, athletic naval officer of twenty-seven was seen complaining of hoarseness of five months' duration, with some dysphagia. On examination he was found to have infiltration and ulceration of the epiglottis, swelling of the right arytenoid, and granulations on the right vocal process and vocal cord. He was also found to have lesions of both apices, and tubercle bacilli were abundant in the sputum. The temperature was 100° at night. He was put under sanatorium conditions, with vocal rest. The epiglottis was removed. Subsequently the arytenoid was punched out, and the granulations curetted by the direct method. Three applications of the cautery were made at intervals. Within a year he was able to return to his professional work in the navy, with chest and larynx arrested, and now, three years after, is in good health.

[1] Grant, Dundas: *Lancet*, June 25, 1910.