

XLV.

(1.)

A CASE OF SUPPURATIVE THYROIDITIS WITH
PERFORATION OF THE TRACHEA.

(2.)

AN UNUSUAL INFECTION OF THE EPIGLOTTIS
AND LARYNX IN A CHILD—TRACHEOTOMY
—RECOVERY.*

BY CLEMENT F. THEISEN, M. D.,

ALBANY.

The first case is that of an Italian, aged thirty-five years. He was first seen by the writer last November. The following incomplete history was obtained from his wife with the aid of an interpreter: About two weeks before, he developed a sore throat, and for several days had been spitting pus and blood. An examination of the throat at this time showed the following conditions: Both tonsils inflamed and enlarged. Slightly below and behind the right tonsil there was a discharge of pus, with an opening leading up behind the tonsil, from which pus could be squeezed out. It looked like an atypical quinsy that had ruptured spontaneously at an unusual place. The patient had lost a good deal of weight, as he had not been able to take much nourishment for nearly two weeks. A wash was prescribed for the throat, and the family was told to send for the writer if the patient did not improve. Nothing was heard from the patient for nearly two weeks, when the writer received a hurry call. On arriving at the house the patient was found sitting up in bed, breathing with difficulty. In the two weeks that had elapsed he had become greatly emaciated, and had been coughing up

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pus and blood almost constantly. With the aid of an interpreter we discovered that he had been in a hospital and had been treated with electricity! At this time there was a tremendous board-like infiltration and swelling of the entire front of the neck, particularly involving the thyroid gland, with a good deal of reddening of the skin. On deep palpation of the right lobe, which seemed to be most inflamed and swollen, we thought we got a feeling of slight fluctuation. Pressure at this point at once increased the cough and expectoration of pus. A diagnosis of probable suppurative thyroiditis was made, and the patient sent to St. Peter's Hospital, where the operation was performed the next morning. An incision into the right thyroid lobe entered an abscess cavity, and there was an immediate escape of air. It was found that there was an opening into the trachea almost large enough to admit the tip of the little finger. The patient got on fairly well for a week or ten days, although he constantly lost weight, when he insisted on going back home, where he died a few days later. There had been a constant profuse discharge of pus from the wound. This was examined for tubercle bacilli, but none were found. Cultures from the throat and also from the wound showed streptococci and staphylococci. No autopsy was permitted.

The primary seat of infection in this case was undoubtedly the abscess in the tissue back of the tonsil which had ruptured before the writer had been called in.

The rapid emaciation suggested a tuberculous process, but no bacilli were found in several examinations of the sputum, or in the pus. The lungs were also negative.

So far as the writer is concerned, this is a unique case.

The second case, an unusual infection of the epiglottis, is that of a boy twelve years old, who was seen by the writer early last May. I was asked to see him by the family physician, at his home in the country, a few miles from Albany. The boy had had measles a month before, and for a few days had complained of a very slight sore throat. When the throat was examined about four o'clock in the afternoon of May 6th, the only thing noticed in the pharynx was a slight redness of the mucosa. Tonsils were not inflamed. There was some trouble in breathing at this time, patient not being able to lie flat. When a laryngeal mirror was used the epi-

glottis was seen to be tremendously edematous and inflamed. Several incisions were made at once, and a culture taken directly from the epiglottis. An iced spray was ordered with ice in the mouth, and an ice coil around the neck. Temperature at this time was 103° F. At six o'clock the same day the boy's breathing was worse, and at seven we again went to the patient's home. He was sitting up in bed, breathing with extreme difficulty, and an immediate tracheotomy was performed. This relieved the breathing at once, and the boy made an uninterrupted recovery, but it was over a week before his temperature was normal, and there was a good deal of swelling of the glands of the neck.

The cultures taken from the epiglottis after scarification, and others taken through the tracheal canula, showed some staphylococci and streptococci. No diphtheria bacilli could be found. He was given an injection of antistreptococcic serum. The temperature, which remained high for a week, slowly subsided, and the swelling of the glands of the neck also slowly disappeared. When the swelling of the epiglottis subsided sufficiently, so that a view of the larynx could be obtained, some edema of the arytenoid mucosa was still present. This must have been considerable during the height of the attack, as suffocation was imminent just before the tracheotomy was performed. This condition was undoubtedly one of the curious infections of the epiglottis occasionally seen with a practically normal pharynx.

The writer has been of the opinion that such cases of acute infection, with edema of the lingual surface of the epiglottis, the edema being mainly limited to this surface, were distinct pathologic conditions belonging in a classification of their own. Several cases of this kind were reported in 1900.¹

An experience with several cases this winter, besides the one that is the subject of this paper, and including one of abscess of the lateral column of the pharynx, in which the edema extended first to the lymphoid tissue at the base of the tongue and then to the epiglottis, has somewhat changed the writer's views in this respect, and has led him to believe that Semon's views still hold good.

Swain,² in a very instructive paper on inflammation of the lateral columns of the pharynx, reports several interesting cases. In one in particular, where he was able to make a

thorough examination of the patient's throat after the rupture of an unsuspected abscess of the lingual tonsil, a subsiding swelling of the epiglottis and aryepiglottic fold could be seen.

Cases of inflammation of the lateral pharyngeal columns, either with or without abscess formation, frequently run the course of an atypical quinsy. Such was the case in the writer's case before referred to. The patient, a man aged fifty years, developed what was apparently a simple tonsillitis, both tonsils being involved. He got constantly worse, and within four or five days after the attack started, could open his mouth only with difficulty. Both tonsillar regions were greatly swollen and edematous, rather more marked on the left side. Several deep incisions in the peritonsillar tissue and in the supratonsillar fossa failed to show pus. A day or two after that the writer was impressed by the amount of swelling along the posterior and lateral wall of the pharynx, extending well up into the nasopharynx, and by the distance between the soft palate and posterior pharyngeal wall. A deep incision into the lateral swelling high up was followed by the escape of some pus, with almost immediate and steady improvement in the patient's condition. When a proper laryngeal examination could be made, considerable edema of the anterior surface of the epiglottis could be seen. This must have been much greater while the angina was severe, because there had been a good deal of difficulty in breathing. The name acute infectious epiglottitis was given to the cases reported in 1900, and the writer's opinion at that time, that these cases should be classified separately, was largely based on the normal pharyngeal findings. Probably if the cases had been seen from their very beginning, a primary origin somewhere in the pharynx might have been discovered.

Semon,³ in his valuable paper on the probable pathologic identity of the various forms of acute septic inflammations of the throat and neck, believes "that the various forms of acute septic inflammations of the throat and neck, hitherto considered as so many essentially different diseases, are in reality pathologically identical—that they merely represent degrees varying in virulence of one and the same process."

Case nine of the series of cases reported by Semon in this paper was similar in some respects to the one that is the sub-

ject of the writer's paper. It occurred in an adult and terminated fatally. In this case an acute edema of the epiglottis and arytenoepiglottic folds followed a transitory inflammation of the pharynx. When seen by Semon the pharynx was normal, but the epiglottis had been changed into "an enormous red colored edematous tumor." The patient also developed a brawny induration of the neck. This intensely acute septic condition had a fatal termination in less than seventy hours from its onset.

The origin of the infection in most such cases is undoubtedly somewhere in the ring of pharyngeal lymphoid tissue. This was so in several cases seen by the writer this winter (severe infections of the epiglottis with great edema, following apparently slight inflammatory processes in the pharynx), and has led him to believe that such conditions should perhaps not be classified as separate processes.

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2. Swain: Trans. of the Amer. Laryngol. Ass'n, 1913.
3. Semon: Medicochirurgical Trans., London, 1895, Vol. 78.