

precipitate labors, and also as a result of manipulation to loosen the cord wound round the neck of the fetus and to slip it over its head. The force necessary to tear the cord differs in different cases; some cords are more resistant than others. The average cord will resist a pull of 5 to 20 pounds, when applied gradually. If applied suddenly, as by letting the weight fall the length of the cord, it will generally break with a weight of 1 to 4 pounds.

The cord generally tears near the fetus and not seldom at the place of insertion. The mode of the tear is interesting and explains why serious bleeding after a tear is not very common—at least much more rare than after the cutting of the cord. The tear is irregular and oblique through the amnion, which ruptures first. Then the arteries tear, and lastly the vein. The intima of the arteries rolls in and the muscularis contracts, which causes a rapid closure of the vessels. Because of this tendency to spontaneous arrest of hemorrhage, compression is generally efficient, as in the case recorded above. Seizure of the vessels with the forceps and the use of a small catgut ligature would be easy and more surgical.

This case might serve to justify Shultze's method of managing cases of winding of the cord around the neck. He objects to any attempt to slip the cord over the head as being unnecessary and likely to rupture the cord or to cause a separation of the placenta. As soon as the head is born there is no longer danger of compression of the cord. If the cord is long, the birth of the body will follow without trouble. If it is absolutely or relatively too short, then it is better to apply a double ligature and cut the cord between the ligature.—Ed.]

A LARGE LIPOMA OF THE LARYNGO- PHARYNX: REMOVAL EXTRA- ORALLY UNDER COCAIN *

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The extreme rarity of fatty tumors in the pharynx, the size of the one under discussion, the comparative safety and simplicity of its removal through the mouth, and the improvement in weight, general health and comfort of the patient due to its extirpation, are reasons for placing this case on record. So extremely rare are lipomata in this region that I finally abandoned searching the literature and accepted the statement in the 1909 edition of Dr. D. Braden Kyle's "Diseases of the Nose and Throat" that but one pharyngeal lipoma had at that time ever been reported. That patient was eighty years of age; the tumor originated from the left side of the epiglottis and from the pharyngeal wall; and the symptoms were those of a movable foreign body.

History.—In October, 1907, when I first saw Mrs. C., she was a rather small woman of 27 years. She had lived in central Wisconsin and had never succeeded in obtaining an explanation of her symptoms. For an indefinite number of years the patient had experienced a vague feeling of "something growing in the throat" and of difficulty in swallowing, requiring an effort to get the bolus started, and sometimes actual inhibition of the swallowing act at its inception. A tendency for food to lodge somewhere and be recovered after some hours or even two or three days had existed. Breathing was quite decidedly interfered with, noticed most on exertion, and a noise in

breathing was present a part of the time, especially at night. But like most instances of similar slow onset of obstructive tumors, the patient seems to have accommodated herself well to the advancing growth; for, aside from slight nervousness, she was apparently in good health, and yet certainly the nutritive processes were being interfered with more than was at the time realized, as shown by the great increase in body weight following removal. Nothing of moment bearing on the condition was apparent in her medical history; she had had goiter at 13, which had receded, rheumatism, measles, acute appendicitis and acute tonsillitis, and moderate nasal occlusion, found to be due to chronic intumescence.

Examination.—Some enlargement of the glands at the angles of the jaw was noted; this had been present for some time. But the external surface of the neck gave no indication of any abnormality within, even on palpation, except that inward pressure slightly below the angle of the jaw on the right produced dyspnea. Thus the external structures of the neck gave not the slightest indication of involvement by the neoplastic process. The tumor could be seen on the posterior and right lateral wall of the pharynx on depressing the tongue. Its uppermost margin reached to the height of the base of the uvula when the soft palate was at rest. From here it extended downward until its broadened lower portion lay over the laryngeal opening half an inch above the arytenoid cartilages. Thus air in passing in and out of the larynx had to take a markedly twisted course, around the overhanging growth. The tumor was much broader at its base, tapering gradually toward its upper end; its shape at any one time was probably modified by the effect of gravitation, due to changed position, for it seemed capable of considerable movement; at its lower part the growth extended more than two-thirds the distance across the laryngopharynx from right to left and gradually this breadth lessened until at the upper part the lateral extent was only one-third the way across. It was covered by healthy-appearing mucous membrane, without evidence of congestion or of enlarged vessels. On palpation the tumor seemed remarkably soft and yielding, not firm enough for an ordinary solid, easily mistaken for a fluid, as if a somewhat flexible-walled sac were only partially distended with a liquid, thus permitting the contents to be pressed from one part of the sac to another. Being not at all tender, and, besides, of long standing, it was thought at this stage of the examination, both by two other experienced laryngologists who examined it and by myself, to be a cyst. The aspirating needle passed through a thick wall and then the distal end could be moved freely about, as if in a cavity; but no fluid could be obtained; the needle was plunged in straighter and entered a soft substance, thought possibly to be viscid fluid, but nothing could be aspirated. A trocar having a much larger bore than that of the needle was then employed, but with an identical experience. Incision then was made and this disclosed fatty tissue, which could easily be separated from what was evidently the capsule of a tumor. The needle and trocar had shoved the tumor away from its capsule, thus creating a cavity, easily mistaken for a fluid sac. The microscope served to confirm the lipomatous appearance of the growth. Thus the examination had proved an encapsulated lipoma superficially placed in the fascia beneath the mucous membrane and with no indication of a vascular supply different from lipomatous growths generally. Clearly the indication was to attempt removal in the simplest manner possible.

Operation.—Ten per cent. cocain with full commercial strength suprarenalin (epinephrin) were applied over the surface of the growth, and cocain was applied also to the operative field during the act of removal. An incision through the mucous membrane and the capsule of the tumor was made vertically, near the center of the swelling, from about the level of the tip of the uvula to a point slightly below the level of the tip of the epiglottis, a distance of 3 inches. The tumor was seized above through this incision with forceps and the process of enucleation carried on. Pulling on the mass brought the hyoid bone plainly into the pharyngeal space. Mostly with blunt instruments, including the finger, but occasionally with tonsil scissors and knives set at an angle in long handles, for the heavier binding threads, the growth was shelled out of its capsule. It was not always easy to see clearly whether

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one was working within or without the capsule and considerable time was wasted at first through this fact, but no more than moderately severe difficulty was experienced at any time. In the course of the enucleation a thick plate-like mass of tissue fell out into the wound and was cut off. This was apparently the overdeveloped fascia that ordinarily exists between the mucous membrane and the constrictor muscles. The hemorrhage was slight and the wound could be kept quite free from blood. It was found unnecessary to ligate any vessel. After removal the edges of the incision lay an inch apart. They were easily brought together and three stitches taken. The fourth was prevented by the breaking of the edges of the mucous membrane; this left the lower angle of the wound open for about three-quarters of an inch in a vertical direction and three-eighths of an inch in width and this was the only provision made for drainage. But moderate pain was experienced until the last stitch was taken.

Postoperative History.—Feeding was carried on through the mouth, using small swallows of milk; the stitches held. The temperature reached 101 F. on the following day. Only moderate reaction occurred, with very little edema. After the third day the temperature did not reach higher than 99.5 F. and the hyperemia then became slight; a gland on the outside opposite the incision became a trifle tender, but quickly disappeared. On the eleventh day the wound was scarcely visible and the pain entirely gone.

Specimen.—The tumor was characteristically lobulated, and, as it lay flat on the table, measured $3\frac{1}{4}$ inches long, $2\frac{1}{4}$ inches broad and 1 inch thick, its shape altering with its position. Since the patient immediately left the city, I did not see her for three years, although rumors of great increase in weight reached me. When I did see her, I was somewhat astonished to note the remarkable change in physique, the patient having altered in type from a somewhat small to a much larger woman. The weight had increased from 124 to 156 pounds. After the operation, the husband had felt alarm at the quietness of his wife's breathing, and the patient would find her food well down the esophagus before she realized the act of swallowing had begun. Excepting for two or three small obscure patches of thin, shiny scar tissue, the pharynx appeared normal.

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GLASS TUBE IN THE MALE URETHRA

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History.—Some time since a man aged 27 came to my office saying there was a piece of glass tubing in his urethra which he was unable to remove. He gave no satisfactory information as to how it came there.

Examination.—A few drops of blood appeared at the meatus and there could be felt in the perineum just behind the scrotum a firm body in the line of the urethra; this proved to be the end of the glass tube. By digital examination of the base of the bladder through the rectum the deeper end of the object could be felt lying within the cavity of the bladder and pushing the posterior wall of the bladder backward on the rectum. The anterior end of the object could be felt by introducing a urethral sound.

Removal.—It occurred to me that the tube might be removed through the lumen of an endoscope or urethroscope. Accordingly, I introduced an endoscope, size 26 F., till it came in contact with the forward end of the glass tube, and after removing the obturator I was able to feel the tube slip into the opening of the endoscope. Then with one finger in the rectum I was able to force the tube forward still farther into the endoscope, until finally it was easily removed within the instrument. No anesthesia was used.

There was little tenderness of the parts after the manipulation. The tube was $3/16$ of an inch in diameter and between 5 and 6 inches in length. At both ends the tube was rough broken. The patient recovered without further difficulty.

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THE STATUS OF SALVARSAN IN PELLAGRA, BASED ON THE REPORTS OF TWENTY-ONE COLLECTED CASES

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MOBILE

The occasional beneficial effects following the administration of various forms of arsenic in pellagra has led several physicians to employ salvarsan in pellagra. In an effort to obtain an early opinion of the therapeutic results we have collected the reports of sixteen unpublished cases, and these together with three cases reported by Nice, McLester and Torrance,¹ and two cases of our own, form the basis of this report. This includes, as nearly as we can ascertain, all the cases of pellagra treated with salvarsan up to May 1, 1911.

We take pleasure in thanking the following physicians for the reports of the sixteen unpublished cases that make this report possible: Dr. Rufus T. Dorsey, Atlanta, Ga., two cases; Dr. E. H. Martin, Hot Springs, Ark., one case; Dr. W. J. Love, Opelika, Ala., one case; Dr. Wilmer L. Allison, Ft. Worth, Texas, three cases; Dr. C. C. Bass, New Orleans, La., one case; Dr. J. Edgar Paullin, Atlanta, Ga., seven cases; Dr. J. D. S. Davis, Birmingham, Ala., one case.

The fact that all the patients have been recently treated precludes any positive conclusions as to any permanent beneficial effects resulting from the use of salvarsan in this disease. All types and stages of the disease have been treated. There has been no uniformity in the manner of administration or the quantity or frequency of the dose. The drug has been given both intramuscularly and intravenously, in amount from 0.1 to 0.69 gm. Most of the cases had a single dose, one had two doses and two were given three doses.

Hospital residence and the coincident administration of other forms of arsenic has to be considered in the reported beneficial results of at least four of the improved cases. To what extent the saline solution administered with the drug intravenously has bearing on some of the cases improved, it would be difficult to say, though it is worthy of consideration. There was an untoward effect in one case, a profuse diarrhea following the drug administration. The physician having this experience administered salvarsan in seven cases and noted no improvement whatsoever in any of the seven cases.

Type of case treated: mild acute, three; mild chronic, four; severe acute, four; severe chronic, seven; type unknown, three; total, twenty-one.

No improvement was noted in ten cases, 47.6 per cent.; improvement noted for at least seven days with no relapse, seven cases, 33.3 per cent.; temporary improvement followed by relapse (death in one), four cases, 20 per cent.

Improvement was noted in the following type of cases: severe chronic, six cases; severe acute, two cases; type unknown, three cases.

CONCLUSIONS

Any administration of salvarsan in this disease of unknown etiology must be considered as empirical when we recall that this drug is considered specific for the *Spirochæta pallida*.

The well-known dangers of administering salvarsan to patients suffering from cardiac and renal lesions

1. Nice, C. M., McLester, J. S., and Torrance, G.: THE JOURNAL A. M. A., March 25, 1911, p. 896.