

SUPPLEMENTAL REPORT OF A CASE OF XANTHOMA, WITH EXHIBITION OF PATIENT.*

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I presented this patient before this Society in May, 1906. (THE LARYNGOSCOPE, October, 1906.) A few days after his presentation here, it became necessary to do tracheotomy to relieve his breathing. He is now wearing a tracheotomy tube, and has done so since that time. Permit me to recall a few points as to the disease, and the history of this patient, for the benefit of those who did not see him at that time. Briefly, xanthoma is a perfectly benign neoplasm, and is of a fibro-fatty character, deposited in the corium. This patient presents the two forms in which the disease is usually seen, the plaques and nodules. There were also the lesions as they are found on mucous membranes, although those that were present in the fauces have disappeared, that on the conjunctiva of the left eye is much less prominent now than then, and had at one time disappeared entirely.

The multiple forms seen here are rare in one individual, and when found in young people are usually congenital, but when found in adults are often associated with chronic jaundice, or with glycosuria, as in this case. The most common form is the xanthoma palpebrarum, which is not so rare. The lesions on the eyelids were marked when this patient was shown before, but have almost entirely disappeared now. The lesions on the skin have a deposit of pigment, varying from a light yellowish or brownish color to a deep bronze. The very rare condition shown here, the patches on the conjunctivae, are of a light yellowish color, and while that on the right eye is large, its position is such that it does not affect his vision, and is absolutely unirritating in its presence. The lesions on the neck have faded somewhat, but those about the shoulders, the gluteal region, the penis, the scrotum, etc., remain about as they were. They are little indurated, except the nodules on the penis, are little raised from the surface, and over some parts of the body are smooth and level with the surface. The patient is twenty years of age, the mother is living and well, and the father died of cerebral hemorrhage about three years ago. There is no

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history of any similar disease in the family. He has never had any severe illness, there has been no venereal trouble, and he has never used alcoholics or tobacco.

His present illness began about six years ago, the first symptoms being an intense itching of the eyelids, shoulders, etc. This was felt at intervals, and finally the eruption appeared simultaneously on the eyelids, neck, shoulders, penis, scrotum, and other parts of the body. Four years ago he began to have an intense and constant thirst, and to pass large quantities of urine, which now amounts to from seven to nine quarts a day. When he was first presented to the Society he complained of spells of dizziness and faintness, lasting a couple of minutes at a time, at intervals of two or three weeks at first, which had gradually increased in frequency to several attacks daily. In addition to this symptom there was an increasing difficulty in breathing, which was progressive in severity, and was very marked at that time. This became so pronounced that the tracheotomy was performed on the third of May, 1907.

This is the point in this case that makes it one of peculiar interest to the laryngologist, for it is the only one on record, so far as I know, where a xanthomatous lesion in the larynx has caused enough obstruction to necessitate such a procedure. When he was examined in 1906 the soft palate showed small, irregular patches of congestion, not raised from the surface, and without pigmentation. There was a slightly nodular condition of the pharynx. The right pillar of the fauces was somewhat contracted at the site of an old lesion, as was also the tip of the epiglottis. In the larynx, the nodules were so thickly placed that the vestibule was almost occluded, leaving only a small opening of two or three millimeters between the vocal bands and the vocal cords, for the passage of air. In a recent examination, I found that the lesions in the fauces had practically disappeared. Thorough cocaineization is necessary to examine the larynx, when drawing forward the epiglottis gives a good view. The change here is marked, the swelling having subsided about fifty per cent, so that the vocal cords are now visible, in part, and respiration through the larynx is fairly easy. The patient, however, has often experimented in removing the tube for a time, but has found it necessary to replace it, as his breathing soon became too labored for comfort. I hope, from the improvement that has taken place, that he will some time be able to remove the tube permanently.

His general health is now excellent. His gain in weight since the tracheotomy has been forty pounds, and during all the inclement weather of the past winter he has followed his occupation, driving a milk wagon. I would call your attention to his voice, which is clear and strong, and which can be heard in all parts of the room, without closing the opening in the tube, which he protects with a few thicknesses of gauze. At first I gave him a tube with a ball valve, which allowed the ingress of air, but was closed on expiration. He discarded this very soon as he could not breathe easily. I then substituted one with an oval opening in the upper surface of the tube allowing free passage of air from the trachea to the larynx. This opening has seemed unnecessary, and since February 1 he has worn an ordinary tube and the amount of air passing around it to the larynx is sufficient for good vocalization.

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Parotid Fistula after Mastoid Operation. F. KRETSCHMANN.
Archiv fur Ohrenheilkunde, July 1909.

Two of these unusual cases are reported. In both cases, a fistula occurred in the scar of a mastoid wound. In one case during the course of the healing of the original wound, in the other following a slight injury three years after the wound had healed. In both cases, the opening of the fistula was situated at about the level of the tip of the mastoid. The fistula was about two centimetres long and was directed upwards and inwards. In both cases a clear, thin watery fluid was discharged, the amount increasing markedly during mastication.

A fistula with a lymph-gland at the bottom would also discharge a large quantity of fluid; but the fluid in such cases is milky and contains fat. These characteristics were not present in the author's cases, but unfortunately a chemical examination of the fluid, which would have definitely established its origin from the parotid gland, was not made.

Both cases were cured by repeated cauterization with solid nitrate of silver, fused on a probe.

YANKAUER.

Tracheotomy in Slight Respiratory Obstruction Associated with Febrile Toxaemia. A. O. BISSON. *Lancet*, Jan. 26, 1907.

In fever practice there is a type of case occasionally encountered in which toxaemia is accompanied by very slight, apparently inconsiderable obstruction of respiration. Such cases are commonest in septic scarlatina, and now and then is seen in small-pox. There is also a septic type of diphtheria defined by Monti, in which the larynx is but little affected; there is slight obstruction, but it is not progressive, and the patient apparently dies as a result of the toxaemia.

The indications for tracheotomy in this type of cases are:

(1) *Difficult breathing.* In addition to the usual cause of obstruction there is not uncommonly marked lymphadenitis on both sides of the neck. This is often accompanied by edema, and even in some cases by an acute inflammation of the subcutaneous tissue of the neck,—possibly causing pressure on the trachea. Stress is laid on the fact that the obstruction is usually extremely light. It is its duration which tells on the general condition, and especially, on the strain of the heart.

(2) *Restlessness.* With this there may be return of fluid through the nose, cyanosis and extreme exhaustion.

(3) *Recession* is usually very slight, or even absent; it is only extreme in cases of laryngeal diphtheria.

(4) *Condition of the heart.*

(5) *Condition of the pulse.* There may be a typical pulsus paradoxus,—a sign of extreme gravity.

(6) *Color of the face*,—slight lividity about the mouth and nose.

(7) *Septic laryngitis.*

Tracheotomy has been done during the last one or two years for haemorrhage from the naso-pharynx in which the plugging of the posterior nares did not arrest the bleeding.

After tracheotomy the improvement within a few hours is remarkable. It is better to operate under a local anaesthesia. A high and rapid tracheotomy with a small incision is recommended.

In children under three the prognosis is not so favorable.

THOMSON.