AMERICAN LARYNGOLOGICAL ASSOCIATION.

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(*Continued from p.* 100.)

Ætiology and Treatment of Dentigerous Cysts.

By Dr. D. Crosby Greene, Jun. (Boston).

It had been shown that it was possible to make an artificial epithelial cyst by transplanting a bit of skin epithelium with its supporting cutis into the deeper tissues, as into the abdominal cavity. The epithelium, growing in its new location, spread over the space into which it had been placed, for which it made a lining with a small cavity within. Such an artificial cyst would continue to grow indefinitely. On the currently accepted theory of pathologists in regard to the growth of tumours, the formation of an artificial epithelial tumour within the jaw-bone could be accounted for rationally. The teeth were essentially epithelial structures, developed by invagination of the jaw epithelium into the body of the jaw. Other elements entered into the final tooth structure, but the origin of the tooth was this ingrowth of the jaw epithelium. Now, doubtless a bit of this in-growing epithelium was pinched off as an island of isolated epithelial tissue, and such an island pinched off from a tooth root grew in an atypical way, with the resulting formation of a cyst. In order to cure thoroughly such growths every bit of the epithelial lining must be removed, otherwise they might recur. The cavity must be opened widely, curetted thoroughly, and drained completely. This opening might be made into the antrum instead of into the mouth, thus avoiding infection from the latter. The closure of the cavity was often extremely slow, in spite of every attention to surgical technique. The antrum method was especially applicable to large cysts. One case history was given illustrated by an X-ray plate.

Dr. W. E. Casselberry asked if there was any method of distinguishing between dentigerous cysts and hydrops antri. He had reported cases under the latter title, but had always felt some doubt as to the correctness of his diagnosis.

Dr. N. H. Pierce (Chicago) said that there were two kinds of dental

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cysts, one due to the inflammation and the other due to errors in development. Cysts arising from inflammation of the peridental mucosa were often removed by the dentist, as the cyst was perched on the end of the root. This might come to occupy the entire antrum and cause what Dr. Casselberry had called hydrops. But it could not cause bulging of the antral wall. This came only from a true dentigerous cyst. The fluid in the latter contained cholesterin crystals.

Dr. J. H. Bryan (Washington) believed in the existence of hydrops antri, and also that it might arise from true dentigerous cysts. There was also such a thing as the hydrops of the frontal sinus.

Dr. D. Bryson Delavan (New York) thought it would be interesting to know what relation, if any, these cysts bore to the expansion found in the ethmoid cells and middle turbinate body.

Dr. Greene said, in closing the discussion, that it would be possible to distinguish between cyst and hydrops by washing out the cyst by puncture made from the cyst to the mouth under pressure. In cyst one got no fluid from the nose through the bulging in the mouth. If necessary a puncture could be made into the antrum intra-nasally, and then if the puncture did not result in fluid coming from the nose one could see the cavity was not the antrum. Transillumination on the side of a dentigerous cyst always gave a brilliant illumination.

Symposium on the Surgery of the Œsophagus.

Opened by Dr. S. J. Mixter (Boston), who considered the subject from the standpoint of the general surgeon. He did not believe that modern instrumentation did away entirely with the general surgeon in reference to œsophageal lesions. He detailed his personal experience with œsophageal strictures, and spoke of the various means of relieving them. In the detection and removal of foreign bodies modern methods with the œsophagoscope had scored many brilliant successes, but in the treatment of strictures the older surgical methods still had many advantages.

Dr. Chevalier Jackson (Pittsburg) continued the symposium from the standpoint of the laryngologist, discussing the question from the laryngological point of view. He said that in all cases a body which had entered the air-passages could be brought out by the same route, and that surgical operations to effect this result were no longer necessary. Rest of the œsophagus to reduce the ever-present inflammation was absolutely necessary, and only fluids should be allowed. In case of new growths, etc., the patient should have an early gastrostomy, and always before a resection of the œsophagus the stomach must be emptied of food (it never could be of secretions) and the bowels emptied by enemata. Care must be taken before operation to exclude aneurysm. The blind passage of a sound in a gullet not examined by previous direct vision was a dangerous procedure. The history of stricture

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from accident did not exclude malignancy. In the author's experience stricture was amenable to treatment by *bouginage per tubam*, dilatation with œsophagoscopically placed laminaria tents, œsophagoscopical string-cutting dilatation, and Abbe's retrograde string-cutting method. These methods were illustrated by the author, who also exhibited various instruments. He also referred to the operations of cervical œsophagotomy, lateral cervical œsophagotomy, and subhyoid pharyngotomy, gave the indications for each, and gave his experience in five cases, two of inoperable malignancy and three of stricture, in which he had inserted a tube into the stenosed lumen, which enabled the patient to swallow liquids and raw and soft-boiled eggs. He also described the operation of autoplastic repair of the œsophagus. He concluded by saying that in no case of dysphagia should œsophageal procedure precede œsophagoscopy, and it should be used to exclude neoplasms, spasms, compressive and inflammatory stenosis, as well as ulcerations and varicosities. Resection of the upper portion of the œsophagus, if it interfered with glottic closure, was so sure to be followed by septic pneumonia that it was wiser to close off the larynx or to extirpate it, bring the trachea forward and stitch it to the skin. In all these operations the strictest watch over the entire operating-room organisation is necessary. Nurses and internes were apt to be led into carelessness by the fact that the field of operation could not be sterilised. They forgot that while the patient was more or less immune to the organisms he himself harboured he was not immune to organisms even of identical kinds introduced from other sources.

Dr. Harris P. Mosher (Boston) gave the histories of two cases of stricture of the œsophagus with dilatation, and one of diverticulum, all resulting successfully. He said that the lumen of the gullet was very much larger than we were accustomed to think, both in the infant and adult. At one year of age it would pass a flat pearl button one inch in diameter. Between two and three years it would admit to its upper part the end of a Jackson spatula. The older text-books stated that three-quarters of an inch was the safe limit for dilatation in stricture cases, but this measurement was manifestly two small. A negative examination with a small tube under cocaine was useless and amounted to nothing. Ether was advisable. Strictures were best diagnosed and treated by means of the œsophagoscope, and instruments used through it. Opening of the stomach for non-malignant strictures ought to become a rare procedure. To open the gullet from the side of the neck for the removal of smooth foreign bodies was already obsolete surgery. The ballooning of the œsophagus for locating the lumen of tight strictures bids fair to be a great help to us. The direct method of carrying a capsule filled with thread through the stricture into the stomach was much better than feeding the thread to the patient. Not all strictures could be dilated;

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some would have to be cut. The instruments for this were similar in principle to those used in cutting urethral strictures. For perhaps two inches in the upper part of the gullet it was safe to cut backward and risk perforating the posterior wall.

Dr. Emil Mayer (New York) referred to a child with congenital stricture of the œsophagus whom he had seen, and whose history had been reported twenty years ago. The passage of a large bougie, under anæsthesia, enabled her to swallow. Since that time she had grown up in a perfectly normal way. In a recent case of a man a bougie was arrested nine inches from the teeth, and could not be passed further. A diverticulum was thought of, and a piece of rubber-tubing was passed, and then an X-ray picture taken showing a pouch. Dr. Mayer thought it was risky to fill such pouches with bismuth, as it might be difficult to get it out.

Dr. J. O. Roe (Rochester) referred to two cases of internal œsophagotomy he had reported. In one patient, a boy, aged eight, with stricture, he had first passed a small bougie and then the œsophageal knife. Five years later the boy was perfectly well. The second patient was a woman, aged thirty, with stricture following the lodgment of a chicken-bone in the throat. Dr. Roe said that he had now under observation a woman, aged sixty-five, with a pouch of the gullet, and that by passing a hollow bougie occasionally he was able to keep his patient in good condition. He did not think it quite safe to do any cutting operation in this case.

Dr. G. L. Richards (Fall River) referred to the case of a colleague who had inserted the familiar "coin-catcher," found it impossible to remove it, and had to do a tracheotomy. He supposed the instrument had been caught by the cartilage, which was not pressed downward and forward as Dr. Mosher had suggested.

Dr. D. Bryson Delavan (New York) thought that the advance of surgery was to-day being seriously threatened by the too general operating in cases requiring special skill by men not specially qualified for it. Such work as that described to-day should be given to those men who make a special study of it, rather than to general surgeons indiscriminately.

Dr. Jackson said that he regarded the old-fashioned "coin-catcher" as a dangerous instrument, as it might get caught, tear out the inside of the larynx, and bring the patient into great danger.

Some Observations upon the Complete Extirpation of the Diseased Faucial Tonsil.

By Dr. J. S. Gibb (Philadelphia).

Particular reference was made to the method followed with the boys who entered Girard College in his city. General anæsthesia was used except with older boys with non-adherent tonsils. The tonsil was pulled from its bed and its attachments to the pillars broken by the Allis blunt dissector. When the attachment was very firm scissors or tonsil knives were used. The finger was introduced, and an endeavour made to break up the deeper adhesions and leave the tonsil hanging to be removed with the wire snare. Fragments of tissue remaining could be removed

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with the punch forceps. If it was necessary to remove a tonsil at all it should be done completely. The wire snare was far more efficient than the tonsillotome in bringing about the desired condition, viz. removal of all diseased crypts. In this method of finger enucleation too strenuous use of the finger should be avoided in breaking up the adhesions. It was far better to snip with a curved scissors. At times the reaction was greater than with the tonsillotome, in spite of all care. Of one hundred cases thus treated the average time in the infirmary was four days. In ninety there was a fever between 99° and 101·5° F. In nine cases in which the friable nature of the tonsillar tissue was very pronounced, and in which there was much dissection and the use of punch forceps called for, the fever rose to 102° F. and over. In two there was regurgitation of fluids through the nose. The fauces were indurated, and there was sloughing over the area of the tonsillar wound. It was rare to have any severe bleeding in this method.

Dr. E. L. Shurly (Detroit) commended the views of Dr. Gibb, but said that, while we were all familiar with the immediate results of tonsillotomy, we did not know so much about the remote results. We must remember that the tonsil had an internal secretion, and we did not know the possible results on the pharynx, stomach, and contiguous or neighbouring organs following the removal of all the tonsillar tissue. He said that disagreeable atrophy might ensue. We should indeed remove all diseased crypts, but have we not done enough by so doing? Should we not leave enough tissue to perform the functions of the tonsils?

Dr. W. E. Casselberry (Chicago) did not agree with Dr. Shurly. We should always remove the tonsillar tissue completely. He used sharp cutting instruments in the operation. We should be sure to remove the tissue included within the velum, which he had named the "velar" lobe. He described his method of operating. He used a tonsillotome, which was a modified Mathieu instrument with the fork cut off, and had a snare-like action.

Dr. O. T. Freer (Chicago) used sharp instruments in freeing the tonsil from its adhesions. He separated the velar lobe last, making traction on the tonsil by means of a sickle-shaped knife. In this way the organ was turned wrong side out and cut away with a curved knife.

The method of finger dissection was commended by several members.

Dr. J. F. Barnhill (Indianapolis) said that whatever function the tonsil might have, there was plenty of other tissue in the throat which would take care of that function, especially since the tonsil was diseased. The tonsil pits often filled up after removal with granulation-tissue, but sometimes adhesions formed between the anterior and posterior pillars, and these might pile up on the tongue and bind it down. After-pain was less with sharp cutting instruments. He made firm pressure with a pad soaked in hydrogen peroxide immediately after removal, and then when the pad was thoroughly dry he covered the area with Monsel's solution, but he did not believe in using this solution until the area was fully dry.

Dr. C. G. Coakley (New York) said that there had been in his cases

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anywhere from two to four weeks after operation a small mass of granulation tissue, which he removed by either the punch or nitrate of silver. There was often left an irregularity of the lower edge of the velum on the two sides, and he wondered what effect, if any, followed in professional voice-users.

Dr. G. Hudson Makuen (Philadelphia) thought that one great element of value in Dr. Gibb's paper was that he had been able to watch his cases so closely and report on their condition some time after operation. He would as soon think of leaving a decayed tooth-root in the mouth as to leave a portion of a tonsil.

Dr. R. C. Myles called attention to the basi-lateral tonsils he had described some fifteen years before. He had seen them extending at least three-quarters of an inch into the palate, and when the entire capsule had been removed there had been a cellulitis extending into the zygomatic fossa. Sections of the superior constrictor muscles were too often removed along with the tonsils.

Dr. J. Price-Brown (Toronto) had been told by a music teacher of his city that several pupils had had their singing voices practically destroyed by the removal of the tonsils.

Dr. W. K. Simpson (New York) thought that we were too apt to base our opinion on the immediate sequel following removal of the tonsils, and that we might get from the filling up of the tonsillar fossa with cicatricial and connective tissue an interference with the muscular action of the velum which would be just as harmful as the leaving behind of a small portion of the tonsil.

Dr. J. O. Roe said that patients sometimes complained more of septic trouble around the neck and of glandular swellings after the tonsil operation than before it. When a tonsil was diseased it was diseased all the way through, for the crypts go all the way to the bottom of the tonsil, and if one left a portion behind one had increased absorption of the septic material in the region.

Dr. Emil Mayer (New York) deprecated the use of the finger. Modern surgery called for the use of rubber gloves. He used a blunt dissector, with an edge filed so that it could be used as a knife. He thought that too much emphasis had been laid on the amount of blood in these regions.

(*To be continued.*)

Correction.

On line 3 of page 79 of the February number of the Journal of Laryngology, Rhinology, and Otology, the words "optic tracts" should read "carotid tracts."

As this error in Dr. Syme's interesting paper is of considerable importance, we trust our readers will make the correction in their copies.

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