PARALYSIS OF THE PHARYNX*

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In this paper I propose to deal with two major diseases which cause pharyngeal paralysis; then to mention various conditions which may appear to cause paralysis but which do not; and lastly to make some comments on so called neurotic choking spasms.

Myasthenia Gravis

This disease is well known to all. The clinical features have been fully and exactly described in the textbooks for over half a century. Despite this it still often gives rise to difficulty in diagnosis. This difficulty is largely a matter of confidence and is more likely to be experienced by those who only see an occasional case than by those who see them frequently. A firm diagnosis may have to be made merely on the complaint of weakness without any objective finding. The clinician who does not see these cases often may be unwilling to make a firm and important diagnosis on such an unsubstantial basis.

The pharyngeal muscles are nearly always affected in myasthenia gravis at some time in the disease. This remark does not apply to the local form which may remain confined to the external eye muscles for the whole of the patient's life. It is unlikely that laryngologists will see a case with an established diagnosis merely because the pharynx becomes paralysed. His important function is to detect, or at any rate suspect, myasthenia when pharyngeal paralysis is the first symptom.

Pharyngeal palsy is the first symptom in about one-fifth of all cases. This is a high proportion. In addition partial paralysis is often present unnoticed or uncomplained of when patients first present themselves for other symptoms. The frequency with which this muscle is paralysed has been made the basis of a diagnostic test which consists of showing radiologically that the movements of the pharynx return to normal under heavy doses of neostigmine.

Something like four-fifths of cases first present between the ages of 20 and 30 years. There is a danger here that pharyngeal myasthenia may be misdiagnosed as hysteria, especially in women. Another common age at which symptoms first appear is between 60 and 70. Pharyngeal palsy may be easily mistaken for the common degenerative conditions and therefore not be given the treatment that would cure it.

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Dermatomyositis

This disease is not common. It is not well known and very inadequately treated in textbooks. Its clinical features in fact are still in the process of description and definition. There is still doubt as to whether scleroderma should be considered the same disease or not. It is therefore quite possible that the diagnosis will never occur to a laryngologist when first presented with a case. The following illustrates both the difficulty and ease of making a diagnosis :

> A woman of 50 complained after a summer holiday that food stuck in her throat. She was sent to a laryngologist who could find no cause for obstruction and referred her to a physician for elucidation. The patient's face and hands at this time were covered with an œdematous, erythematous rash. She made no complaint of this believing it to be sunburn from her holiday and her medical attendants apparently accepted this diagnosis. While she was waiting in the ward, a dermatologist passed by and casually asked where that acute case of dermatomyositis had come from. The diagnosis was immediately obvious to him as he was familiar with these cases.

Dermatomyositis is an inflammatory condition of unknown origin which affects chiefly the skin and the striated muscles. The skin of the face and hands is most commonly affected. In the acute stage it consists of erythema and œdema which is sufficient to cause swelling of the eyelids. The hands show erythema and slight swelling, particularly over the knuckles. As the inflammation progresses the usual phenomena of atrophy and fibrosis appear. The skin then becomes taut and shiny with obliteration of the usual creases. Pigmentation, depigmentation and telangiectasis appear. The hands may be clawed and fixed, owing to the shrinking and tightening of the skin. The muscular paralysis may be the predominant symptom in acute cases. Some paralysis is always present in the more chronic ones but may at first hardly be noticed compared with the skin changes. Paralysis of the pharynx is quite common. Later the muscles of the trunk and limbs are extensively involved.

These appearances, like all appearances, are difficult to describe and can only be recognized with certainty after they have been seen. There is no specific test, though the daily urinary creatine excretion is raised. This happens in other states of muscular wasting, and its chief value is that a diagnosis of paralytic dermatomyositis is unlikely to be correct if the excretion is normal. Perhaps it is sufficient for the laryngologist to remember that dermatomyositis may be worth considering where any rash on the face or hands accompanies a pharyngeal palsy.

The prognosis is variable. About half the cases die in a year or two.

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A few, especially in the young, appear to clear up without serious sequelae after a few months' acute inflammation. Others persist with many fluctations but on a slow downhill course for many years. There is no cure.

Scleroderma, if it is indeed distinct from dermatomyositis, does not cause paralysis of the striated muscle. Smooth muscle, however, is progressively disintegrated so that dysphagia may result from paralysis of the lower two-thirds of the œsophagus. The skin lesions may be very similar.

Conditions which may simulate Paralysis

It may be difficult to be certain that the pharynx is paralysed, especially if it is mild and symmetrical. Paralysis may, therefore, often be suspected in cases of dysphagia due to other causes.

Iron deficiency is a common cause of such dysphagia. Its true nature has to be diagnosed by the accompanying anæmia and epithelial dystrophy which is shown in the brittle nails, angular stomatitis, smooth (not sore) tongue and the peculiar change in the hair and face. The incidence of these symptoms may vary considerably in different patients. Anæmia is certainly the commonest though others may be present without it. Dysphagia is unlikely to be due to iron deficiency if the tongue remains furred. Dysphagia appears to be rare in southern England, or perhaps the patients are recognized before they get to this stage. It seems, however, to be a common presenting symptom in parts of Scandinavia, Ireland and the States. The symptoms, if not too chronic, are rapidly cured by iron given by mouth or intravenously. Hydrochloric acid is unnecessary and useless. It has recently been shown that achlorhydric gastritis is the result of iron deficiency and not the cause of it.

Xerostomia is a common degenerative change of old age which causes difficulty in swallowing. It is usually accompanied by smooth tongue and there may well be epithelial atrophy of the pharynx as well as diminution of the salivary secretion. In younger persons xerostomia may follow influenza or other virus infections, or may be part of Sjögren's syndrome.

A recent dysphagia is often due to carcinoma of the bronchus, lower œsophagus or upper end of the stomach, even though they cannot be demonstrated at the time of examination. Inability to swallow food, or " heaving against it " may be nothing more than an expression of severe anorexia, which turns to actual vomiting when the anorexia is even more severe.

Choking Spasms

I am referring here to the sudden attacks of choking and inability to swallow which may occur in middle aged or older persons and continue a chronic course without obvious cause. The symptoms are most distressing

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and added to this is a reasonable fear of cancer. The patients go from doctor to doctor and are investigated by various specialists without conclusion. In the end they are seen by a psychiatrist who will naturally reveal various emotional difficulties which are bound to have occurred in anyone throughout the course of a normal life. The symptoms are eventually diagnosed as neurotic, but as this leads to no cure the patient in the end has to become reconciled to what is in any case inevitable.

In the present climate of opinion it is considered satisfactory by the profession to make a diagnosis of neurosis where organic mechanisms cannot be recognized. Since the cause of these patients' symptoms is unknown it is, of course, impossible to deny that they may not be psychogenic, but I feel that considerable scepticism should be introduced to counteract the readiness with which this diagnosis is made.

It is obviously true that the throat is a part of the body where emotional symptoms are commonly shown, especially in young women. The patients I am referring to, however, have apparently been normal for the whole of their life, and even if they have had emotional difficulties it is impossible to show their relevance to the symptoms.

Whatever the origin of the disturbance it is probable that the choking has in fact an immediate organic basis in pharyngeal spasm. X-ray photographs have from time to time been obtained showing this phenomenon. (One was shown through the courtesy of Dr. Frank Elliott.)

The question may be asked whether there is any known organic condition which does cause intermittent spasm of the pharynx because if there is then clearly other organic disturbances at the same part of the nervous system would cause the same symptoms. Such an example is seen in rabies in which " hydrophobia " is due to a spasm of the pharynx induced by the action or thought of swallowing food or fluid. The syndrome I am referring to is clearly not due to hydrophobia, but it is not inconceivable that its origin may be a disturbance of the same part of the nervous system, perhaps degenerative in nature. Swallowing is a complicated movement and as we know is easily disturbed either through failure of the nervous mechanisms anywhere from their most peripheral point, up through the automatic co-ordinating mechanisms to the highest points where it becomes pointless to argue whether the disturbance is organic or psychogenic.

We are often faced in medicine with the unknown. In these circumstances there is a temptation to settle for the diagnosis which satisfies ourselves. It is better, however, to decide what is most useful for our patients. It is never in these cases comforting or convincing to the patient to be told that the trouble is psychogenic. It merely adds shame and guilt to their distress. Psychotherapy does not cure, though at least the patient has got a doctor who tries to relieve the symptoms, and this

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is infinitely better than repeated investigations. A patient is much worse off with no diagnosis than with no cure, so that it is essential early on to give a confident opinion. It is best to give this in terms which lay the blame for lack of cure on the inadequacy of medicine and the ignorance of doctors rather than on the shortcomings of the patient's personality.

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