A Case of Laryngeal Disease for Diagnosis. Shown by Mr. E. W. Roughton.

A man aged forty-two, suffering from hoarseness, cough, and dyspnœa of three months' duration. There was a swelling involving and fixing the left cord and arytænoid. No evidence of tuberculosis and no history of syphilis. He asked for a diagnosis.

Mr. de Santi was of opinion that this case was a case of epithelioma. There was marked infiltration of the parts and very impaired mobility. Moreover, the redness was quite unilateral, and fulness could be seen below the cord. An early laryngo-fissure was urgently needed.

Dr. William Hill said he was inclined to think it was malignant. There were no glands on the outside; it was the sort of case well suited for an exploratory thyrotomy.

Sir Felix Semon suggested removing a piece first.

Mr. Roughton said there was nothing to catch hold of; he might puncture the arytænoid cartilages, and most of the growth was lower down. Mr. Roughton had no definite suspicion of its nature.

Dr. StClair Thomson said the cord was quite fixed, and the growth extended below the cord. He thought it a good case for laryngo-fissure.

AMERICAN LARYNGOLOGICAL ASSOCIATION.

Twenty-first Annual Congress, held at Chicago, May 22, 23, 24, 1899.

President, Dr. William E. Casselberry, *of Chicago.*

First Day.—Monday, May 22.—*Morning Session.*

President's address: This association was organized in response to an invitation sent out by the late Dr. Frank H. Davis, of Chicago, who may thus be said to have been its real founder. It is therefore eminently fitting that we should meet in the city where the founder lived and worked. The time-honoured custom of an address from the President affords opportunities for dwelling upon various matters which might not be appropriate for any set paper or discussion. I therefore beg leave to call your attention to some of the topics which may thus properly be considered. All are doubtless conscious of the changes wrought in laryngological practice by the advance of nasal pathology, and by the inclusion of the ear in the sphere of work. The laryngologist formerly treated

https://doi.org/10.1017/S1755146300193436 Published online by Cambridge University Press

diseases of the throat and chest. Now he tends to be a surgeon with a routine of practice limited to local measures applied to the upper respiratory area. We should strenuously deprecate the tendency to deal with the nose and throat exclusively in a mechanical way, and as if they were parts without organic relation to the rest of the body. Such a view engenders narrowness of thought, and the practitioner thereby loses much of that fundamental knowledge of pathology and applied therapeutics so demanded by the patient's best welfare. The proper care and treatment of nasal troubles are by no means effected simply by boring a hole through the nares and thereby making them patent, though the ill-advised procedures of many posing as laryngologists would seem to indicate that such was the case. It is freely conceded that the ear and nose stand in intimate relations. The laryngologist must treat aural affections, and he should cultivate an exhaustive knowledge of this branch of medical science. Care should be taken not to neglect, in enthusiasm for the ear, the original laryngological study. Such a tendency to render undue homage to the ear is shown in the use of such words as otolaryngology, otorhino-laryngology, etc. In addition to this, there are many in the smaller towns who combine eye-work with that of the nose and throat, and hence there are many posing as laryngologists whose education and restricted routine of practice put them out of touch with many pertinent phases of the subject. The laryngologist of to-day should constantly endeavour to make the real diagnosis in the earliest stage of lung tuberculosis. Many of these patients are liable to come first to him complaining of cough, irritable throat, husky voice, and inclination to nasal inflammations. While they may complain only of throat trouble, they should be exhaustively examined. The conventional injection, spray, or cauterization does not suffice. The laryngologist need not embrace in his practice the entire broad field of chest diseases, but he should be familiar with every art of diagnosis and every therapeutic resource in order to do his patient justice. For the former he should keep himself proficient in the making of physical examinations of the chest, should carefully note the height and weight of his patients, their chest conformation and perimeter, should ascertain the vital capacity, be able to stain for bacilli, and be versed in the use and interpretation of the tuberculin test. Incipient infiltration of the larynx, disclosed only by the mirror, may afford the earliest clue to the existence of pulmonary trouble. The presence of polypi in the nose, with degeneration of the middle turbinal and unassociation of sinus disease will enable us to exclude tuberculosis in favour of bronchial asthma or chronic broncho-

https://doi.org/10.1017/S1755146300193436 Published online by Cambridge University Press

pneumonia. Inspection of the throat will also frequently reveal the cause of cough or hæmorrhage, which otherwise might be regarded as evidence of pulmonary mischief. Attention must also be given to the heart, aorta, and mediastinum. Aneurismal pressure will often show itself by the paralysis of a vocal cord. In old persons an elongated uvula will often appear to be the cause of an irritable cough, but a more careful examination may reveal an enlarged heart with valvular lesions. Hence, while the uvula may be an exciting factor in the production of the cough, the underlying cause must be attributed to the irritability of the respiratory tract brought about by failing cardiac compensation.

The laryngologist should also be a good systematic therapeutist, and cultivate the habit of careful prescribing. He should study the conditions of natural immunity and susceptibility, so that he may be able to designate the proper mode of life and place of abode best adapted for each individual case, familiarizing himself with sanitation, hydrotherapy, climatology, and sanitary methods. Reports from the Rocky Mountain region show that 20 per cent. of cases of laryngeal tuberculosis can be cured in that locality, and that an additional 20 per cent. can live along greatly improved for an indefinite period.

In connection with bronchial asthma, present-day studies in nasal pathology establish the fact that vaso-motor changes are at the bottom of many of these cases, which are accompanied with polypoid changes in the ethmoid region. The laryngologist should be ready to assume complete charge of all such cases, treating them along broad therapeutic lines.

All laryngologists are familiar with many throat conditions which appear as salient features of underlying systemic states. Œdema of the larynx is often secondary to nephritis; laryngeal ictus is often the forerunner of tabes. Hence the true clinician in the special field of laryngology should be first of all a good physician, and after that a specialist. Nor need a man with this breadth of view be any less skilled in the operative technics of tonsillotomy, in the rectification of deflected septa nasi, in the surgery of sinusitis, and in mastoid affections. He can appreciate the disadvantage of nasal obstruction just as well as another who perceives that alone.

Gentlemen, we have met to aid each other in the search for more truth. Let us profit by each other's experience, search along more liberal lines, and endeavour to realize that conception of power phrased by the Sage of Concord: "A cultivated man, wise

https://doi.org/10.1017/S1755146300193436 Published online by Cambridge University Press

to know and bold to perceive, is the end toward which Nature works."

Is the so-called American Voice due to Catarrhal or other Pathological Conditions of the Upper Air Passages? By Dr. JOHN W. FARLOW, of Boston.

He said that the so-called American voice was characterized by a peculiar nasal twang, which was quite distinct from the vocal modifications arising from faulty conditions in the fauces and larynx, which are not here considered. Such latter were the thick voice of enlarged tonsils and the voice of low carrying power, due to various laryngeal affections. Any interference with the free passage of air through the nares impaired vocal resonance, but did not produce the peculiar American nasal voice. Anterior deviations and spurs of the nasal septum occasioned abnormal air vibration in the nose, as also did a narrowing of the organ at the tip, especially when it was bent downward. Anterior turbinal enlargements and polyps acted in a similar manner, and in the same category might be included chronic catarrhal inflammation of the nasal mucosa without hypertrophy. From all these causes there resulted anæsthesia and paresis of the soft palate; hence some tones which should be formed in the mouth were produced in the naso-pharynx at a higher level. This was probably the reason why the nasal twang persisted after operations had been done for adenoids, for it took some time for the palate to grow out of its paretic condition. The twang did not seem to be caused by merely atrophic conditions. For purposes of study we might group our patients into three classes, according to age—below twelve, between twelve and thirty, and over thirty years. In the first class, nasal voice was very common, but the foregoing lesions, which might be regarded as its cause, were not especially frequent at this stage of life. In the second class, the lesions were more common, but this particular variety of voice was less so. In the third and older class, nasal voice was comparatively infrequent. From this line of reasoning, it followed that the nose alone did not determine the classification into nasal and non-nasal voices. Voice-training would often improve its quality without any special intervention, medical or surgical. In short, pathological conditions seemed to have far more influence on the range and power of endurance of the singing voice than upon its quality in the median register. In children, nasal voice was often only a matter of imitation, cured by placing them with persons who spoke properly. It must be stated also that the possession of an agreeable voice was quite compatible with

https://doi.org/10.1017/S1755146300193436 Published online by Cambridge University Press

the existence of abnormal anatomical conditions. All civilized races presented anterior obstructions. The great emigration of all nationalities to this country had introduced into our common speech all sorts of bizarre vocal sounds, and we were very careless as to the best methods of speaking. Yet some of the most pronounced nasal voices were heard in country villages, where the population was purely native. The necessity of properly training children's voices could not be too strongly urged. They should be removed as far as possible from vicious influences in this respect. Every autumn our newspapers were flooded with advertisements of singing teachers, each one of whom claimed to possess the correct method, but only one person sang while a hundred talked. People fell into the conversational habits of the community in which they lived, and made no effort to better faulty methods.

Discussion of this paper was opened by Dr. G. Hudson Makuen, of Philadelphia, who deplored the lack of attention given to tone formation as a rule. The medical man knew little about the subject, but the laryngologist especially should be in a position to instruct the singing teacher. The excessive tension of our American life was partly the cause of the nasal voice, and we must learn to cultivate the teachings of the "gospel of relaxation," for our American push was fast assuming the proportions of a national calamity. So far as the anatomical factor in this question was concerned, the low-hanging palate during speech was probably the prime element, as it centred the vibrations of sound-waves in the naso-pharynx. By practising before a mirror with the mouth open, the patient could learn to give the proper tone to the levator palati muscles.

Dr. T. Amory De Blois, of Boston, thought that the peculiar quality of voice was largely a racial question. The guttural of the German, the vibratory nasal voice of the French, and the high-pitched tones of the Yankee were familiar illustrations, while the English voice among all social ranks was of an agreeable low pitch.

Dr. John O. Roe, of Rochester, called attention to the "resonator" office of the nasal sinuses, the size and shape of which strongly modified the voice. Their influence was not cut off by anterior obstructions, but posterior ones greatly affected it. The structure of a given language affected voice tone. Languages with many consonants, as German and Russian, gave low-pitched voices, while one with many vowels, as French, gave the opposite.

Dr. A. W. De Roaldes, of New Orleans, mentioned American conversational habits, instancing the fact that racial mixtures and the easy mode of living in the South produced lower-toned voices

https://doi.org/10.1017/S1755146300193436 Published online by Cambridge University Press

than different conditions in this respect in the North. Negro voices were rarely high-pitched.

Dr. Thomas Hubbard, of Toledo, ascribed to the noise of our American cities much of the prevalent high-pitched speaking. This was necessary in order to make one's self heard. From the noisy environment, also, the ear became dulled, and the appreciation of vocal misuse was blunted.

In closing the discussion, Dr. Farlow expressed the view that the low palate was often due to lack of use, but he could not look upon it as the initial cause of nasal voice. Its causative relation was secondary, not primary. So far as the influence of the sinuses was concerned, he would remind the Association that nasal voice was most common in children in whom the sinuses were scarcely at all developed. Voice was but very little due to language, for English was spoken in many lands, none of which presented the American nasal tone. As to city noises, the most pronounced twang was often heard in the quiet village.

Adeno-Carcinoma of Nose, with Report of Case. This was a paper by Dr. James E. Newcomb, of New York.

The Transactions of the Association for two years ago contained the report of two cases of this nature, and allusions in all to twenty-three other cases in which the clinical diagnosis had been verified by microscopical observation. The additional case to be reported was that of a woman, aged sixty-one years, who had suffered for nearly six months, before coming under observation, from daily nose-bleed, with obstruction of the left naris. Bleeding had been severe on one or two occasions, but had never required any operative interference. There was some emaciation. Three months before coming under observation she had blown from the nostril what was probably an ordinary polyp. Examination showed enlargement with polypoid degeneration of the left middle turbinate. Around it were several fleshy proliferations, which bled easily upon manipulation. Pressure symptoms and glandular enlargements were absent. Masses were removed under cocaine. The pathologist's report was adeno-carcinoma. The patient has thus far refused radical operation. Some six authentic cases of this nature have been reported during the last two years. Cancer of the nose is rare. Gurit was able to find only four cases among 9,554 cases of cancer of all organs. It was claimed that the association of ordinary polyps with carcinoma was only a coincidence. Tissier, who has written at length upon this phase of malignant disease, does not believe that the epitheliomatous degeneration of simple

https://doi.org/10.1017/S1755146300193436 Published online by Cambridge University Press

polypi had ever been definitely proven. What we know about the etiology of nasal polypi would explain their occurrence in a cancerous nasal fossa. On the other hand, Plicque stated that it was pretty frequent after the ablation of numerous benign polypi to find new polypi appearing, this time composed of epitheliomatous tissue. Dr. Newcomb thought the latter statement incorrect, for polypi were very numerous and often removed by very crude means, while the occurrence of cancer here was very rare. Mention was made of a surgical procedure suggested by Dr. Dawbarn. It consisted of the ligation on both sides (a suitable interval occurring between the two operations) of the eight branches of the external carotid artery, and then of the excision of the entire trunk of this vessel in the attempt to starve the growth by shutting off its blood-supply.

Dr. G. V. Woolen, of Indianapolis, mentioned the case of a girl of eight years who had in the nostril what appeared to be an ordinary polyp, which came on two years after an injury. Removal was followed by recurrence. The microscopist reported on the original polyp that it was non-malignant, and only mucoidal in character. The later clinical history showed that it was malignant, and it extended over so wide an area as to be inoperable.

Dr. J. L. Goodale, of Boston, spoke of the case of a man aged fifty-one years from whose nose polyps had been annually removed for some years. The last removal was in May, 1898. Five months later there came on exophthalmos, pain, and nasal obstruction, with the left naris full of a soft bleeding mass, which was removed and showed a fibrous stroma with epithelial cell nests. Recurrence took place.

Dr. Thomas Hubbard, of Toledo, said that he had under his care a farmer who had had antral suppuration for seven years. Later a growth appeared within the antrum and thence extended into the naris. Examination of a portion removed revealed the presence of cancer.

Removal of a Foreign Body from the Bronchial Tube through a Tracheal Opening. This paper was by Dr. A. Coolidge, Jun., of Boston.

The patient, a young man aged twenty-three years, was tracheotomized in early childhood and had worn a tube ever since. The last one, of hard rubber, from long use gave way, the tube proper becoming detached from the shield and being inhaled. Severe cough with difficult and noisy breathing was present on admission to the hospital twelve hours later. An X-ray examination was negative. He was etherized and placed on his back, with

https://doi.org/10.1017/S1755146300193436 Published online by Cambridge University Press

head extended and rotated to the right. The original tracheal wound was enlarged downward and to the right. A urethroscope half an inch wide and three inches long was passed down (with stylet in position); the stylet was then withdrawn and the speculum without difficulty pushed down the trachea to within an inch of the bifurcation. A hand-mirror and sunlight afforded suitable illumination, by which means the upper end of the tube was seen in the right bronchus about half an inch below the bifurcation. A pair of alligator forceps passed through the speculum effected its removal without disagreeable after-effects. During the entire operation breathing was carried on through the tube. Cocaine had been applied to the tracheal mucosa, so that there was no inconvenience from secretion, though at first the cough caused some annoyance. Septic pneumonia was the ever-present danger when foreign bodies in the air-passages were treated on the expectant plan. Hence it was necessary to have well-defined courses of procedure to follow as occasion required. When the body was so large as to lead one to believe that it was still in a main bronchus, tracheotomy with exploration by straight tubes was the course to follow. If the smaller size of the body had carried it down to a secondary bronchus, we might still operate if there was a good chance of reaching it after illuminating the primary bronchus. This might be done, especially on the right side. A body which was moving to and fro in the windpipe was not so dangerous as the same body impacted in a bronchus. We should therefore sedulously avoid everything calculated to excite respiratory spasm. Consequently cocaine was preferable to ether for tracheotomy. Occasionally it might be possible to pass a straight tube down through the glottis, but care must be taken to avoid pushing a loose body farther down. Here it was wiser to attempt to reach it by tracheotomy from below. The most rigid rules of surgical cleanliness must be followed. We knew that the lower trachea and the bronchi were quite flexible, and this was a favouring circumstance, as it allowed us to bring into a straight line the bronchus under observation.

Dr. H. L. Swain, of Newhaven, related the histories of two cases. Statistics showed that foreign bodies were frequently expelled, sometimes months after they had found lodgment. Then ulcerative processes caused their dislodgment. In one of the cases mentioned by him a shingle nail had remained in the bronchus for several months, when the patient was struck by a train and knocked senseless. Upon coming to he was seized with a fit of coughing, and the nail was brought up.

Dr. Roe declared that, after looking over the statistics of

https://doi.org/10.1017/S1755146300193436 Published online by Cambridge University Press

thousands of cases, he had come to the conclusion that the best procedure was to leave the body alone if it was not producing active symptoms, for in the vast majority of cases the body had been expelled later.

Dr. ROALDES believed that operation should not be deferred. In eight cases which had come under his personal observation, operative intervention had been undertaken, and the body was removed in seven. A low tracheotomy should be done, and the bronchus titillated so that a reflex cough would be set up, the edges of the tracheal wound being held widely open. He would object to the Association's advising a policy of non-intervention in this class of cases.

Dr. WOOLEN thought that if there were no immediate symptoms, and if the body was of such a nature that it might as a possibility be easily expelled, it was prudent to wait; but if the reverse conditions obtained, one should operate at once.

Exhibition of a Case of Stammering, with Demonstration of the Methods Employed in Treatment. This paper was read by Dr. G. HUDSON MAKUEN, of Philadelphia.

His patient was a civil engineer, twenty-nine years of age, who had suffered since childhood without assignable cause. The condition appeared to be the outcome of a congenital neurosis. The main feature of this defect was a spasmodic action of the palatal muscles whenever attempts at speech were made. There resulted a sudden closure of what the writer would call the posterior palato-lingual chink. The frequency and duration of the attacks varied. They came on at most unexpected times, giving the speech a jerky character and at times stopping it completely. Attempts at reading increased the difficulty, and the patient seemed at times to be unable to think connectedly. We must study out the site of the neurosis in each individual case, for no two were exactly alike. A younger brother of this particular patient began to stammer, but was cured by giving attention to his malady. The occurrence of the speech difficulty in two members of the same family, and at such an early age, rendered the theory of a congenital neurosis in this particular case extremely probable. In the patient shown, the chief neurosis was in the nerves going to the respiratory and not those going to the pharyngeal muscles, the spasm of the latter being secondary and due to a reflex overflow of nervous energy from the respiratory and vocal mechanisms. The vocal element of speech was lacking in promptitude. It was as if the bow-hand of one playing the violin should cease to operate in unison with the string-

https://doi.org/10.1017/S1755146300193436 Published online by Cambridge University Press

fingers, and as if the latter should try by increased energy of action to make up for the defective bowing. This forced and unnatural fingering had its counterpart in articulatory and other spasms of the stammerer. Normal speech was characterized by automatic action of the various muscles, and when any portion of the complex mechanism failed to functionate, this automatic sequence was broken, and stammering resulted from a failure to make the various sets of muscles co-ordinate. In this particular case, inasmuch as the primary fault was in the respiratory mechanism, resort was had to direct nervimuscle training. In this the faulty muscles were singled out and by voluntary exercises made to act properly. This plan was superior to the indirect method, which led the patient unconsciously by means of correct speech to use the muscles properly. The advantage of the former was that it developed the nerves as well as the muscles, and established a volitional control over the faulty mechanism. The essential parts of the respiratory mechanism were the thorax, the muscles regulating its size, and the nerves supplying them. The muscles were divided into two sets according as they elevated or depressed the ribs. The levators were inspiratory and the depressors expiratory. We could train our patients to develop the action of any of these muscles, even the diaphragm. Then we could combine the muscular mechanism with the vocal.

At the close of the morning session the following specimens and instruments were exhibited : By Dr. FARLOW, large adenoids removed from a woman fifty years old, also an intranasal splint. By Dr. SWAIN, for Dr. THOMAS R. FRENCH, of Brooklyn, post-nasal forceps, mouth-gag, and a modification of Bosworth's nasal speculum. By Dr. COOLIDGE, a nasal splint for external injuries, and a laryngeal applicator devised by Dr. J. Payson Clark, of Boston. By Dr. CASSELBERRY, a nasal snare.

Afternoon Session.

Septic Phlebitis with Thrombus as a Complication of Peritonsillar Abscess ; Report of Two Cases. This paper was by Dr. M. R. WARD, of Pittsburg.

Dr. WARD briefly discussed the pathology of this condition, saying that the lungs were most frequently infected, an infarction resulting with subsequent septic pneumonia and even gangrene. Less frequently the liver suffered, along with the kidney, spleen, and brain. He had been unable to find recorded more than three cases exactly identical with his own, and gave a summary of the clinical features of each. His own first case was that of a woman

https://doi.org/10.1017/S1755146300193436 Published online by Cambridge University Press

thirty years old, who for three weeks had pain and soreness in the left tonsil. These subsided, and then in three days a tumour appeared in the right side of the neck with right peritonsillitis, though no fluctuation could be made out. The post-cervical glands were swollen, as were also the muscles of the neck, and the temperature rose to 102° F. Soon pain developed in the lower portion of the right lung, with a speedy chill and a pyæmic course. Pus was present under the superficial fascia of the neck. No connection between this focus of inflammation and the abscess about the tonsil could be made out. The pneumonia extended, and the patient died on the ninth day. A thrombus was found in the internal jugular extending up to the tonsillar plexus. The second case was that of a German, aged forty-two years, who died four hours after admission to the hospital. It was found that he had had a left peritonsillar abscess which had been incised, and that two days later his symptoms returned with chill and a commencing pyæmia. He died on the sixth day. The autopsy findings were the same as in the case preceding, with, in addition, the presence in the kidneys of numerous small abscesses.

Report of Cases of Chronic Empyema of the Antrum of Highmore. Operated upon by the Caldwell-Luc Method. This was a paper by Dr. A. W. De Roaldes, of New Orleans.

Five cases were reported. In all of them a radical and speedy cure was obtained. The writer expressed surprise that his plan of operation, originally devised in this country, had not been more generally followed. It was believed to be superior to the older plans. The various steps of the operation could be summarized as follows: (1) A buccal incision was made parallel with and near enough to the upper gingivo-labial fold in order to allow of the subsequent easy union of the muco-periosteal flaps. (2) The anterior wall of the antrum was opened in the canine fossa, the opening being ovoid in shape. Its extremities gave easy access to the tuberosity on one side and to the nasal wall on the other. (3) The cavity was thoroughly curetted and all diseased tissue removed. (4) A portion of the anterior extremity of the inferior turbinate was removed. (5) A large artificial opening was made in the nasal wall of the antrum as close as possible to the angle formed by the floor and anterior wall. (6) The cavity was finally inspected, cleansed, dried, and lightly dusted with iodoform, followed by suture of the muco-periosteal flaps. Iodoform gauze was gently packed into the antrum and also in the nasal fossa, changed on the third to fifth day, and afterward on alternate days until about the

https://doi.org/10.1017/S1755146300193436 Published online by Cambridge University Press

twelfth day. The patient was then allowed to irrigate the cavity with a syringe and cannula, using boric-acid solution. In all the cases forming the basis of the paper radical cure resulted in from four to six weeks. In one of them a little secretion could sometimes be found at the entrance of the sinus, but this was ascribed to an old ethmoidal trouble, the pus leaking into the sinus through an opening in its nasal wall from old necrosis. Dr. Roaldes dwelt especially upon the importance of locating any other possible focus of suppuration, as the latter might prove a serious complication or materially retard healing.

In discussing this paper, Dr. Roe remarked that one should bear in mind the level of the antrum floor with reference to that of the nares, and also the fact that pockets and septa might exist in the antrum.

Dr. E. L. Shurly did not think that operation was always necessary. Dentists and general surgeons were more likely to see these cases frequently than was the laryngologist. The acute form of the disease, such as followed upon influenza, often got well of its own accord, while in the chronic cases curetting was often necessary. He thought that the opening into the nasal cavity would offer far greater likelihood of infection than one into the mouth.

Dr. Makuen observed that the law of gravitation did not seem to hold good in drainage of the antrum. There seemed to be a sort of capillary drainage going on which was increased by nasal respiration.

Dr. G. A. Leland, of Boston, called attention to the fact that man was not always an upright animal, and that the cavity drained by gravity when he lay down. The establishment of free drainage through the natural openings would often cure the discharge. The Caldwell-Luc operation was in reality a combination of those of Mikulicz and Jansen.

Acute Suppurative Processes in the Faucial Tonsils. Dr. J. L. Goodale, of Boston, read this paper, which was based upon a study of eight cases of intrafollicular abscesses.

He would desire to mention especially the etiological relation of special bacteria to this form of abscess, the relation of the abscess to peritonsillitis, its prognostic significance, and its clinical recognition. He spoke of the histological changes of this form of tonsillar inflammation, remarking that streptococci were more numerous than staphylococci. Two of the intratonsillar abscesses

https://doi.org/10.1017/S1755146300193436 Published online by Cambridge University Press

had been followed by peritonsillar inflammation. All were characterized by severe infection, as was evidenced by the clinical history, the severe type of fever, and the adenitis. In most of the cases, the clinical course of the disease afforded no suggestion of this special lesion. The superficial foci varied in size and number. The fibrinous exudation was more marked than in simple proliferative tonsillitis. Many polynuclear neutrophiles (pus cells) were found in the lymph channels near the base of the tonsils. The pyogenic infection of the follicles seemed secondary to that of the crypts; in the two peritonsillar cases it was evident that a discharge of the abscess into the efferent lymph channels had taken place. The importance of this special lesion was obvious, when it was borne in mind that acute pyogenic infection of the follicles might lead to pyæmia. Its presence might be suggested by whitish subepithelial spots, and by the bursting of the abscess contents through the overlying tonsillar tissue to the surface that condition might be produced which E. J. Moure and other French observers have named "acute ulcerative tonsillitis."

Peritonsillar Abscess. This paper was read by Dr. G. A. LELAND, of Boston.

He believed that a thorough discission of the tonsil was the best method to be followed in these cases. A long incision should be made through the tonsil from top to bottom, and then the sterilized finger was passed in, and all pus pockets were broken down. Circumtonsillar infection was an extension of the process from the lacunæ in the direction of least resistance. Cold, rheumatism, etc., did not signify as exciting causes anything but temporary lowering of vitality and of resistance power. The digital method was not dangerous. There was no dangerous hæmorrhage. It was very painful, but a few whiffs of an anæsthetic might be given. Its advantages were that the abscess was drained from below; there were no relapses, and the patient was able to swallow liquids in six hours and solids in twelve. If the vertical incision was slow in healing, daily applications might be made of tincture of iodine in glycerine. This operation was merely the rejuvenating of a procedure which was followed fifty years ago.

https://doi.org/10.1017/S1755146300193436 Published online by Cambridge University Press