LARYNX.

VOLTOLINI (Breslau).—**Illumination of the Larynx and other Cavities of the Body.** *Monats. für Ohrenheilk., No.* 11, 1888.

Vide the review (in this number) of this author's work. **Michael.**

OGSTON.—Intubation of the Larynx. *Brit. Med. Assoc., Aberdeen, Banff, and Kincardine Branch, May* 16, 1888.

AN account of the method of intubation, with a demonstration of O'Dwyer's instruments, and narration of a case of croupous laryngitis in which it had been successfully employed. **Hunter Mackenzie.**

CÆSAR, R. T. (Wellington, Salop).—**Leeches in the Air Passages.** *British Medical Journal, July* 28, 1888.

AN extract from a journal of date 1802, referring to the case of a sailor who, in drinking from a stagnant pool, imbibed two leeches. After causing a good deal of hæmorrhage, there were extracted on the thirteenth day, one from the nose, and the other from the mouth. **Hunter Mackenzie.**

LEYDEN (Berlin).—**Foreign Body in the Respiratory Passages.** *Verein für innere Medicin in Berlin. Meeting, December* 17, 1888.

THE author exhibited a piece of bone two centimètres long and one centimètre broad, which had remained for eight and a half months in the respiratory tract of a young lady. After swallowing the bone, the patient had cough and dyspnœa, but the foreign body could not be found. During the whole period the patient was very ill, but was cured suddenly when the bone was coughed out. The bone had been lodged in the right bronchus. **Michael.**

HARRISON, REGINALD (Liverpool).—**A case where a Damson Stone was lodged in the right Bronchus—Tracheotomy—Recovery.** *British Medical Journal, June* 23, 1888.

CASE of a child aged eight years. A free incision was made into the trachea, and, just as the child was being inverted, the stone shot out into the wound.

The author states that the very free incision into the trachea not only favoured the immediate expulsion of the stone, but proved of service as a vent for the free expectoration which followed. **Hunter Mackenzie.**

WRIGHT.—Rupture of the Larynx. *Manc. Med. Soc., June* 6, 1888.

DEMONSTRATION of a case, without particulars. **Hunter Mackenzie.**

LUSCOMBE, W. E., and BROADBENT, FRANK (Collingham, Notts). **Incised Wound in the Thyro-hyoid Space.** *British Medical Journal, August* 25, 1888.

CASE of attempted suicide with recovery. The author believes that it is

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of great advantage not to stitch up such wounds, so as to permit of the free discharge of mucus, which in the present case was very copious.

Hunter Mackenzie.

KEMM, ST. JOHN, and MARTIN, EDWARD F. (Weston-super-Mare).—**Suicidal Case of Cut Throat.** *British Medical Journal, August 25,* 1888.

SHORT note of a case in which recovery took place. **Hunter Mackenzie.**

M'BRIDE (Edinburgh).—**Clinical Notes on Lipomata of the Larynx.** *Edinburgh Medico-Chirurgical Society, December* 19, 1888.

So far as is known only four cases of this kind have been previously recorded. Two of these were observed on the dissecting table by Wagner and Tobold, and two had been operated by Bruns and Schrötter. Dr. M'Bride has lately seen two cases, both in males. The first patient complained of occasional noisy respiration, followed after some months by difficulty in swallowing, but no pain. A pale pink tumour was seen behind the tongue attached to the epiglottis, and about the size of a pigeon's egg. It could not be removed with the cold snare. The galvano-caustic snare was more effectual, getting away the greater portion of the growth which was operated on again after recurrence, and this time with more success, as the tumour had the appearance of having been enucleated. The second patient complained of feeling a lump in his throat, which caused a thickness of speech, and obstructed breathing when he lay on his left side. Latterly, he had also experienced difficulty in swallowing. A pale pink tumour, overlying the left arytenoid cartilage, was removed, along with its capsule, and after removal it was seen that the pedicle had been attached to the outer part of the sinus pyriformis. The galvano-caustic loop was used in this case as in the former.

Mr. CATHCART asked if the term laryngeal was strictly applicable to these tumours. It seemed to him that the first at any rate grew from the back of the tongue, rather than the larynx. Tumours of the size shown, growing into the larynx, must have produced severe obstruction.

Dr. M'BRIDE said he, in the first place, pleaded precedent for calling these tumours laryngeal, and in the second they grew from laryngeal structures. Though so large, they had a wonderful power of adapting themselves to the sinuosities of the larynx, so much so that they might at times be missed, even by those accustomed to make laryngoscopic examinations.

[Though Dr. M'Bride pleads precedence for calling these tumours laryngeal it may be noted that in the article on Lipoma in Drs. Wolfenden and Martin's studies in Pathological Anatomy it is stated the "the four cases in which it has occurred, have all been extra-laryngeal."]

Maxwell Ross.

FRAENKEL, B. (Berlin).—**Anatomy of the Vocal Cords.** *Berlin Med. Gesellschaft, July* 11, 1888.

THE author exhibited microscopical specimens of the true cords, showing small glands, in which pathological increase gave rise to nodules and polypi. **Michael.**

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SCHECH (Munich).—**On Recurrent Paralysis.** *Münch., Med. Woch.*, 1888.

A REPORT upon forty-two cases of paralyses caused by different conditions.

Michael.

DRESCHFIELD.—Case of Fibroid Phthisis of Left Lung. *Manc. Med. Soc., June* 6, 1888.

HERE a pulmonary murmur was heard, and the left vocal cord was paralysed. **Hunter Mackensie.**

PLESKOFF (Heidelberg).—**A Case of Hæmorrhage from the Laryngeal Mucous Membrane, during a Chronic Laryngeal Catarrh.** *Münch. Med. Woch., No.* 49, 1888.

THE patient was a teacher, and the condition had arisen from overstraining the voice. The bleeding spot was found to be on the left vocal cord, near the processus vocalis. **Michael.**

BATEMAN, F.—Obscure Case of Œdematous Laryngitis. *Brit. Med. Assoc. (East Anglian Branch), June* 29, 1888.

PAPER read, but not reported. **Hunter Mackenzie.**

GRIMME.—Casuistics and Statistics of Laryngeal Carcinoma. *Inaugural Diss. Munich*, 1888.

OUT of a total of 13,517 autopsies, laryngeal carcinoma was found in fifteen cases, or 0·1 per cent. Most of the patients were men, and the ages between forty and seventy. **Michael.**

HOLLINGSHEAD, FRANCIS (Selly Oak, Birmingham).—**Perichondritis of the Larynx—Tracheotomy—Recovery.** *British Medical Journal, June* 2, 1888.

RECORD of a case. **Hunter Mackenzie.**

RAZUMOVSKY, Prof. VASILY I. (Kazan).—**Extraction of Two Tracheotomy Tubes from the Trachea.** *Dnevnik Kazanskaho Obshtchestva Vratchëi za*, 1887, *December* 27, p. 277.

THE author details the following, probably unique, case. A woman, aged fifty-five, was admitted to the Alexandrovsky Hospital in July, 1887, complaining of having foreign bodies in the trachea. In 1882 she had been tracheotomised on account of cicatricial laryngo-stenosis, and had ever since worn a silver tube. In May, 1884, the external tube had broken across close to the shield, and had disappeared within the windpipe. She had at once inserted another silver tube, but from that time had been incessantly suffering from an agonising feeling of suffocation—sometimes amounting to genuine asphyxial attacks, from violent paroxysmal cough, with occasional blood-stained (though scanty) sputa, severe pain behind the sternum, and most obstinate sleeplessness (only being able to get sleep in snatches).

Three years later, in May, 1887, the other tube had broken off exactly in the same manner, ultimately making her sufferings simply

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intolerable. On admission, about three months after the second accident, the woman looked wretchedly ill, being emaciated, prostrated, and peculiarly excited, "producing the impression that she was insane." On closing the tracheal hole she could speak only in a weak, hardly audible, whisper. A probe at once struck a foreign body at the site of tracheal bifurcation. Without any delay, the author introduced a pair of pharyngeal forceps, and was able to seize the tube fairly easily, and to bring it close to the tracheal opening. The extraction, however, proved rather tedious, and caused a slight laceration of the tracheal wound. The other tube was struck by the forceps in the right bronchus at the depth of 15 centimètres (from the fistula). Many times it could be caught and lifted up, but again and again slipped out only to fall back. After prolonged unsuccessful efforts, it was ultimately firmly seized and dragged up into the windpipe, but during the extraction broke into two large and several small-sized pieces. The large fragments were extracted with the forceps, while the small ones were subsequently coughed out. The former tube was found plugged up with mucous matter, but did not present any alterations, while the older cannula which had remained in the bronchus for three and a quarter years was quite black (from the formation of Ag_2S), corroded, and thinned. The extraction was performed at three sittings, with intervals of a few days. Already after the removal of the first tube considerable relief was given, the pain and cough markedly decreasing.

Immediately after the second extraction a steady and rapid improvement set in. When re-examined four months later, the patient looked stouter, and was practically well. In fact, she complained solely of a slight pain behind the sternum. On closing the fistula, she could speak in a fairly loud, though still rather hoarse, voice. Percussion of the lungs did not elicit anything abnormal. On auscultation between the scapulæ and vertebral column, the respiratory sounds were found to be slightly harsher on the right than on the left side. Having analysed his case and reviewed international literature on the subject, Professor Razumovsky draws the following deductions :—(1) The accident represents, as a rule, a very grave complication, which is liable to be followed by a train of serious symptoms, and even by fatal issue. (2) It can be prevented by using good tubes. A tracheotomy tube can be termed "good" when (*a*) it is made of silver of a high standard (84) ; (*b*) when the shield and stem are made of one piece ; (*c*) when the tube is thick walled. (3) In cases were the tube is to be worn permanently, the patient (even when wearing the best possible tube) must be examined by his medical attendant not less than twice a year. The inspection is necessary, because metallic silver in the course of time undergoes partly oxidation, partly transformation into Ag_2S, the oxide and sulphide layers subsequently falling off from friction. (4) In case of the accident, the best plan is to extract by means of a pair of slightly curved pharyngeal forceps. When an enlargement of the tracheal fistula if required, the trachea should be laid open after Bogdanovsky's method, that is, by a free incision, after preliminary ligature, and division of the thyroid isthmus.

Of non-Russian cases Professor Razumovsky mentions only those

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published by Champouillon, Sander, Burow, Howse, Lucas, Settegast Kirchkoff, and Godlee. Similar cases were reported further by Hueter, Schueller, Nélaton, Pauly, Erichsen, Koenig. *Vide* also Dr. R. Neale's *Medical Digest*, section 621, 5. The Russian literature contains the following cases :—

1. Masing's (*St. Petersburger Medizinische Wochenschrift*, 1870) case. At the necropsy of a man who had died from an accidental cause (left-sided pneumonia), there was found a fragment of a silver tube lying encapsulated in a right-sided enlarged bronchus.

2. Professor Evgeny I. Bogdanovsky's two cases (*Ejenedelnaia Klinitcheskaia Gazeta*, No. 1, 1881, p. 1). In one of the patients, an external indiarubber tube screwed off from the shield and fell down to the bifurcation. Having divided the thyroid isthmus between two ligatures, the author freely split up the trachea, and very easily brought out the foreign body by means of long curved forceps. The man made good recovery. The other case refers to a man with right-sided purulent pleurisy. At the *post-mortem* examination there was discovered a fragment of the lower portions of an indiarubber tube, fixed in a large bronchus on the right side. The fragment had given rise to a peribronchitic abscess, which had found its way into the corresponding pleural cavity, causing pyopneumothorax. Professor Bogdanovsky advises (1) to give up all use of indiarubber tubes, especially of those furnished with a screw joint ; (2) to use solely silver tubes, which are said to be more durable ; and (3) to duly teach the patient the management of the tube.

3. Dr. Vladimir I. Radulovitch, of Orel, describes in the *Vratch* (1881, No. 26, p. 425), the case of a gatekeeper who had been tracheotomized by him in 1870 for syphilitic laryngo-stenosis, and had been wearing a silver cannula ever since. Four tubes had been changed in the course of ten years, the change being necessitated each time by extreme corrosion in consequence of profuse oxidation and formation of green copper salts. In 1880, the outer tube broke across close to the shield, immediately causing most alarming symptoms of suffocation. About a quarter of an hour later, the author slightly enlarged (by means of Pott's knife) the tracheal fistula downwards, and without much difficulty extracted the cannula with curved laryngeal forceps. The incision passing through an old cicatricial tissue, no blood was lost. About half an hour after the operation, the man resumed his professional duties. An analysis of the tube proved that its silver was of a low standard, the proportion of copper being exceedingly high. The writer emphasises the necessity of (1) using gilt-silver tubes of a high standard, and (2) of periodically examining the patient.

4. In the *Vratch*, No. 25, 1883, p. 396, Dr. Vasily P. Goldinger, of Moscow, records the case of a labourer who had been tracheotomised for syphilitic laryngo-stenosis, and had worn a silver tube for two years. By the end of that time, when the man was one day walking on the street, the tube suddenly gave way about the shield, and caused an extreme difficulty in breathing. He at once ran to the hospital, where the author at first tried to extract the foreign body with long laryngeal forceps, but failed, on account of the fistula being too narrow ; hence he slightly

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enlarged the latter downwards, but this time found himself unable to catch the cannula. Notwithstanding the failure, after the insertion of a large tube, the patient could breathe quite comfortably. A series of similarly unsuccessful attempts at the extraction was made subsequently by other medical men; the patient ultimately (about two months after the accident) leaving quite well, with the foreign body fixed somewhere in the large bronchi. Dr. Goldinger believes that it would be worth while to invent a suitable instrument for catching the tubes, the accident occurring by far more frequently than one is accustomed to think.

5. In the *Ejenedelnaia Klinitcheskaia Gazeta*, No. 8, 1884, p. 113, Dr. Vladimir N. Zenenko, of St. Petersburg, publishes the case of a male peasant of thirty-six, tracheotomised ten years previously for cicatricial laryngo-stenosis, and wearing Luer's silver tubes (changed every 1½-2 years) ever since, who was admitted about three or four hours after the tube had suddenly slipped down into his trachea during some muscular effort. The foreign body was at once struck by laryngeal forceps about the bifurcation. It was easily grasped and brought up to the fistula, but all attempts at its extraction remained unsuccessful (in consequence of its slipping out) until the opening was slightly (1 or 2 millimètres) enlarged upwards and downwards, after which the cannula could be removed by means of manipulations with two laryngeal forceps. On the third day the man was discharged well. The tube extracted measured 6½ by 5 by 1·2 to 1·1 centimètres. It proved to consist of silver of a high standard (84). Nevertheless it was greatly corroded, thinned, and blackened, the (very irregular) fracture having occurred close to the shield. Having discussed at some length all particulars of the case, Dr. Zenenko lays down the following propositions concerning the management of the accident under consideration:—(1) The extractions should be preceded by a digital dilatation of the tracheal fistula. (2) It should be performed after the patient has been placed on his back, with his head hanging down. (3) The most convenient instrument is a pair of curved laryngeal forceps (as used for extraction of foreign bodies from the larynx), with thin and narrow blades. (4) After the foreign body has been brought up to the level of the fistula, the instrument should be replaced by less curved and stronger forceps. (5) A surgical enlargement of the fistula must be resorted to only after the preceding plan has failed. (6) The incision must be then sufficiently free (after Bogdanovsky's method; *vide supra*). (7) Small incisions into the cicatricial ring surrounding the fistula are justified only as a means for accomplishing the extraction through the tracheal opening. According to Prof. Razumovsky, in 1886, Prof. Studensky, of Kazan, succeeded in extracting (by means of laryngeal forceps) a fragment of an indiarubber tube which had remained in the trachea for several days.

Valerius Idelson.

IVANOFF (St. Petersburgh). — **Fibrinous Laryngo-tracheo-bronchitis treated by Tracheotomy and Cleansing the Parts by means of Feathers.** *Vratch*, 1888, No. 49, p. 992.

AT a recent meeting of the St. Petersburgh Society of Pædiatrics, Dr. Ivanoff read a paper on the case of a girl, aged 17 months, in whom there

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had suddenly appeared agonizing cough, accompanied by fever and prostration. In the course of a few days, the cough gradually became dry, hoarse and rough, while there supervened a steadily increasing difficulty in breathing. On examination, the author found cyanosis of the skin, dyspnœa, and distension of the pulmonary bases ; the fauces, however, did not present anything abnormal. Neither wet packings, nor steam inhalations, nor an apomorphia spray brought any relief whatever. The symptoms rapidly growing worse, tracheotomy was performed, but was followed only by a slight and fleeting alleviation of the respiratory phenomena. As a last resource, Dr. Ivanoff tried a mechanical removal of the (probably diphtheritic) pseudo-membranes by means of small feathers, which procedure swiftly and strikingly relieved all symptoms of asphyxia. There occurred several relapses of the stenosis in the course of the next 48 hours, but the cleansing, resorted to without delay on each occasion, was invariably followed by the same satisfactory results. A steady and permanent recovery took place ultimately. In another similar case occurring in a boy of three, the procedure successfully removed asphyxia, but the child subsequently died from prostration. **Valerius Idelson.**

PETERSSON, O. V. (Sweden).—**A Case of Bronchitis Fibrinosa.** *Upsala Laekarefoerenings Foerhandlingar. Vol. XXIV., p.* 193, 1888.

THE patient, a young man aged eighteen, in good health, had a slight cough, with blood-streaked expectoration lasting twenty-four hours, but was otherwise well. After a temporary feeling of pressure in the chest, he expectorated a white mass, which was found on examination to consist of two membraneous tubes, the one being 9 the other 14 centimètres long, exhibiting the characteristic appearance of the bronchial tree to its smallest ramifications. There were no symptoms from the pharynx or the larynx. The patient felt well afterwards, having only for some days a slight cough, with blood-streaked expectoration. **Holger Mygind.**

NECK, &c.

HARSANT, W. H. (Bristol).—**Cases illustrating the Surgery of the Thyroid Body.** *Bristol Medico-Chirurgical Journal, December*, 1888.

THE author lays down the rule that no cutting operation should be performed for simple hypertrophy of the thyroid, unless dyspnœa, or dysphagia, or aphonia be present, causing serious distress or danger.

He has treated a large number of cases of simple hypertrophy by injections of iodine and solution of ergotin, but in most cases the result has been disappointing. In a case occurring in a woman and causing severe dyspnœa, the author divided the isthmus, curing the dysphagia and dyspnœa, and with disappearance of the tumour. In another case,

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