SOCIETIES' PROCEEDINGS

SECTION OF LARYNGOLOGY—BRITISH MEDICAL ASSOCIATION, GLASGOW.

July 1922.

President—Dr JOHN MACINTYRE.

SYMPTOMS AND DIAGNOSIS OF DISEASES OF THE ŒSOPHAGUS—ABSTRACT.

1. **Affections of the Superior Opening of the Œsophagus** —D. R. PATERSON, M.D., C.M. (Cardiff).—The semeiology of œsophageal disease consists essentially of dysphagia and regurgitation of food. The onset of dysphagia may be gradual, commencing with difficulty in passing solids, extending later to semi-solids, then liquids; when the lesion is high up, at the orifice of the canal, fits of coughing are apt to accompany any attempts to swallow, food finding its way into the air-passage. On the other hand, the appearance of dysphagia may be sudden, and is often related to spasm. It is not unusual, in early malignant disease, to find an element of spasm which is largely responsible for the dysphagia.

In certain states, *i.e.*, anorexia and neurosis, there may be disinclination, amounting to a declared inability, to swallow, but, as a rule, there is not much difficulty in their differentiation. On the other hand, dysphagia may not be well marked even with malignant disease, and secondary glands, or a secondary infiltration of the thyroid, may be surgically dealt with while the original focus remains undetected.

Additional symptoms of less value sometimes present are—Pain in the region of the thyroid or in the ear, and salivation. This last may be present in cases of trauma, impacted foreign body, or in malignant disease. Careful palpation of the neck and region of the larynx, and internal palpation with the finger should be carried out in every case; disease of the laryngeal-pharynx is within reach of the finger. The laryngeal mirror should also be used and may establish the diagnosis at once. X-ray examination is invaluable for information as to how the food bolus behaves in the mouth of the gullet, and a malignant tumour may be well defined by particles of bismuth adhering to the fissures and erosions. The bougie for diagnostic purposes must be condemned, but the most precise information of all is obtained from endoscopy, and, in some cases, suspension laryngoscopy.

Spasm of the upper end of the œsophagus may be secondary to a small local lesion, such as an ulcer or the impaction of a fish bone; it may be due to hydrophobia, tetanus, or certain poisons; it may be

https://doi.org/10.1017/S0022215100024087 Published online by Cambridge University Press

associated with malignant disease at the other end of the œsophagus; it may also be a manifestation of hysteria.

Of greater importance are cases of œsophageal spasm occurring in women of middle age; a long history is frequent and characteristic. Passage of a tube may relieve it for a time. On the other hand the onset may be sudden, and associated with some severe illness. This condition is very frequently associated with changes in the buccal and pharyngeal mucosa. The so-called chronic glossitis, with smooth, glossy upper surface of the tongue, with whitish patches and dryness, is only part of a condition which involves also the laryngeal-pharynx. In the latter situation, as in the tongue, malignant disease may later appear. This clinical type of spasmodic dysphagia should be recognised as a separate entity. On endoscopy the tissues are rigid and the thin mucosa may crack and bleed even on careful examination. Malignant disease at the upper end of the œsophagus is much more common in women than in men, as borne out by Logan Turner's statistics. It may occur very early—in one case at the age of 23; it is almost always squamous-celled epithelioma. The so-called œsophageal pouch always has its point of origin in the laryngeal-pharynx above the upper opening of the gullet.

2. **Affections of the Lower Segment of the Œsophagus**—Walter G. Howarth, M.A., M.B., F.R.C.S. (London).—The manifestations of disease in this section of the gullet are usually due to cicatricial or compression stenosis and to the various forms of malignant disease, or, are a complex variety of phenomena of nervous origin. Dysphagia is in all types the prominent symptom; regurgitation of food is usual. Irritable cough may be present, as also hiccough, choking sensation, and a feeling of suffocation; excessive salivation is also sometimes troublesome. Select from and group these symptoms as we will, however, it is impossible to present a clinical picture that is pathognomonic of any single condition. Dysphagia to solids is more usual in organic strictures, and dysphagia to fluids in achalasia and allied conditions; a varying dysphagia is more common in nervous disorders.

The earliest symptoms of disease of the lower end of the œsophagus may be referred to the upper, so that sudden choking attacks at the beginning of a meal may be the first sign of disease in the phreno-cardiac segment. X-ray examination should be conducted in the presence of the surgeon; thickish bismuth emulsion being used, as the bismuth cachet is valueless and misleading. In the nervous group of cases the shadow is broad, regularly conical, or with a round end that bends to the left. In malignant stenosis the shadow does not present a smooth outline but is often irregularly notched and funnel-shaped. The injection of 4 grams of papaverine will cause immediate

https://doi.org/10.1017/S0022215100024087 Published online by Cambridge University Press

relaxation in spasmodic cases. The triangular space behind the œsophagus as it turns forward and to the left to enter on the diaphragmatic part of its course should be particularly noted — in malignant cases this space is often obliterated, while in spasmodic cases it is clear.

Dr A. BROWN-KELLY (Glasgow) said that in cardiospasm the œsophagoscope reveals the normal opening and closing of the hiatal œsophagus as long as the tube is kept at least 3 cm. above the hiatus, but when it is pushed 1 or 2 cm. further, the wall of the hiatal œsophagus gathers itself together so that the mucous membrane forms a closed rosette. This closure becomes firmer when the tube is pressed down more firmly. If moderate pressure is maintained for about a minute the closed œsophagus usually yields and the tube glides into the stomach. Hypertrophy of the sphincter does not as a rule occur, because the spasm is intermittent. His conclusions are :—

1. That the obstruction at the lower end of the gullet in the affection, commonly termed cardiospasm, is due to spasm.
2. That the spasm is predisposed to by a state of irritability of the muscle fibres, or of the nervous mechanism controlling them.
3. That all the endoscopic appearances are against the theory of achalasia.

Sir St Clair Thomson, Dr W. S. Syme, and the President, Dr Macintyre, also took part in the discussion. T. RITCHIE RODGER.

THE SCOTTISH SOCIETY OF OTOLOGY AND LARYNGOLOGY.

EXTRAORDINARY MEETING HELD IN THE WESTERN INFIRMARY, GLASGOW.

July 28, 1922.

President.—DR J. G. CONNAL.

Demonstration upon Analysis of Sound by Resonance.—Mr GEORGE WILKINSON—(See *Journ. of Laryngology*, September 1922).

The Relations of the Optic and Vidian Nerves to the Sphenoidal Sinus.—Dr GAVIN YOUNG—(See *Journ. of Laryngology*, December 1922.)

Two patients with Malignant Disease of the Nose. Lateral Rhinotomy—Dr J. G. CONNAL.

1. Female, aged 45, with right nasal obstruction of one year's duration, associated with discharge and bleeding. Pain and swelling over right side of nose and cheek; vascular growth in right nostril; squamous epithelioma on section. Lateral rhinotomy on 6.11.19.

https://doi.org/10.1017/S0022215100024087 Published online by Cambridge University Press