ASSOCIATION MEETINGS.

American Laryngological Association.

Eleventh Annual Congress, held in Washington, D. C., May 30, 31, *and June* 1, 1889.

FIRST DAY, THURSDAY, MAY 30TH—MORNING SESSION.

THE Association was called to order by the President, Dr. ETHELBERT CARROLL MORGAN, of Washington, who delivered the Presidential address, expressing the profound pleasure which he experienced in welcoming the Association to the national capital, the home of scientific libraries, laboratories, and museums fostered and encouraged by a liberal government. The Association had wisely followed in the wake of numerous other scientific bodies, which made pilgrimages to Washington, and exerted a healthy influence toward popularizing their special fields of scientific investigation. The noble work of this Association during its eleven years of existence has resulted in placing laryngology upon a substantial basis, and in demonstrating its truths and benefits alike to the profession and to suffering humanity. The outlook for laryngology was never brighter than at present.

The tenth volume of the "Transactions" is now in the press, and in addition to the papers read at the last meeting of the Association, contains a table of contents of all the papers read to the Association since its organization.

The library now contains nearly nine hundred separate titles. The librarian thinks that the collection would be more accessible if in charge of the Surgeon-General's Office, and recommends its donation to that library.

The Association has lost no members by death since the last meeting.

After some suggestion in regard to the social features of the annual meetings, the President closed by reiterating the assurance of his heartfelt appreciation of the goodwill and friendship which influenced the Association in selecting him as the President of this distinguished body.

The PRESIDENT then read the report of a case of *Removal of Supernumerary Tonsil*, with specimen and drawings.

The patient, a male, aged twenty-six years, vigorous and otherwise healthy, came under observation September 7, 1886, with what he feared was malignant disease of the pharynx. The growth was first discovered four years previous. It had occasioned considerable pain, especially after smoking. During the past two months the growth had rapidly increased in size, and the pain had become of a shooting character, extending to the ears, larynx, and top of the head. Examination revealed a pendant tumour between the right palatine folds near the uvula and protruding beyond their borders half an inch. The tumour was as large as a small almond. Its colour, as well as that of the pillars, was a dusky red. Slight engorgement of the cervical glands appeared to exist. The patient's mother had died of cancer of the breast, and he felt convinced that the growth was malignant. Local and general treatment having no effect, the tumour was excised and the raw surface cauterized with the galvano-cautery. In ten days the wound had healed. The patient was recently examined and there has been no recurrence, now four years after the operation. The specimen removed

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was examined by Dr. W. M. Gray, microscopist to the Army Medical Museum, who stated that its structure was identical with that of a faucial tonsil which had undergone hypertrophy. The location and microscopic characters of this tumour, as well as the history of the patient prior to and subsequent to operation, proves that this was a hypertrophied accessory or supernumerary tonsil, an exceedingly rare anomaly. A search of the literature had revealed only two other cases of a similar character, reported by Jurasz in 1885. In the first case the tumour was as large as a hen's egg, and was found to spring from the lower anterior portion of the right posterior pillar by a small and short pedicle. It was removed and found on microscopical examination, to present the structure of a hypertrophied tonsil. In the second case the tumour was of the size of a hazel-nut, and attached below the right tubal prominence. The microscope revealed a structure similar to that of the faucial tonsil.

Conclusions.—1. The lymphoid follicles of the soft palate and pharynx are liable to be aggregated, resembling in arrangement the faucial tonsil. 2. The condition is exceedingly rare, since, excepting the so-called "pharyngeal tonsil," the author had found but one case reported. 3. These lymphoid follicles are also liable to hypertrophy. 4. Such hypertrophies probably occur oftener than is generally supposed. 5. The indications for operative interference in this condition are identical with those for the faucial tonsil.

DISCUSSION.

Dr. D. BRYSON DELAVAN, of New York, thought that possibly cases of supernumerary tonsil were not so infrequent as was commonly supposed. Pedunculated tumours of the tonsil, which on examination show a fibroid structure, are not rare, and it may be that these are degenerated supernumerary tonsils; just as the tonsil may, from long continued inflammation, become the seat of fibroid change.

Dr. GEORGE W. MAJOR, of Montreal, Canada, read a paper entitled *The Relation between Facial Erysipelas and Erythema on the one hand, and Intra-nasal Pressure on the other.*

The following cases were cited as showing that facial erysipelas may be produced by nasal conditions, particularly when they are productive of pressure.

Case 1.—A girl, aged twelve, came under observation in March, 1884, for the treatment of nasal catarrh. There was a general hypertrophic condition, with pressure of the middle turbinated body of one side against the septum. On the cheek bone of the same side there was a red patch of erythema, which had existed for five months. Treatment of the nasal condition by scarification, puncture, and galvano-cautery was followed by disappearance of the erythematous rash, and it did not return.

Case 2.—A child, four years of age, was seen in February, 1885, suffering with facial erysipelas, commencing on the bridge of the nose and extending to the cheeks. It had already lasted five days, and was not disposed to yield to treatment. Both nostrils were occluded by swelling. All treatment directed to the relief of the erysipelas was suspended, and attention directed to the relief of the nasal condition. In twenty-four hours the erysipelas had disappeared.

Case 3.—In the winter of 1884, a boy, aged twelve, the subject of recurring attacks of erysipelas, was seen with an attack involving the nose and cheeks. Nasal injections were alone used, and the erysipelas disappeared in thirty-six hours.

Case 4.—February, 1889, a female, aged fifty-six, presented herself with an erythematous patch on the left cheek. This had lasted four months. There was swelling of the left turbinated bone, which pressed against the septum. Under treatment of the nose the erythema disappeared in the course of a week. Six other cases were alluded to in which the same connection was seen.

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DISCUSSION.

Dr. J. O. ROE, of Rochester, N. Y., had seen a number of cases of erythematous rash due to the nasal trouble. A case recently seen was that of a girl, aged twenty-three. There was a very red erythematous patch on the face, associated with blebs. She had been treated by various physicians without benefit. In both nares the middle turbinated bodies pressed firmly against the septum. This was relieved, and there was immediately a subsidence of the erythematous trouble. He, however, could not admit that erysipelas is due *per se* to the intra-nasal trouble. He held that erysipelas was an infectious disease due to a distinct germ. The presence of erosions in the nasal cavity would render the patient more liable to become infected.

Dr. J. N. MACKENZIE, of Baltimore, Md., said that the relation between erythema of the nose and face and intra-nasal trouble had been recognised centuries ago in the times of Willis, and by Sylvius. He himself had seen many cases of this kind, but he had never seen true erysipelas due to this cause.

Dr. WILLIAM H. DALY, of Pittsburg, Pa., was not a believer in the theory of intra-nasal pressure. The evils referred to pressure are really due to intra-nasal turgescence. The condition of erythema is nothing more than a condition of hypernutrition, due to a permanently dilated and enlarged blood-supply. He believed that the term chronic facial erysipelas is a misnomer.

Dr. F. I. KNIGHT, of Boston, Mass., remarked that in these cases of erythema of the nose and face he always looked for neurosis, and very often found it. Where the trouble has been relieved, the affection of the skin has disappeared.

Dr. D. BRYSON DELAVAN, of New York: I have seen several of these cases, and in three or four the erysipelatous attacks have been severe. One, a girl, aged seventeen, had recurrent attacks of severe erysipelatous swelling, starting from the nose and extending over the cheeks. These recurred at intervals of two or three weeks. There was no necrosis, but marked turgescence of the nasal mucous membrane. This was treated topically, and with the subsidence of the catarrhal trouble the attacks of erysipelas disappeared.

Dr. SAMUEL W. LANGMAID, of Boston, Mass., read a paper entitled *A Case of Acute Multiple Adenitis (Septic?), Œdema of the Larynx, with Spontaneous Cure.* The patient, a lady aged forty, had been sick for seven days. When first seen she was found restless, with an anxious expression, breathing with difficulty, and with a dry, croupy cough. There was no lividity of the face, but it was stated that during the preceding twenty-four hours there had been danger of strangulation. The sub-maxillary glands, as well as those in the region of the neck, were much swollen. Temperature 99°; voice fairly loud and clear; no enlargement of the tonsils; nothing unusual in the naso-pharynx. With the laryngoscope, a tumour, apparently as large as a filbert, was seen occupying the posterior arytenoid space. The anterior third of the vocal cords could be seen approximated and scarcely moving during respiration. The throat had not been examined until four days after the commencement of the attack. As the patient was breathing fairly well it was decided to do nothing. If necessary, the tumour in the larynx was to be excised. A few hours later something was felt to break in the throat, and a free mucoid discharge took place. Three hours later nothing could be seen but the erect epiglottis, with muco-purulent matter welling up. There was a continued discharge, but the relief to breathing was not complete. There had been also the discharge of half an ounce of pus. The discharge continued for several days, and the patient gradually recovered.

It was thought that the case was in all probability due to diphtheria, the evidence of which had passed away when the author examined the throat. The

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patient stated that at the commencement of the illness the throat had been sore, and that on one side she had noticed red spots, on which there had been a white covering.

Dr. WILLIAM C. GLASGOW, of St. Louis, Mo., followed with a paper on *An Œdematous Form of Disease of the Upper Air-Passages.* The paper described an œdematous form of disease which had been epidemic in the Mississippi Valley for some two years. During the existence of this affection there has been a disturbance of the ordinary catarrhal throat troubles. In all cases of this disease there is found a pale, œdematous condition of the fauces. A peculiar glistening appearance is at times very marked. In the majority of cases the soft palate is the seat of the œdema. At times the nasal mucous membrane is found in the same condition. The epiglottis and different portions of the larynx may be involved. In some cases the true cords are markedly œdematous. A swollen condition of the veins, particularly the palatine veins, is present. This sometimes causes purpura-looking spots, and the mucous membrane appears mottled; in two cases these purpura-looking spots had been seen in the trachea. In one case enlarged veins were seen on the true cord. In some cases ulceration occurs. In some cases, in addition to œdema, there were patches of exudation in different parts of the throat. These, when removed, leave a bleeding surface. The symptoms of the disease and appearance of the throat preclude the diagnosis of diphtheria. In six cases spots of mycosis were seen. Glandular enlargement of the neck is quite frequent. In two cases suppuration occurred.

The symptoms are constitutional and local. The affection occurs suddenly in persons of previous good health. There is languor and weakness, and general pains throughout the body. Headache is present, usually frontal, sometimes occipital. In many cases it is simply a dull, heavy feeling; in others it is an intense, violent, throbbing pain. Pain in the back, in the region of the sacrum, is a characteristic symptom. Fever is present in varying degrees. In the exudative cases the disease commences with chill followed by fever, and the temperature may reach 105° F. This soon passes off, and we have a sub-febrile condition remaining, possibly with a temperature of 101° F. This continues a short time, and then there is a return to the normal temperature. When there is simply œdema, the temperature scarcely ever rises above 101—102° F. This remains for only twelve hours, and during the remainder of the attack the temperature is normal. The pulse is always rapid, soft, and compressible. There has been no exception to this noted. The pulse ranges between 90 and 110 per minute. Profuse sweating is often present, especially during the night. It may be localized.

The local symptoms vary with the part of the throat involved. Sometimes they are prominent, sometimes they are wanting. Hæmorrhages are common. They are usually slight, but recur frequently.

This is a constitutional disease due, the author believes, to some change in the blood, exactly what he was unprepared to say, but probably due to micro-organisms. He thought that the disease described was nothing more than influenza, the same influenza which has been described so often, particularly by Graves. The disease has not been limited to the Mississippi Valley, for the speaker had seen cases of it from all parts of the country.

The treatment is very simple. The system must be saturated with benzoate of sodium. Under this remedy the affection subsides in a few days or hours. If left to itself, it may continue for weeks and even months.

DISCUSSION.

Dr. W. H. DALY, of Pittsburg, Pa., had seen a number of cases similar to those described. He did not consider the condition as one of œdema, but rather

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as a sub-acute inflammatory condition of the mucous membrane. There was a sufficient number of these cases, which had thin and superficial diphtheritic patches in various parts of the fauces, to warrant him in considering the disease of a diphtheroid character. This view was confirmed by the subsequent occurrence of glandular enlargement in nearly all the cases.

Dr. J. C. MULHALL, of St. Louis, Mo., confirmed the statements of Dr. Glasgow from his own experience with the disease in St. Louis, and reported a case in which the affection had recurred three times.

Dr. S. H. CHAPMAN, of New Haven, Ct., had seen cases similar to those reported, but agreed with Dr. Daly that they were rather of a diphtheritic character. In one case the disease attacked a child aged seventeen months. In the same family was a boy, nine years of age, with well-marked diphtheria. The first thing noted in the case of the child was a dense swelling of the submaxillary gland. There was great prostration and some fever, temp. 100° to 102° F. The swelling increased until it extended from the jaw to the clavicles. There was hoarseness and difficulty of breathing, which daily increased. By the seventh day it had increased so much that deep incisions were made into the gland, but no pus was found. A tube was then inserted into the larynx and allowed to remain four days. The child during this time was kept alive by rectal alimentation. At the end of thirteen days the swelling begun to diminish. The knife was again used, and a quantity of pus discharged. The child recovered.

Dr. C. E. SAJOUS, of Philadelphia, Pa., referred to a case of this disease which occurred to a young man living on a farm in New Jersey, twenty miles from any neighbours, and who had not been exposed to diphtheria. The throat presented small, white patches, not resembling the yellowish, leathery membrane seen in diphtheria. Slight œdema of the soft palate was also present. The temperature was high throughout the entire course of the disease. There was incessant pain in the back and in one limb. After trying a number of remedies, he was placed upon benzoate of sodium.

Dr. D. B. DELAVAN remarked that this discussion was a timely one, coming as it did in connection with a recent celebrated case. He had himself seen a case suffering from a disease similar to that described, in which sudden death took place from heart failure. Other apparently similar cases had been occasionally reported. He believed that they were analogous to those described by the older French authors and Sir Morell Mackenzie as acute œdematous laryngitis, and, more recently, by Senator, under the name of acute infectious phlegmon of the pharynx. He thought that the possibility of the disease being diphtheritic had not been sufficiently eliminated. In view of the dangers attending it, he urged that the affection be more carefully studied and explained, and he thanked the reader of the paper for the valuable light which he had thrown upon it.

Dr. W. C. GLASGOW, of St. Louis, Mo., remarked that he had at first regarded these cases as diphtheritic. The membrane in them is adherent. It can be torn away, but a bleeding spot is left. Applications made it worse. If left to itself, it gradually grows thinner and thinner until it resembles a white, pearly patch. Diphtheritic membrane does not pursue such a course. The glandular enlargements always occur, even where there is no exudation. He did not think that anyone would assert that this œdema was diphtheria.

Dr. GEORGE M. LEFFERTS, of New York, presented the histories of three rare cases, each accompanied by a superb illustration :—

I. Large papilloma of the velum palati.

II. Large fibroma of the tonsil.

III. Tumour of the nasal septum.

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Dr. W. H. DALY, of Pittsburg, Pa., read a paper entitled *Some Discursive Remarks based upon a few Observations of the Intimate Relations of Chronic Disease of the Upper Air-Tract and Neurasthenia.* His experience had led him to believe that there was an intimate relation in conditions of the intra-nasal cavities and neurasthenia in some of its forms. This view was based upon the study of twenty-five cases. In these cases removal of the nasal trouble was followed by relief of the neurasthenic condition, no special treatment being directed to the general condition.

DISCUSSION.

Dr. J. O. ROE, of Rochester, N. Y., said that most of the members had seen many such cases, and they illustrate the effect that a constant local irritation will have upon the system. The constant annoyance of a local irritant will sooner or later produce a depressed condition of the system.

Dr. F. W. HINKEL, of Buffalo, N. Y., remarked that before we could admit that neurasthenic condition could be the result of any nasal lesion as the sole cause, a careful analysis of all the constituent conditions would be required.

Dr. S. W. LANGMAID, of Boston, Mass., thought that often the nasal trouble was the result of the neurasthenia. It often happens that operative interference fails to relieve the nasal condition because the neurasthenia is not cured.

Dr. C. E. SAJOUS, of Philadelphia, Pa., was inclined to support rather vigorously the view of Dr. Daly. In a number of cases he had observed that there were fluctuations in the nervous condition according as the local disease improved or became worse. In one case of neurasthenia associated with deviated septum, correction of the displacement was followed by improvement in the nervous condition. The operation, however, failed to be permanent, and with the return of the deviation the neurasthenic condition recurred, to again disappear with a more thorough operation upon the septum.

PRESENTATION OF INSTRUMENTS.

Dr. SAMUEL JOHNSTON, of Baltimore, Md., referred to the ease with which the mouth and nose could be washed out by means of an ordinary seltzer bottle filled with soda water, a rubber tube being attached to the delivery pipe.

Dr. J. O. ROE, of Rochester, N. Y., exhibited œsophageal bougies, made of hard rubber, with a flexible tip of soft rubber. Also jewellers' saws in frames, suggested to overcome the objection of flexibility in the ordinary Bosworth saw. Also a powder-blower with reservoir.

Dr. E. CARROLL MORGAN exhibited an instrument to pull the return forward in applying the galvano-cautery to the pharyngeal tonsil.

AFTERNOON SESSION.

Dr. JOHN MACKENZIE, of Baltimore, Md., read a paper on *Some Points in the Pathology and Treatment of Diseases of the Nasal Pharynx.*

The following conclusions were presented:—1. The nasal pharynx is, in quite a large proportion of individuals, extremely sensitive to reflex-producing stimulation. 2. The areas chiefly involved are the posterior portions of the turbinated erectile tissue, and various points along the upper and posterior portions of the nasal pharynx. 3. In consequence of this extreme sensitiveness, a local pathological process, which in many persons would give rise to no reflex neuro-vascular changes, may awake a host of neurotic phenomena referrable not only to the region primarily involved, but also to other and even remote organs of the body. These may include cough, asthma and various neuralgic affections; or the local structural lesion may be the starting point of various sympathetic affections of the respiratory tract. 4. That these classes of naso-pharyngeal neuroses are explicable on the

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same general principle laid down in the article on "Neuroses of the Nose," and the pathology of the nasal and post-nasal affections is therefore one and the same. 5. That the treatment should be carried out according to the general directions laid down in the article just mentioned. 6. That when morbid processes originate in the pharyngeal tonsil, attention should not be directed to the bursa alone, but an endeavour should be made to extirpate the tonsil, as far as possible, in its entirety. 7. That while a favourable prognosis cannot be safely predicted by treatment of the bursa alone, extirpation of the pharyngeal tonsil often affords a most favourable prospect in long-standing cases of post-nasal trouble.

Dr. D. BRYSON DELAVAN, of New York, read a paper entitled *Observations upon the Condition known as Adenoid Hypertrophy at the Vault of the Pharynx, and the Methods used for its Removal.*

A case was described in which, with each acute attack of catarrhal trouble, there would be enlargement of the adenoid tissue of the vault of the pharynx, forming a large tumour. When the attack passed away the hypertrophy disappeared.

The author then referred to the methods of operation and the accidents which might occur. As the operation was attended with considerable pain, he insisted upon the employment of anæsthesia. He had in a number of cases employed chloroform with satisfactory result, the object being to avoid the profuse mucoid secretion which is apt to follow the use of ether. Where chloroform is used, the operation is performed with the patient on his back.

DISCUSSION.

Dr. F. H. HOOPER, of Boston, Mass., reported a case of a young lady who came to him with acute coryza, and in whom he found a large-sized adenoid of the vault. After the attack subsided the adenoid almost entirely disappeared. In order to avoid error the post-nasal probe should be always used; with it conditions not apparent to the eye may be recognized. He had never seen serious hæmorrhage follow operations for the removal of this tissue. In operating he first removes all that is possible with the post-nasal forceps, and completes the removal with the finger-nail. He had never used chloroform. The amount of secretion, after the use of chloroform, varies very much in different cases.

Dr. HARRISON ALLEN, of Philadelphia, Pa., advocated the use of the finger as a means of detecting these post-nasal affections. To examine the case thoroughly requires the use of an anæsthetic. In the treatment of adenoid hypertrophy it is better to remove all the diseased tissue at one sitting, under ether, than to remove it in portions at different times.

Dr. J. C. MULHALL, of St. Louis, Mo., held that for practical purposes the pathology of the pharyngeal tonsil was exactly the same as that of the faucial tonsil. In operating he had applied cocaine thoroughly to the pharyngeal wall and soft palate, to avoid the disagreeable sensation caused by the scraping of the forceps against the healthy pharyngeal wall, and had succeeded very well.

Dr. F. I. KNIGHT, of Boston, Mass., related a case of acute hypertrophy of the pharyngeal tonsil, in which the surgeon proposed to perform tracheotomy preparatory to removing the tumour. When about to operate, he found that the growth had disappeared.

Dr. WILLIAM E. CASSELBERRY, of Chicago, Ill., referred to the importance of thoroughly eradicating these growths. In two cases in which portions of the mass had been left, the reflex symptoms, while greatly lessened, continued to recur. In two cases he had attempted to use the mirror during operation. To do this he pulled the soft palate forward by two rubber bands, passing through each nostril. In one case he succeeded to a certain extent, but in the other failed

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This procedure, however, greatly facilitated the operation. In order to prevent the passage of blood into the larynx he was in the habit of bending the head forward at intervals so as to allow the escape of the blood.

Dr. J. N. MACKENZIE, of Baltimore, Md., as a rule operates without anæsthesia, removing a portion of the mass every day, or every other day, continuing the operation for a week or ten days. He had seen very little pain from the operation. There is one point in regard to the nature of this so-called adenoid. He had examined a number of these growths under the microscope, and they do not differ from papillomatous growths. There is also, in addition, a true adenoid growth; this is more difficult of removal than the former.

Dr. F. H. HOOPER, of Boston, Mass., read a paper on *Experimental Methods of Studying the Action of the Intrinsic Muscles of the Larynx.*

The author exhibited the apparatus which he had employed in studying the effect of stimulation upon the internal thyro-arytenoid, the lateral crico-arytenoid, and posterior crico-arytenoid muscles. The larynx of a dog is quickly excised, and the mucous membrane removed, and the muscles subjected to electrical stimulation.

Dr. F. I. KNIGHT, of Boston, Mass., read a paper on *Dysphonia Spastica.*

The speaker briefly reported the four cases of this affection which he had seen in the last seven years. He regarded the condition as rare. There is probably a spasmodic action of the muscles of phonation, or respiration, or both, giving rise to a high-pitched, jerking voice. The prognosis is unfavourable. The object of the paper was to elicit reports of other cases.

DISCUSSION.

Dr. G. W. MAJOR, of Montreal, Canada, had seen one case of aphonia spastica, and two cases of dysphonia spastica. In none of the cases was benefit obtained by treatment.

Dr. S. W. LANGMAID, of Montreal, Canada, had reported one case in which treatment was unsuccessful. The patient, when he had to use his voice, prescribed for himself a little whiskey, and this answered temporarily. There seems to be no change in the voice since the affection first came on, fifteen years ago.

Dr. D. BRYSON DELAVAN, of New York, said that in one case coming under his observation, the patient was able to talk tolerably well after fortifying himself with a stimulant. This patient seemed to improve under local treatment to the larynx and vocal training, but the treatment could not be continued.

Dr. C. E. BEAN, of St. Paul, Minn., had seen one case two years ago. Various methods of treatment had been employed without benefit. The voice is now the same as at the commencement.

Dr. RUFUS P. LINCOLN, of New York, read a paper on *Recurrent Laryngeal Growth.* The patient had come under the care of the late Dr. Elsberg, twenty-four years ago. Dr. Elsberg first operated by the intra-laryngeal method, but could not remove the growth. Twenty-two years ago he did laryngotomy, and removed the growth. The microscopical examination made at that time was unsatisfactory. There was no further trouble until a short time ago, when the growth recurred. Dr. Lincoln recently removed the tumour, which upon microscopical examination proved to be a papilloma.

Adjourned.

FRIDAY, MAY 31st.—SECOND DAY.—MORNING SESSION.

Dr. T. AMORY DE BLOIS, of Boston, read a paper describing *Some of the Manifestations of Syphilis of the Upper Air-Passages,* and exhibited drawings showing the conditions which he had found.

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DISCUSSION.

Dr. F. H. BOSWORTH, of New York, referred to the necrosis of bone which occurs in syphilitic ulcerations. He did not believe that syphilitic ulcerations extended from one part to an adjacent part. Such ulceration is due to the breaking down of a gummatous deposit, and does not extend beyond the limits of the original gummatous deposit. The necrosis of the bone he held to be due to the interference with nutrition of the bone caused by the original deposit, and that, after the breaking down of the gummatous infiltration has taken place, the ulceration is kept up by the necrosed bone, and treatment should, therefore, be directed to this point. He agreed with the reader of the paper, that potassium iodide was to be employed until the disappearance of the lesion, and that mercury should be used subsequently. Operative interference should be postponed until the syphilitic disease was well under control.

Dr. C. C. RICE, of New York, said that in these cases there was cicatrisation and contraction above the visible adhesions, so that, after the adhesions are freed, the results as regards phonation and respiration, are not what would be expected. This contraction in the post-nasal pharynx requires to be stretched, in order to obtain good results.

In regard to operations, in one case where there were adhesions, and where there had been no syphilitic manifestation for several years, he separated the adhesions with the galvano-cautery. The ulceration which followed took on an unfavourable character, and continued to spread despite constitutional and local treatment.

Dr. J. N. MACKENZIE, of Baltimore, protested against the too vigorous removal of diseased bone from the nasal passages. It frequently happens that more is pulled out than is desired, and sometimes from dangerous regions.

Dr. WM. H. DALY, of Pittsburg, objected to the use of the galvano-cautery in tissues of the low vitality of syphilitic tissues. He believed that the galvano-cautery was a much abused useful instrument. He felt satisfied that better results could be obtained in the fauces, in the nose, in the larynx, in any operation, by using a sharp cutting instrument, and allowing as free hæmorrhage as is consistent with good judgment. The freer the hæmorrhage, within certain limits, the more certain is there to be immunity from septicæmia, and rapid union.

Dr. CHAS. H. KNIGHT, of Boston, read a paper entitled *Note on the Galvano-Cautery in the Treatment of Hypertrophied Tonsils.*

This paper was supplementary to one read two years ago. The galvano-cautery cannot be satisfactorily used in young children, and in them the guillotine is preferable. In older children and adults, the galvano-caustic point will prove of service. The galvano-loop was especially considered. With this the operation can be done at one sitting. The portion removed by the loop does not indicate the real extent of the operation. A portion of the remaining tissue sloughs, so that the operation with the loop is better than with cutting instruments. There seems to be very little more pain with the galvano-loop than with the guillotine. The former operation is, however, more disagreeable, on account of the odour of burning flesh.

DISCUSSION.

Dr. T. A. DeBlois, of Boston, had used the electrolytic needle with good effect. Under cocaine, the pain of the procedure is very slight. Half-a-dozen punctures each day will in a short time produce great diminution. This method is used only in adults. In children the tonsils are very apt to diminish in size without treatment.

Dr. C. E. SAJOUS, of Philadelphia, had frequently used the galvano-point.

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but had to make as many as eighteen or twenty punctures in order to obtain satisfactory results. After the second visit the patient expresses very little objection to the operation. The galvano-point is useful in the treatment of enlarged tonsils, especially where the density is not great. Here the cicatricial contraction assists in reducing the size.

Dr. WILLIAM H. DALY, of Pittsburg, believed that in the normal throat no portion of the tonsil extended beyond the line of the half arches, and in abscission of the tonsil our object should be to restore the throat as nearly as possible to its normal condition. This can be thoroughly done with the tonsillotome.

Dr. F. H. BOSWORTH, of New York, could see no reason for treating this condition by means of eighteen or twenty punctures, when the whole trouble could be removed in a few seconds by a very simple operation.

Dr. C. C. RICE, of New York, believed that there are a few cases in adults where there has been frequent attacks of tonsillitis, and the tonsils are greatly congested, where the galvano-cautery is of service.

Dr. JOHN O. ROE, of Rochester, read a paper entitled *The Treatment of Diseased Tonsils when Unattended with Hypertrophy.*

The conditions referred to are of marked clinical importance, but their consideration is ignored by writers upon these subjects. The most common form of disease of the tonsil is hypertrophy, and in children it is rare to find any other form. During adolescence the tonsils may diminish in size, but they do not return to their normal conditions. The small tonsils in adults have often followed hypertrophy. This is a point in favour of the removal of enlarged tonsils. The two forms of disease of the tonsil to which attention was called were, first, chronic disease of the crypts and lacunæ, and, second, fibroid degeneration of the stroma of the organ, the cicatricial form of the disease. The first is the result of chronic follicular catarrh of the tonsil, and is usually associated with chronic follicular catarrh of the pharynx. The treatment of these conditions is important, not only on account of the disease itself, but also because they are the source of recurrent trouble, and may cause reflex symptoms. Local applications are practically useless. The galvano-cautery, which is useful in the treatment of hypertrophied tonsil, may be employed here, but is not as efficient as it is in the former condition. The treatment *par excellence* is ablation with the knife. The diseased crypts may be laid open and cauterized with chromic acid or fused nitrate of silver. Excision is, however, the best plan. It is rarely advisable to attempt removal of the whole mass at one time, on account of the adhesions to the pillars. The use of cocaine lessens pain and hemorrhage. In every instance in which the speaker had employed excision, the cure had been perfect, with entire relief from the attendant symptoms.

DISCUSSION.

Dr. H. L. SWAIN, of New Haven, reported a case in which recurrent attacks of swelling of the lingual tonsil were caused by the presence of hard masses in the faucial tonsil. The attacks were subdued by treatment of the crypts, by cutting into them with the galvano-cautery and thoroughly cauterizing their interior.

Dr. J. SOLIS-COHEN, of Philadelphia, had seen many cases of spasmodic cough due to nothing but the presence of these masses in the crypts and lacunæ of the tonsil. These had been found not only in enlarged, but also in apparently contracted tonsils. It is sometimes necessary to produce some gagging so that the posterior portion of the tonsil presents, in order to discover this condition. In enlarged tonsil the best treatment is probably excision, but in these atrophied tonsils he had pressed the matter out with a blunt scoop, and then applied a

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simple astringent consisting of creosote, gr. j., iodine, gr. j., potassii iodide, gr. v. and glycerine, ℥ j. If this does not answer, he cuts the crypts open with scissors and scrapes them as thoroughly as possible. This affection is not as thoroughly appreciated by the profession as it should be. He had seen cases where cough, existing for five to ten or more years, had been permanently relieved by treating this condition.

Dr. WILLIAM H. DALY, of Pittsburg, referred to cases in which the patients were really sick as the result of these lacunæ becoming filled with cheesy matter.

Dr. F. I. KNIGHT, of Boston, described a case of long-continued irritative cough, in which the removal of a cretaceous mass, as large as a pea, from a crypt of the tonsil, was followed by complete cure.

Dr. SAM. JOHNSTON, of Baltimore, referred to three cases in which the collection, instead of consisting of soft cheesy material, was hard, looking like spicules of bone, and adhered with great intensity. These bodies were not limited to the tonsil, but were also found on the lower part of the fauces and on the post-pharyngeal wall.

Dr. HARRISON ALLEN, of Philadelphia, stated that he had referred to this condition in a paper published in 1882. The solid matter is retained in the crypts. This pressure is often produced by the anterior fold. Sometimes the secretion has gotten out of the tonsil, but is still retained behind the fold. More frequently these masses are beneath the tonsil, under an adventitious membrane.

Dr. J. SOLIS-COHEN, of Philadelphia, read a paper entitled, *A Case of Sarcoma of the Thyroid Gland.* The case was one of sarcoma of the thyroid gland, with pressure on the right sympathetic nerve; unilateral tonic spasm of the laryngeal muscles; intermittent clonic spasm of the muscles of the opposite side. There was stenosis from the pressure of the tumour. For this, tracheotomy was performed. This afforded relief for a number of months. Hæmorrhage occurred twenty months later, but was controlled without much difficulty. Gradually marked disturbance of the two pneumogastrics supervened, and there was great interference with respiration. It was accidently discovered that any irritation of the mucous membrane of the trachea would relieve the dyspnœa, and at once the lividity of the face would disappear. This effect was readily produced by touching the posterior wall of the trachea with a bent wire passed through the tracheotomy tube. The patient died of exhaustion.

Adjourned.

At the invitation of the president, the afternoon was devoted to an excursion to Mount Vernon.

SATURDAY, JUNE 1ST—THIRD DAY—MORNING SESSION.

Dr. C. C. RICE, of New York, read a paper entitled, *Some Unusual Manifestation of Tuberculosis of the Larynx.* The first unusual manifestation referred to, was where syphilis and tuberculosis of the larynx coexist. Here the lesions of one process mask those of the other, and the prognosis depends upon which is the more active; this combination is more common than is generally supposed, and probably some cases of cure of supposed tuberculosis should be placed under this head. A second unusual manifestation, is the engrafting on the tuberculous process of a new tissue, rendering the diagnosis difficult. This new tissue may be of two forms, either a granulation tissue or papillomatous growth. The third condition is adhesive inflammation at the interior ends of the vocal bands. This must be rare, as the tubercular process shows little tendency to cicatrisation and healing. It is

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liable to occur only when the cords are immovable and there is general proliferation of tissue. The last condition referred to, was one in which the tubercular deposit in one arytenoid was the only manifestation of the disease in the larynx, the remaining parts of the larynx being perfectly normal.

DISCUSSION.

Dr. W. H. DALY, of Pittsburg, was satisfied, from his experience in three or four cases, that in some instances tubercular ulceration of the larynx may be cured. In these cases there was no evidence of syphilitic disease, and in at least some of them, the tubercle bacilli were found. Recovery has followed the use of alkaline sprays and inhalations, with the free use of iodoform. He believed that tuberculous ulceration of the larynx might occur, without evidences of tubercular deposit elsewhere.

Dr. J. C. MULHALL, of St. Louis, thought that there might be a catarrhal ulceration of the larynx, and that this was a curable condition. He did not think that it would be easy to prove that tubercular disease of the larynx was ever primary, although it is sometimes the first sign of the condition. In tubercular ulceration of the larynx, he had used pure lactic acid, and had seen the ulceration heal, but he could not say that he had ever seen life prolonged to any appreciable extent.

Dr. F. I. KNIGHT, of Boston, had not the slightest doubt, that tubercular ulceration of the larynx does get well. He had seen such ulcers heal under alkaline sprays and iodoform, and more especially under lactic acid. He thought that it was possible to have the tubercular disease of the larynx as a primary affection, but in the majority of cases, careful examination will reveal evidences of disease of the lung. He did not regard changes in the respiratory murmur and in respiration, as the most important signs of early phthisis. He placed more reliance upon the localized *râles* which are heard on coughing. In order to develop this sign, the patient should not inspire immediately before or after the cough, but should cough from a rest. He had seen but a few cases in which he regarded the disease as primary, in the larynx.

Dr. DELAVAN had found that lactic acid, applied to superficial tubercular ulcers of the pharynx had caused them to heal. With deep ulcerations this had not been the case.

Dr. M. E. CASSELBERY, of Chicago, reported a case in which he found catarrhal ulcerations of the larynx. These readily healed under cleansing treatment, and there had been no return of the ulceration during a period of two years.

Dr. J. N. MACKENZIE, of Baltimore, thought that the question of the possibility of the existence of primary tubercular disease of the larynx had been settled by examinations, upon the post-mortem table, where in a few cases, careful examina- of the body revealed tubercular deposit nowhere but in the larynx. While a tubercular ulceration of the larynx may heal, this by no means indicates the cure of the disease. He had seen the co-existence of syphilis and tuberculosis in the larynx several times, and it is difficult to say which is the syphilitic and which the tubercular ulceration. The only test is that of treatment. He had never seen what could be called catarrhal ulceration of the larynx. In regard to treatment, he thought that more harm than good was produced by the employment of harsh measures. There is a form of ulceration which occurs in the later stages of phthisis principally near the bifurcation of the trachea, which is probably due to the corrosive action of the sputa.

Dr. W. C. GLASGOW, of St. Louis, believed that tubercular ulcers of the larynx were never healed. He had seen cases of ulceration of the larynx heal

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under treatment, but he did not consider these to be true tubercular ulcerations. These have healed under simple treatment. He had used with great satisfaction, during the past two years, the peroxide of hydrogen in the treatment of such ulcerations, and under its use there is rapid healing. He did not believe in primary tubercular disease of the larynx. In all the cases that he had seen, there had been more or less disease of the lungs. In true miliary tuberculosis of the larynx, he had always found some evidence of disease in the lung, and these cases he thought never recovered. He had seen cases of catarrhal ulceration of the larynx.

Dr. S. SOLIS-COHEN, of Philadelphia, read a paper entitled, *The Occasional Topical Use of Solutions of Nitrate of Silver in the Treatment of Chronic Laryngitis.* The cases reported were not due to nasal disease or obstruction; nor were they those in which all topical treatment is unnecessary. Where indigestion, constitutional disease, or diathesis have been present, these have received due attention. It was simply of topical applications for the relief of local conditions that he spoke; chronic laryngitis in which, after all discoverable sources of irritation, local or general, have been removed, and approved topical treatment suited to the individual case has been faithfully tried, for a longer or shorter time, improvement takes place to a certain point and then stops. Perhaps all visible evidences of disease, except an irregular, pinkish striping of the vocal bands have disappeared, or perhaps there would be a faint uniform coloration, or may be only a loss of lustre, but something there would be that persisted, and that prevented the patient from resuming with comfort full use of the voice in singing or speaking, or perhaps even in ordinary conversation.

It is in such conditions as these, the last obstinate remnants of the disease, that he had derived considerable satisfaction from the topical use, by sponge, cotton-wad, or brush, of weak solutions of silver nitrate, about ten grains to the ounce, applications being made every day, for two or three days, until some congestive reaction is produced; after that at longer intervals. In the course of treatment, too, in some cases before reaching the last stage above described, he had found recovery apparently hastened by occasionally substituting stronger solutions of silver nitrate, forty to sixty grains to the ounce, for the iodized glycerine, tannin, tar, or other routine application. A visible increase in congestion immediately follows the use of the silver solution, but this passes off quickly, and at the next visit great improvement is usually manifested. These applications are made once in about two or three weeks according to circumstances.

Dr. C. E. BEAN, of St. Paul, read a paper entitled *Tuberculosis of the Tongue.* The author described two cases of tuberculosis of the tongue, one in a male and the other in a female. In both the disease had made extensive progress when they came under observation, and no operative measures seemed warrantable. In both these there was well-marked involvement of the lungs. Death occurred in both cases a short time later. Attention was called to the differential diagnosis between tuberculosis, carcinoma, and syphilis. Carcinoma is to be excluded by the absence of glandular enlargement, and of the lancinating pains peculiar to that disease. The question of syphilis can only be determined by the history and by the effects of anti-syphilitic remedies.

Dr. J. C. MULHALL, of St. Louis, read a paper entitled *The Local Treatment of Diphtheria.* The method of treatment which he suggested was based upon the following considerations: 1. That diphtheria is a germ disease. 2. That the specific microbe, in the majority of cases, selects the tonsils. 3. That unless checked by treatment the colonization of these germs results in local putrefactive changes with subsequent involvement of the general system. 4. That implication of the

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larynx or of the nasal passages, increases the mortality. 5. That the disease is acutely adynamic. It had occurred to him that in this disease it would be better to wash out the throat than to spray it. This is accomplished by means of an ordinary syringe, and in this way the throat can be washed out without difficulty. The patient should be kept in the recumbent position, the head being brought to the edge of the bed. This procedure is repeated every hour during the day, and at no time is a longer period than three hours allowed to elapse. The only solution that he has used has been carbolic acid with compound solution of iodine. The water is frequently saturated with boracic acid.

The post-nasal space requires careful attention. In every case of diphtheria the nasal cavities should be kept sterile from the first. Where it is certain that the nasal cavities are not affected, the insufflation of a non-irritating, antiseptic powder may be sufficient. Where there is uncertainty, or where it is certain that infection has taken place, the nasal cavities are to be washed out with a weaker solution of the same kind—not more than a tea-spoonful for each nostril. For this purpose he recommended a small glass syringe with a bulbous extremity, to prevent injury to the nose. After cleansing he frequently resorts to solvents, and has obtained the best results with papoid. In laryngeal diphtheria, inhalation is the only practicable method. The inhalation of the vapour from slaking lime should not be forgotten. In several cases of laryngeal diphtheria he had obtained good results by placing the patient in a small room which had been fumigated with sulphur, and by keeping water, to which has been added pine-tar and turpentine, constantly at the boiling point.

Discussion.

Dr. W. C. Glasgow, of St. Louis, believed that diphtheria is a blood disease rather than a local affection, and that the only objects in local treatment are cleanliness, disinfection, and loosening of the membrane. One remedy which he had used with advantage was the peroxide of hydrogen by spray. It seems to act by lifting up the membrane, by the formation of gas. He considered the constitutional treatment as the most important, and he thought the bichloride of mercury and benzoate of soda were the most successful remedies. With these he uses very simple local treatment. In the cases of severe local manifestations the method described by Dr. Mulhall would be valuable.

Dr. D. Bryson Delavan, of New York, referred to the value of the bichloride and cyanide of mercury, in the treatment of diphtheria, the former being the most destructive agent to the streptococcus known.

Dr. W. H. Daly, of Pittsburg, had on previous occasions recommended the use of calomel in the treatment of this affection, and he thought that it was as efficient as a local agent, as it was active as a constitutional remedy. He believed that calomel in large and frequently repeated doses—two, three, four, or five grains to children, one and a half, to two years of age—exerted a valuable therapeutic effect. He thought that a large part of the effect, was from the local action upon the diphtheritic poison.

Dr. Harrison Allen, of Philadelphia, referred to the value of trypsin, as a solvent for the diphtheritic membrane.

Dr. F. Whitehall Hinkel, of Buffalo, read a paper entitled, *Some Manifestations of Lithæmia in the Upper Air-passages.* The influence of lithæmia and allied conditions upon the air-passages, has received little attention in laryngology, as is shown by the scanty literature extant upon the subject. There is a distinction to be made between distinctly gouty sore throat, and that due to lithæmia or some allied conditions. The subjects of the latter may never have attacks of true gout,

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nor irregular manifestations of it—indeed, as a rule, they are not so affected. The term lithæmia is elastic in application to cases, varying from extreme digestive and nervous disturbances to almost normal health; consequently its manifestations in the upper air-passages are not sharply distinguished, nor are they typical or pathognomonic. One of the most characteristic manifestations, is a patchy or streaked irregular congestion of the mucous membrane of the larynx and pharynx. In the former case a dry, explosive cough accompanies; in the latter, uneasiness or positive pain is referred to the sides of the throat, occasionally extending to the ears. These cases are notably irritated and made worse by stimulant applications. Local sedatives and general antilithic treatment give the best results. Occasionally, acute naso-pharyngeal catarrh is a manifestation of an exacerbation of the lithæmic tendency. Alkaline and diluent medication, with proper diet, give more relief than local treatment. Obstinate relaxation of the nervous plexuses of the turbinated bodies in some individuals, appears associated with lithiasis. Such cases stand operative—caustic—applications badly, and receive little or no benefit from them. Some of these cases are much improved by antilithics and general hygiene. Others are intractable on account of uncontrollable lithæmic tendencies.

Dr. E. FLETCHER INGALS, of Chicago, presented a paper on "Warty Growths of the Nasal Passages," and Dr. WM. PORTER, of St. Louis, one upon "Hæmorrhage from the Larynx."

OFFICERS FOR ENSUING YEAR.

President—Dr. John N. Mackenzie, Baltimore; *1st Vice-President*—Dr. Edgar Holden, Newark; *2nd Vice-President*—Dr. C. E. Bean, St. Paul; *Secretary and Treasurer*—Dr. C. H. Knight, New York (No. 20 West Thirty-first Street); *Librarian*—Dr. T. R. French, Brooklyn; *Council*—Drs. Franklin H. Hooper, Boston; George M. Lefferts, New York; Frederick I. Knight, Boston; D. Bryson Delavan, New York; *Representative on the Committee of the Congress of American Physicians and Surgeons*—Dr. Harrison Allen, of Philadelphia.

The following were elected to membership; Drs. William E. Casselbery, Chicago; H. L. Swain, New Haven.

The Association then adjourned to meet in Baltimore, in 1890.

D. Bryson Delavan.

NEW PREPARATIONS.

Rubinat Mineral Water. (Gallais & Co.)

THE nauseous taste and irritating properties of many of the well-known purgative waters is due to the magnesia salts contained in them. For cases in which it is desirable to avoid this, and to obtain the full hepatic action of sulphate of soda, we know of no more suitable water than the Rubinat, which is prepared in Spain from the natural spring. The composition of this water is indicated by the following analysis made by Prof. Bouchardat, of Paris:—

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