recommended to repeat the experiment every two hours, and very soon complete recovery took place.

Dr. REINHARDT asked whether Dr. Moll had found serous collections of fluid in the accessory cavities, as lately recorded by Noltemus. He had himself made frequent punctures, but without similar results.

Dr. MOLL had never found a serous exudation; but he avoided making exploratory punctures in acute affections.

Dr. BULGER had seen several cases such as described by Dr. Moll, after influenza, which had recovered spontaneously. He attributed great value to transillumination in such cases. He recommended frequent irrigations through the nose under slight pressure.

Dr. MOLL agreed that spontaneous recovery could take place: but he had seen cases which remained stationary for several weeks, and only recovered when the aspiration method was practised. The pressure pain disappeared, as a rule, immediately after the aspiration..

Dr. P. Q. BRONDGEEST. *The Treatment of Lupus and Tuberculosis of the Larynx in Advanced Stages.*

Founding upon several communicated cases, the writer advised that the treatment under these circumstances should be as vigorous as possible; and he considered it indicated to remove all diseased tissue by means of the thermal cautery, after the performance of laryngotomy. This treatment should be resorted to when cure is not brought about by endo-laryngeal means. In lupus, which often attacks the epiglottis so severely, this part must be removed completely by means of sub-hyoid pharyngotomy; and, should the interior of the larynx be affected, laryngotomy (thyrotomy) should be carried out shortly after. Finally, he raised the question as to whether, in commencing tuberculosis of the larynx, it was not desirable to remove all diseased tissue by means of laryngo-fissure. *Dundas Grant* (*Trans. and Abs.*).

BRITISH MEDICAL ASSOCIATION.

Meeting, July, 1896.

ABSTRACT OF PAPER.

The Operation of Thyrotomy. By PHILIP DE SANTI.

The following is a short abstract of the paper I read on the operation of thyrotomy, especially in relation to its efficacy in the treatment of malignant disease of the larynx, at the last meeting of the British Medical Association, held in London in August last.

The cases that I have been able to make use of are those that have been in the hands of Mr. Butlin, both in his hospital and private practice, during the last fifteen years. I am much indebted to him for giving me access to his notes.

In the "Lancet" of December, 1894, a paper was published by Dr. Felix Semon, "On the Results of Radical Operation for Malignant Disease

https://doi.org/10.1017/S1755146300164182 Published online by Cambridge University Press

of the Larynx from the Experience of Private Practice." His results are most encouraging, and he strongly advocates the operation in suitable cases.

At St. Bartholomew's Hospital, my old *alma mater*, Mr. Butlin has performed thyrotomy seventeen times, as follows :—

In 7 cases for intrinsic malignant disease.

In 2 cases for extrinsic malignant disease, 1 of the latter being a secondary thyrotomy for a recurrence.

For innocent tumours, 6 thyrotomies on 5 patients.

For other causes (exploratory, etc.), 2 thyrotomies on 1 patient.

In private practice he has performed 11 thyrotomies—

7 for intrinsic malignant disease, 1 being exploratory, and 1 a second thyrotomy for recurrence.

2 for extrinsic malignant disease and disease of uncertain nature.

2 for innocent tumours.

Total of these cases—

For intrinsic malignant disease	14	thyrotomies on	13	patients.	
For extrinsic " "	4	" "	3	"	
For innocent tumours	8	" "	7	"	
For other causes	2	" "	1	"	

Total, 28 thyrotomies on 24 patients.

His results have been as follows :—

Of the thyrotomies for intrinsic malignant disease (14)—

1 death from the operation itself.

3 cases too extensive for removal.

5 cases recurrence.

2 cases, patients quite well three years after.

1 case a complete cure. (Death five years after from internal disease of uncertain origin.)

1 case quite well a year after (May, 1895).

1 case for supposed malignant disease : quite well up to the present.

Of the thyrotomies for extrinsic malignant disease (3 cases)—

1 death from the operation.

In the other recurrence occurred, and a second thyrotomy was performed two years subsequently ; within another two years recurrence took place in the cervical glands, death following an attempt to remove them.

For innocent tumours, etc., not a single death occurred, and 6 out of 8 patients were completely cured.

These results are sufficiently good to warrant the performance of thyrotomy in suitable cases, and offer a greater chance of permanent relief than any other treatment advocated.

The dangers of exploratory thyrotomy, and of thyrotomy for the removal of intrinsic malignant disease, are decidedly small if the details of the operation and the after-treatment be properly carried out.

The Operation of Thyrotomy.—The patient should be anæsthetized, with chloroform preferably, as ether excites the secretion of much mucus and saliva, which obscure the parts to be removed : an incision is made mesially from the upper border of the thyroid cartilage to about one

https://doi.org/10.1017/S1755146300164182 Published online by Cambridge University Press

and a-half inches below the cricoid. The trachea is exposed and opened and a Hahn's compressed sponge canula inserted. After the lapse of ten to fifteen minutes the compressed sponge will have expanded sufficiently to prevent entry of blood into the larynx, and the parts over the thyroid are divided and the cartilage exposed and divided mesially with bone forceps or small saw. The alæ are then held aside, and the interior of the larynx is painted with a five per cent. solution of cocaine to diminish the sensibility of the parts.

Two elliptical incisions are now made round the diseased tissues, going wide of them, and down to the perichondrium; the growth is seized with forceps, and removed, together with the mucous membrane, with curved, sharp-pointed scissors. The base is sharp-spooned, the interior of the wound dusted with iodoform, and *the Hahn's canula removed at once.* This is important, as septic infection has followed the retention of the sponge canula for twenty-four to forty-eight hours. The whole external wound is left open, being covered with a layer of iodoform gauze.

For innocent growths avoid sharp-spooning, and suture the thyroid alæ accurately together with fine silver wire.

After-Treatment.—Keep the patient on the side corresponding to the half of the larynx operated on, and the head low. Feed the patient for the first day or two on nutrient enemata; on the day subsequent to the operation try to give fluids by the mouth, the patient being made to sit up and lean well forwards. Give water as a trial: if it gets into the larynx it at once runs out through the wound; should it be successfully swallowed, beef tea, milk, etc., are given.

The wound must be carefully dusted with iodoform daily. During the act of swallowing the two lips of the wound into the larynx separate sufficiently to allow of the introduction of the nozzle of an insufflator between them. As a rule there is but little constitutional disturbance, and the wound rapidly heals by granulation.

For the full details of the individual cases, including the occupation, sex, and age of the patients, whether hospital or private case, part of the larynx affected, symptoms, nature of growth, date of operation, operator, method of operation, parts removed, results of operation, and condition when last seen or heard of, reference must be made to the table published with my paper in the "British Medical Journal" of October 26th, 1895.

https://doi.org/10.1017/S1755146300164182 Published online by Cambridge University Press