FATAL CASE
OF
DYSPHAGIA;
PRODUCED BY A POLYPOUS GROWTH IN THE
ÆSOPHAGUS.

BY R. ARROWSMITH, M.D.,
SENIOR PHYSICIAN TO THE COVENTRY AND WARWICKSHIRE HOSPITAL.

COMMUNICATED BY RICHARD PARTRIDGE, F.R.S.,
VICE-PRESIDENT OF THE SOCIETY.

Received June 20th—Read June 22nd, 1847.

JAMES KELSEY, æt. 48, a ribbon-weaver, tall, spare, not intemperate nor previously unhealthy, applied to Dr. Phillips of this city, at the end of the first week in January last, on account of sore throat and difficulty of swallowing. On the 3rd of January, in consequence, as he supposed, of food disagreeing with him, he had vomited violently, and he observed to his family at the time, that he thought he had injured his throat by it. On inspection of the throat, no signs of disease could be discovered. He received some simple treatment, and returned to his employment in the course of about a fortnight. He continued at work for the space of three weeks, the complaint gradually returning and increasing, till at length the dysphagia became severe.

About the beginning of March he was entered as an out-patient at the Coventry Hospital, under my care. He had then much difficulty in swallowing, with frequent and, at times, severe cough (always excited by attempts to swallow,

as well as occurring independently of them), very copious frothy expectoration, fever, but no dyspnoea. The tonsils, uvula and pharynx were healthy. In examining the throat every endeavour was used to bring the epiglottis into view, but in vain, the narrowness of the man's mouth contributing to the difficulty of the examination. The stroke-sound of the chest was everywhere moderately clear, the respiratory murmur uniformly feeble, but without *râle*. On applying the stethoscope over the front of the neck, the inspiratory sound was heard preternaturally loud and rough. At this time it was conjectured that some result or product of inflammation occupied the commencement of the œsophagus, and permitted the glottis to remain unclosed during deglutition.

In a few weeks the feverishness and cough (excepting when attempts were made to swallow) had very much subsided, but the dysphagia had progressively increased, till, at length, deglutition became nearly impossible, and the man was evidently sinking from inanition. The only position indeed in which he could at all swallow was, by lying decumbent and then throwing his head farther back. In this way some portion of fluid could be got down. Attempts were several times made to pass a tube into the œsophagus, but these uniformly failed. They were followed by some bloody excretion, and occasioned, at the moment, so much spasm of the glottis, as apparently to endanger suffocation.

As the efforts to swallow and to pass instruments into the œsophagus appeared to be mainly frustrated by spasm of the glottis, and impediments to inspiration thereby induced, it occurred to me as not improbable that, if tracheotomy were performed, respiration might be carried on through a tube left in the trachea, with far less impediment, whilst more deliberate and persevering attempts to swallow and to pass instruments were made. Accordingly, on the 14th of April, the operation was performed, and with much skill, by Dr. Dewes, the resident medical officer of the hospital; the trachea tube was inserted and secured, and allowed to remain to the period of the patient's death.

Although the attempts to pass a tube into the œsophagus proved equally unavailing after the operation as before it, and were but little less irritating, the power of deglutition a good deal improved in two or three days, and for nearly a week afterwards he was able to swallow half a pint of milk at a time. Yet, from the period of the operation, whenever he swallowed, even most successfully, some portion of the fluid always returned through the tube in the trachea, showing that the glottis was imperfectly closed. After the lapse of about a week the dysphagia again increased, and swallowing soon became quite impracticable, and death ensued purely from inanition. For eight or nine days preceding his death he never swallowed anything, yet he vomited bitter yellow fluid occasionally, which passed upwards without unusual difficulty. Previous to the performance of tracheotomy and subsequently, nutritive enemata were regularly administered. The pangs of hunger were the chief source of suffering, and even these and an occasional cough were mitigated by sucking syrup of morphia. Death took place on the 14th of May, about fourteen weeks from the apparent commencement of the disease.

The *post-mortem* examination was made twenty-two hours after death by Dr. Dewes, assisted by Dr. Phillips. The tongue, larynx, trachea and pharynx were removed in connection, and the cause of death became at once revealed. A polypous growth was discovered at the commencement of the œsophagus immediately behind the glottis. The tumour was lobulated, freely mobile, of a sub-livid colour and cellular texture, and about two inches in length at the periphery. In bulk it was somewhat larger than a walnut, and was attached to the mucous tissue by a short thinnish fibrous base, commencing about half an inch from the posterior commissure of the glottis, and extending for the same distance in a straight line in the axis of the œsophagus. This fibrous attachment extended laterally also for about three quarters of an inch towards the right, in a direction between the hyoid bone

and thyroid cartilage. The structure of the tumour was vascular and homogeneous.

A. The glottis. B. The larger polypoid growth. C. The smaller tumour.

This tumour formed on the one hand a mechanical obstacle to the perviousness of the œsophagus, and on the other, by passing under the epiglottis during attempts to swallow, prevented the closure of the glottis, and thus allowed fluids to pass into the trachea. Another smaller tumour of very white colour, about three quarters of an inch long, and attached by a broad base, was found nearly two inches lower down the œsophagus. The epiglottis, larynx and trachea were free from disease. The pleuræ and lungs were everywhere sound, with the exception of a limited tubercular deposit, of granitic aspect, in the apex of the right lung. The further examination of the body was prohibited by the friends, some of whom were present during the inspection, but the morbid specimen was brought away.

The case now related differs from any other instance of

polypus of the œsophagus which I have seen referred to, in the dysphagia being complicated with, and greatly increased by, the tendency of food to pass into the glottis, and thereby to induce distressing cough and to threaten asphyxia, a circumstance simply due to the peculiar position and form of the morbid growth. Polypi in this situation must, therefore, be exceedingly rare; indeed polypi of the œsophagus are probably of less frequent occurrence than in any other of the open cavities of the body. (Portal—*Memoires sur plusieurs Maladies*, 1808, tom. iii.) Yet they are distinctly referred to by writers on Morbid Anatomy, as by Otto (*Handbuch des Path. Anatomie*. Breslau, 1814, s. 257) and Monro (*Morbid Anatomy of the Gullet, &c.*). An interesting case from this latter work is copied by Hodgkin (*Lectures on the Morbid Anatomy of the Serous and Mucous Membranes*, ii. 249), and, indeed, is referred to by almost every other author on the subject since it appeared. Blandin quotes a case from Schneider of a woman who died from dysphagia, occasioned by two polypi in the œsophagus, the existence of which had not been suspected during life. This author adds, with reference to the disease, “leur diagnostic est d’une désespérante obscurité.” (*Dict. de Medic. et de Chir. Pratiq.* xiii.) It seems right, therefore, that the present case should be recorded as a contribution towards the removal of that obscurity in diagnosis which Blandin, in another place, pronounces to be inevitable, but which careful and extended observation may hereafter elucidate.