Syringing is unsuccessful in making the fluid return by the opposite nostril." On February 21st, a large mass of adenoid growths was removed with a single grasp of Catti's forceps; and on the 28th, part of the left posterior naris was visible by posterior rhinoscopy. Repeated applications of the forceps (altogether seven), and the use of the galvanocautery (five applications of Voltolini's galvanocauteric gauge), were so successful in clearing the cavity, that on April 9th it was noted that the patient could sit with her mouth shut; and finally, a few small vegetations on the posterior pharyngeal wall were all that could be detected with the finger.

If, in this condensed and fragmentary communication, I have not been able to bring forward anything novel, I trust that it will at least have served the purpose of drawing attention to this important and widespread disease.

THE LARYNGEAL COMPLICATIONS OF CONSUMPTION.

By JAMES M. WILLIAMSON, M.D., Ventnor.

ALTHOUGH the average case of phthisis cannot be said to run by any means a painful course, the disease is very far from being a painless one when particular complications arise. Perhaps the laryngeal complications are those which a patient has most reason to dread in this respect; for, the functions of the region being so important and so constantly in operation, the encroachment of destructive disease there nearly always entails a form of suffering which is not only painful, but harassing and exhaustive.

The existence of laryngeal complications in a case of phthisis indicates that the affection has become, even if it were not at first, a constitutional one; and the new malady, like the cerebral and intestinal complications which also occur, is one of its local expressions. Now, although the predisposing cause is the constitutional disease, we may look for many exciting causes to explain why the morbid action should localise itself in the larynx. First of all, sex has considerable influence. Although, on the whole, women are somewhat more prone to phthisis than men, men are much more subject to the laryngeal complications than women are. Out of fifty cases, thirty-nine were men and eleven women. Possibly the changes going on in the male larynx during and for some time after puberty have something to do with this. Then age might be expected to have some effect; but, phthisis being for the most part a disease of early life, it is difficult to estimate this. So far as I have seen, this complication more often occurs towards the later rather than the earlier limit of the average phthisical age. I have not been able to satisfy myself that occupation has much to do with it. In some cases, there has been a history of considerable vocal exertion; in others, there has not. Something probably depends on the abuse of alcohol and tobacco, especially the former, and particularly when the upper part of the tract is involved. Lastly, is the exposure to infection from the passage of sputa an exciting cause? If it be, it surprises us that its effects are not more common. It is worth noting, also, that a patient with an actively softening lung usually lies on the sound side. Hence sputa lying about the upper respiratory tract would gravitate to the side corresponding to the healthy lung; whereas we know that the disease attacks by preference the side of the larynx corresponding to the unsound lung.

There is good reason to believe that laryngeal complications are more prevalent in phthisis than we generally realise in practice. Out of 500 cases of consumption which came before me consecutively, no more than 34 complained of symptoms pointing to laryngeal mischief; in other words, 6.8 per cent. It must, however, be borne in mind that the complication is mostly found in the advanced stage of the disease. Taking none but fatal cases of consumption, therefore, I find that in 106 there were 25, equal to 23.6 per cent., who complained of throat-troubles. Even this would not appear to convey a full idea of the frequency; for Louis, in his *post mortem* examinations, found ulcerations in one or more portions of the tract in 33.2 per cent. of the subjects. Probably the discrepancy is due to the overlooking of tracheal and certain epiglottic ulcers during life. Some of these the laryngoscope would detect; and, in the interests of exact diagnosis, it is to be hoped that before long no investigation of chronic disease of the respiratory organs will be deemed complete unless both stethoscope and laryngoscope have been used with equal thoroughness.

It will be gathered, then, from what has been said, that symptoms are not by any means always present. At the same time, when we have them to guide us, it is generally possible to judge from them what part of the tract is involved. When there is heat and pricking low

down in the throat, with dryness and dysphagia, we suspect inflammation or superficial abrasions about the epiglottis, or in the folds of mucous membrane running between it and the tops of the arytenoid cartilages. Great suprathyroid pain, with burning and marked dysphagia, and with pain shooting up to one ear, will point to acute inflammation or deep ulceration of the same parts. I think the dysphagia is greatest when the angles of the epiglottis and the aryteno-epiglottidean folds are involved. Pricking in the box of the larynx, with hoarseness or intermitting aphonia and semilaryngeal cough, most often depend upon thickening or inflammation of one or both cords. Thyroid pain, with aphonia and more or less complete laryngeal cough, are caused by deep ulceration about the cords. Then suprasternal pain, constriction, or perhaps spasmodic dyspnoea, generally none of them very positive, will give a hint of inflamed spots, thickened patches or ulcers of the trachea. Of course, various combinations of lesions will occasion correspondingly combined symptoms. It is most usual to find tracheal and laryngeal ulcers combined, or else these with epiglottic ulcers superadded. It is rare for the disease to pass over the vocal cords. It is worth observing that the symptoms of pure laryngeal ulceration are the most constant, those of the trachea being vague and uncertain, and those of the epiglottis being often more or less latent, especially when the destruction of tissue is small and the damage is near the middle part of the border of the cartilage. The parts are not all equally liable to suffer. The nearer the lungs, the greater the danger. Fortunately, the urgency of the symptoms is the reverse of this; the nearer the lungs, the less the suffering.

In addition to these symptoms, some help will be obtained by observing the physical signs of the chest. The laryngeal affection is largely unilateral, corresponds to the side of the chest implicated, and goes with advanced mischief. So far as my experience has gone, ulceration never exists in the larynx unless the pulmonary phthisis has reached the stage of excavation. It is true that such symptoms as aphonic cough and diarrhoea are met with at a seemingly early stage of some primary tubercular cases; indeed, they may almost appear to be initial symptoms. But one characteristic of this variety of consumption is the want of definition about the physical signs over the chest; and this very indefiniteness is apt to mislead even a vigilant observer as to the condition of the lungs.

In considering the diagnosis, the first point to decide is that the symptoms do not arise from some morbid state of the fauces or pharynx, but that they are due to causes in the larynx. This question settled, the laryngoscope will eliminate hysteria and paralysis of the vocal cords. Dr. Walshe says that, as a rule, if a woman with hysteria become genuinely phthisical, the nervous affection falls into abeyance. If this be so, exceptions cannot be scarce. I have seen several cases of hysterical aphonia in phthisical women. As to chronic laryngitis, if it coexist with pulmonary phthisis, it is correct to connect the two pathologically. It must be remembered, too, that where there is no morbid constitutional tendency, such as phthisis or syphilis, ordinary inflammatory action about the larynx does not tend to run on to ulceration of tissue, nor does it resist treatment. Putting these foregoing conditions aside, only phthisis, syphilis, and cancer are left. Although so much has been written about the distinctions between the appearances in these diseases, I doubt very much whether anyone can form an absolutely reliable diagnosis from simply looking into the larynx. Such attempts are likely to trip up the specialist. Besides, other information is to be had for the seeking. The best plan, after examining the interior of the larynx, is to investigate thoroughly the general condition and history of the patient. My figures show that, at any rate, 23.6 per cent. of phthisical patients may be expected to have laryngeal complications. The syphilitic individual has a better chance of escape from them. Mr. E. C. Morgan, in a recent paper, says that 4.8 per cent. of the syphilitic have the larynx affected. On the other hand, instances of primary laryngeal cancer, which is generally of the epithelial variety, are very rare. I believe I am right in stating that, although there may be no constitutional antagonism between cancer and phthisis, yet clinically they are not often found in combination. We cannot say as much for phthisis and syphilis. It will be evident, however, that it will not do to neglect the valuable diagnostic information which is to be had for the trouble of examining the patient's chest, his lymphatic glands, and his history. It is not too much to say that, if the general and local signs are taken together, there should not be any insuperable difficulty in diagnosing between syphilitic, cancerous, and tubercular disease of the larynx.

It is impossible to touch upon the pathology in a paper confined to such brief limits as the present; but, before passing on to the subject of the treatment of this complication, a word should be said on the prognosis. Prognosis in phthisis, trustworthy prognosis that is worth the patient's having, and is at the same time quite satisfactory to our-

selves, is not the easiest of medical duties. So far as the ultimate prognosis is concerned, this duty is simplified by the appearance of the laryngeal complications: for they are a sign that the patient's tether of life is not a long one, even for consumption. Still, there should be no readiness to fix a duration. But, above all, more care is now required in giving an immediate prognosis of the case. Extreme emaciation is by no means a common feature long before death, as in some varieties; but there is often a striking pallor of countenance, which ought to put us on our guard. Such patients are not generally confined to bed long, and they pass rapidly through the final stage of the disease. Moreover, it does not seem to be sufficiently recognised, that cases of this class are very liable to fatal syncope, under apparently trifling and not unaccustomed strain. For this reason, it is well to caution against long railway journeys, fatigue, or even sudden change of posture. A guarded opinion should be given whenever a pallid individual has, along with phthisis, well-marked laryngeal symptoms with pyrexia, without relying much upon the extent of lung disintegration, the amount of emaciation, or whether he keeps to his bed.

The treatment of the laryngeal complications of phthisis must be aimed at their arrest, and the consequent abolition of those sufferings which, running an uninterrupted course, would materially hasten the fatal issue of the disease. When there is any activity about the disease in the larynx, the patient's mind is entirely taken up with his new symptoms to the exclusion of his old troubles, and he will demand prompt measures for his relief; while in those cases where the symptoms are latent, or in the more quiescent forms of the affection, treatment must be kept up so as to favour retrogression.

Recurring to those forms in which the disease in the larynx is active, the special indications are for rest and sedatives. The rest given to these parts during sleep is so beneficial, that a sedative night-draught should be resorted to from time to time. Objections are strong against using morphia in phthisis; but in these cases thirty minims of the solution of hydrochlorate of morphia, for a few successive nights, will produce very satisfactory results, and do no harm. Even during the day, minute doses of morphia give so much relief to the exhausting cough, that its use may be justified as the less of two evils. All talking and needless coughing should be suppressed, and as little whispering allowed as possible. Where dysphagia is prominent, ice to suck before medicine and food will be of service, and the night dose may then be given hypodermically. Then sedatives are to be applied more locally. Outwardly, poultices, or, better still, the spongio-piline, is to be wrung out of hot water, well sprinkled with laudanum, and applied from the front of the neck right round, and over the ear on the affected side. Warmth over the ear is of great value; and, indeed, owing to the intricate nervous anastomoses in this region, the ear offers an opening for getting at and soothing the superior laryngeal nerve, whose internal branch is responsible for most of the pain in these cases. In this way, I have seen a few drops of Battley's solution give relief by no means to be despised. Inwardly, inhalations of medicated steam are of service. I find a common quart jug the best inhaler; the inhalers with mouthpieces, like Nelson's and Maw's porcelain instruments, focus the steam in too pungent a stream of vapour for the tender throats of many of these patients. For medicating the steam, I prefer a mixture of chloroform, compound tincture of benzoin, and juice of hemlock, combined. Hop or henbane may be substituted. This sedative treatment should be continued too long, rather than left off too soon.

In latent, chronic, or quiescent cases, where there is no active inflammation and no suffering, it is important to avoid doing too much. The object here is to render the disease more inactive, if possible to heal it; over-treatment will excite it. If the disease is in the upper part of the tract and accessible, the best plan is to paint the surface once, not oftener than twice, a week with nitrate of silver solution (twenty-five grains to the ounce). The silver salt is preferred, because the irritation it sets up so soon subsides; but its stimulant and alterative action may be varied with the stimulant and astringent action of a sulphate of copper solution (fifteen grains to the ounce). When the disease is more out of reach, the same remedies are useful; but, instead of a brush, a spray-producer with a conical receiver to focus the vapour should be used. This will necessitate the use of weak solutions—one or two grains of each salt to the ounce; and by a little art and instruction, the patient will learn to avoid drawing the vapour deep into the chest. Externally, counter-irritation should be kept up, although not too much over the larynx itself. Small flying blisters, liniment of iodine, or—less severe—Laritz's fir wool oil, are the best; croton applications are objectionable, from the difficulty in limiting their action. There must be no attempt to hurry on these cases, and any change to strong stimulant local applications requires great caution. On the other hand, treatment should not be abruptly abandoned.

In a large proportion of cases, the chief part of treatment will con-

sist in how best to feed the patient. I know of no disease in which a kind and painstaking nurse can be of greater assistance: for, although the patient will himself indicate best the form and consistence of diet most readily swallowed, still great forethought will be necessary in excluding flavours, seasonings, and pungent stimulants. When there is great dysphagia, it will be fortunate if diarrhoea be absent, for then rectal alimentation can be resorted to. The use of the cesophageal tube, advised by some, would generally cause too much suffering to allow of its being tried.

Tracheotomy might, in some exceptional cases, be permissible; I never saw a case suited for it. When there is great œdema of the epiglottis, or the arytenoid region, scarification is indicated.

With all this, we should counsel as little interruption as possible to the general treatment of the phthisical state. There is no specific for that disease; but there is no case in which there are not plain indications for constitutional treatment.

A CASE OF STRUMOUS DISEASE OF KIDNEYS, IN RELATION TO NEPHRECTOMY.

By THOMAS COLE, M.D.Lond., M.R.C.P.,
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F. S., aged 18, a light-complexioned, intelligent errand-boy, rather tall and spare, was admitted into the Royal United Hospital on March 24th, 1881. His mother died of consumption; and one sister died, the cause being unknown. His father and his two surviving sisters are well. He had typhoid fever a year ago; but never had scarlet or rheumatic fever. In January, while micturating, he was seized with a sudden and severe pain at the end of the penis. At the end of the act, blood was passed. Defæcation was painless. He had suffered no pain in the renal region, nor down the inner surfaces of the thighs; nor was there any retraction of the testicles. The appetite was good; the bowels regular. He had no cough, nor physical signs of pulmonary lesion. The cardiac impulse was somewhat heaving, and there was a basic systolic *bruit*, heard also at the lower part of the sternum, and more faintly at the apex and in the interscapular area. The *bruit* was no doubt harmic; for it became inaudible after some time, and no valvular mischief was subsequently found. There was a little pain, with tenderness, over the upper dorsal spines, but it soon passed away. Micturition was necessary every two or three hours by day; but not quite so frequently at night. There was always pain at the end of the penis at the conclusion of the process. The urine was rather below the normal density, contained a fourth of albumen, and microscopic blood and pus, but no casts nor crystals. The latter two were never present. My colleague (Mr. Stockwell) was unable to detect a calculus. There was no renal tumour perceptible. The temperature was occasionally a little elevated, and the pulse-rate too. The diagnosis was scrofulous pyelitis. Rest, good food, and tonics materially improved his general condition, and for a time he lost the pain. On April 21st, he complained of a good deal of tenderness and pain over the right abdomen, with headache, vertigo, and cough; and the temperature rose to 102.4° Fahr. But these symptoms soon passed away; and there was a great diminution of the albumen. On June 1st, there was a return of the pain in the abdomen, which now extended to the right loin; and the pulse rose to 132, and the temperature to 104.4°. I was now able to detect an enlargement of the right kidney, which, although not very great, was appreciable by careful examination and comparison. No enlargement of the other kidney was ever observed. After this the blood and pus disappeared, and the albumen diminished. The patient, being much improved, was sent away for change on July 4th. For some months, he occasionally attended as an out-patient, and his general condition remained satisfactory—the tumour not being larger than perhaps double the size of a normal organ. I had determined that any accession of trouble should be the signal for nephrectomy. On February 2nd, 1882, he presented himself for readmission. I could not understand his rapid deterioration. He had lost flesh considerably, being only six stones two pounds; was flushed and haggard; the tongue was red and raw-looking; there was sharp pyrexia; and much more blood, pus, and albumen than ever. I had warned him never to do any work without my consent; but the poor lad confessed that, feeling so well, he had been induced to recommence his employment—in fact, he had been at it for nearly three weeks; and to this I mainly attribute the swiftly fatal result of his case. His bladder symptoms were the same as formerly, but he had some tenderness over the bladder. The renal tumour was a little larger. The first sound of the heart was weak, but there was