GUMMA OF THE LARYNX NECESSITATING TRACHEOTOMY

(NEGATIVE WASSERMANN REACTION).

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THE following case of gumma of the larynx presents several interesting points, and so seems worthy of being recorded.

In the first place, although there was no doubt that the case was one of syphilis, yet the Wassermann reaction was negative. The serum from this case was used in one or two subsequent examinations, and so had any error occurred in the first examination, one would have expected it to show itself subsequently. Instead, it always behaved as a normal serum.

A second point of interest is that a gumma of the larynx is rarely seen, is generally of much smaller size, and in consequence the symptoms in these cases do not become urgent.

A third point is the rapid increase in size in the short space of twelve hours. In the morning the patient was examined in the sitting position, whilst at night she was in a semi-recumbent position, and the dyspnoea was more urgent. Still the examination was carried out as carefully as possible, a clear view of the larynx was obtained, and every endeavour was made to see the left cord. At the time it was feared that the increased size might indicate that breaking down processes had commenced, although against this was the fact that little or no congestion of the mucous membrane was present.

The very large doses of iodide which the patient took without the slightest inconvenience is a further point of interest. Had tracheotomy not been done one would have hesitated about pushing the drug so vigorously, lest oedema of the already irritated larynx should occur and render an operation unavoidable. Large doses of iodine are, as a rule, very much better tolerated than is generally supposed, provided that they are not used for too long a period. In the present case the large doses were given in order to get the patient rapidly under the influence of the drug, as had so large a gumma broken down convalescence would have been much prolonged, and marked deformity and impairment of function of the larynx would have resulted even had the cartilage escaped. The patient was constantly watched for any signs of iodism, but none appeared.

Mrs. X., aged 40, was sent to me on the morning of August 28th, 1913, on account of some difficulty of breathing and intermittent attacks of dyspnoea, which had first appeared a month before and had been getting more frequent and more severe. She had been very nervous for some years, and for the past six weeks had been undergoing a modified rest cure at home. On the night of August 27th she had a severe attack of dyspnoea, which had not passed off when she came to me.

Condition when First Seen.

The breathing was rapid, the face pale, the eyes widely open with an anxious expression, and the alae nasi were dilated. Expiration was quiet, but inspiration was difficult and accompanied by a loud crowing sound. The voice was reduced to a whisper.

On the right side the arytenoid cartilage was displaced backwards by a large smooth swelling, which completely hid the vocal cord and protruded beyond the middle line. The tumour appeared to obliterate the ventricle completely, and distended the ventricular band. The mucous membrane was normal in colour or only very slightly reddened. The left cord could be partially seen throughout its entire length, and by manipulating the mirror so that a better view could be obtained it was seen to be slightly congested. A very narrow chink between it and the swelling represented the breathing space, except for the opening at the posterior end caused by the displacement of the right arytenoid. On gently touching the swelling with a probe it felt fairly firm.

On the front of the right tibia was a small node somewhat tender to pressure, and which, she said, was sometimes painful,

especially when lying in bed. Over each ligamentum patellae was a small punched-out sore, surrounded by a dusky area. On the right thigh was a sore about the size of a shilling, which communicated with a smaller one, a small bridge of skin being left between the two, and both were covered by a hard, thick crust. There was a definite history of rash, sore throat, and falling out of hair some four years previously. All the children (seven) were said to be healthy, and only one miscarriage had occurred seven years previously.

Blood was taken for the Wassermann test, and potassium iodide and mercury perchloride prescribed. Arrangements were made for her reception into a nursing home, to which, however, she did not go till 4 o'clock.

Tracheotomy.

As she had not been out of doors for several weeks and was brought to me in an open motor car, it was thought that possibly some of the dyspnoea might be due to this and to her excitable state, so she was put to bed and kept as quiet as possible for a few hours. At first the breathing became slightly easier, but later, in spite of a dose of potassium bromide, the respirations became rapid (36) and pulse 120, and the inspiratory crowing very noisy; there was marked retraction of the lower intercostal spaces, dilatation of the alae nasi, and some cyanosis, so that tracheotomy, for which preparation had been made, had become imperative. On examining the larynx before operation only the posterior third of the left cord could be seen clearly, and only occasionally could a glimpse of a portion of the rest of the cord be caught. The accompanying sketches give some idea of the appearance of the parts.

After-History.

Immediately after operation the respirations dropped to 25 and the pulse to 96. On the third day the swelling was still large,

but from then onwards it rapidly diminished, and on the sixteenth day the tube was removed. This might have been done sooner, but at the time it was thought safer to keep a small tube in for a few days. The patient was of a talkative disposition and difficult to control in this respect, and it was feared that the gumma might again increase in size if she began to use her larynx too soon.

Owing to circumstances in the laboratory the Wassermann test could not be carried out for several days, and the iodide was pushed till by the fourth day the patient was taking 100 grains a day in 25-grain doses. The Wassermann reaction was negative, and although the case was clinically undoubtedly syphilis, for various reasons it was decided not to use salvarsan, and this could be more safely omitted as she was reacting so well to potassium iodide. The periosteal node was getting smaller, the sores were healing well, and in every way the patient was improving.

On the twentieth day she went home with the larynx almost normal in appearance and the voice weak but clear. Six weeks later the voice was still somewhat weak but the larynx was normal in every respect.

Fig. 1.—11 a.m.

Fig. 2.—11 p.m.

A RARE FORM OF LICHEN RUBER PLANUS.

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THE cases of skin disease described in the Epitome of the JOURNAL of May 9th (No. 266) so closely resemble a case lately under my care that I think the following notes worth reporting:

The patient was a married woman, aged 32, and healthy except for the skin affection. There was nothing important in the previous history except the tendency of the rash to relapse. At one time the mouth was so badly affected with the "silver grey patches" described by Malcolm Morris¹ that an opinion was expressed that the disease was syphilitic. A careful consideration of all the facts convinced me it was not syphilis. The one thing that made me doubt my diagnosis of lichen planus was the same author's statement:² "In the adult there are never any vesicles or pustules mingled with the papules." Having now seen the report of Pollard's cases in the Epitome, I no longer doubt the correctness of the original diagnosis. Brooke and MacLeod state, "A bullous eruption has appeared in a few cases."³