must be shown that the micro-organism can by suitable methods be obtained from a long series of cases, which must be chosen with due regard to their acuteness and their freedom from suspicion of complications; and secondly, it must be clearly demonstrated that the organism itself is a distinct and definite variety of streptococcus.

A CASE OF RETROPHARYNGEAL FIBROMA.

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SIMPLE tumours growing in or behind the walls of the pharynx seem to be of such rarity that I think the following case is worth recording. I have succeeded in finding less than half a dozen in the literature similar to my own, while neither the College of Surgeons Museum nor those of the London hospitals contain a like specimen.

HISTORY.

A lady, aged 31, was sent to me by Dr. Stone, of Northampton, on August 3rd, 1906. Since Easter, 1904, she had been unable to breathe through her nose and had had some difficulty in swallowing. In May, 1906, she had two attacks of epistaxis; she had never been deaf. She did not think that during the last twelve months, at all events, the tumour had increased in size. On looking into her mouth, behind the right side of the posterior pharyngeal wall was a pyriform swelling, firm, regular, and well defined; the mucous membrane over it was stretched and thin but not involved. It reached to just beyond the middle line; it extended upwards to the lower border of the atlas, while its lower limit was determined by the upper border of the fifth cervical vertebra. It bulged forward the soft palate and the right posterior faucial pillar and filled two-thirds of the nasopharynx. A finger could be swept all round it except along its outer border. Grasped with the finger and thumb it was freely movable laterally on the vertebral column, while the mucous membrane could be pinched up over it.

OPERATION.

A six weeks' course of iodide and mercury had no effect upon it, and on October 30th I operated. Chloroform being given, the head was brought well over the edge of the table and Mr. Whitehead's gag was inserted. With the soft palate drawn gently forward with a small pair of tongue forceps, a longitudinal incision was made through the mucous membrane over the tumour, and the latter was then readily enucleated with the finger, assisted by two or three snips of scissors, curved on the flat. The haemorrhage, brisk for an instant, stopped almost immediately, and the mucous membrane was then sutured by two medium catgut sutures mounted on Mr. Arbuthnot Lane's cleft palate needle holder. Her convalescence was uneventful, rectal feeding being enforced for the first forty-eight hours.

The tumour when removed was the size of a hen's egg, and the following is the report of the Clinical Research Association, who examined it microscopically: "This tumour is an angio-fibroma with a more or less definite capsule; the vessels are chiefly capillary, but there are many large venous channels at the periphery. The stroma is richly nucleated in places, but it is forming fibrous tissue, and we do not observe any definite indications of sarcoma in the sections."

The first description of fibrous tumours in this region was published, in so far as I can ascertain, by Mr. Syme¹ in 1856. He mentions having operated on 4 such cases, but all of them originated in the neighbourhood of the faucial pillars rather than in the posterior pharyngeal wall. In 1857 Dr. Busch² recorded 3 cases of retropharyngeal tumour, and his authority is referred to in the only detailed account I could find of them in any text-book—namely, that in v. Bergmann's *System of Practical Surgery*. His first case was that of a man, aged 34, who gave a fourteen years' history of alteration in voice; for eight years he had been conscious of a mass behind the angle of the left lower jaw, and for six months had noticed a tumour in his mouth. This was the size of a goose's egg and well defined. Fearing haemorrhage, Dr. Busch first tied the left external carotid, and then, without an anaesthetic, split the soft palate and enucleated the tumour after incising the mucous membrane. On section, he says, the growth was a sarcoma with a good connective tissue capsule or a soft fibroma, with some portions of cartilage and some fatty degeneration. From the length of the history and the ease with which it was shelled out it would appear to be similar to my own case.

His second case occurred in a man, aged 70, who gave only a year's history. The mucous membrane was ulcerated over the tumour, and although this was enucleated as

readily as the first, and was like it on section; the involvement of the mucous membrane suggests malignancy. The third case he mentions was undoubtedly a sarcoma. Another similar tumour was reported by Dr. Ficano³ in 1895, but unfortunately I have been unable to verify the reference I found to his article.

Other benign growths have been described by Dr. Roe,⁴ who in 1894 removed a fibro-lipoma from the pharyngeal wall, and by Dr. Frederick Taylor,⁵ who in 1876 had a case of a retropharyngeal lipoma, the specimen of which is in the Guy's Hospital museum.

With regard to the origin of these tumours, Dr. Busch describes them as growing from the pharyngeal aponeurosis. They should, therefore, be styled "pharyngeal" rather than "retropharyngeal." I confess that, before reading his article, I myself thought my specimen sprang from the connective tissue of the retropharyngeal space.

The accompanying photograph was taken unfortunately after the tumour had been in formalin for some two months, and had shrunk somewhat.

I saw the patient again in February. There is no sign of anything like a recurrence of the tumour.

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- ² W. Busch, *Annalen des Charité Krankenhauses*, Acht Jahrg., I Heft, 1857, Ueber Retropharyngealgeschwülste.
- ³ G. Ficano, *Boll. d. mal. d. orecchio d. gola e. d. naso*, Firenze, 1895, xlii, 145, Fibroma della paretta posteriore della faringe.
- ⁴ J. O. Roe, *Journ. Amer. Med. Assoc.*, Chicago, 1894, xxlii, p. 491, Fibro-lipoma of Pharynx.
- ⁵ F. Taylor, *Lancet*, vol. ii, 1876, p. 685.

EPITHELIOMA OF THE LARYNX IN A YOUNG MAN.

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This case appears to be worth recording, as it presents several very unusual features.

The patient was a hawker, aged 27. He came to the throat department of St. George's Hospital in June, 1906, complaining of gradually increasing difficulty in swallowing, together with shortness of breath. These symptoms had been noticed for about two months; the dysphagia was not extreme, for he could take a normal quantity of soft food; there was some inspiratory stridor on deep inspiration, but the voice was very little affected, being only slightly hoarse. He was unable to work on account of the dyspnoea which came on with active exertion, but otherwise the general health was fairly good; he denied syphilis and no signs of the disease were to be discovered. The cervical glands were not enlarged, but a slight fullness could be detected about the right ala of the thyroid cartilage.

On examination of the larynx a large rounded swelling was seen to occupy the right lateral wall; internally it filled a large part of the lumen of the larynx and concealed both vocal cords, while externally it bulged into the right pyriform fossa and vallecula. It was situated below the level of the right aryteno-epiglottidean fold, which projected above the mass and appeared in the mirror to bisect it. The diagnosis appeared to me to lie between gumma and perichondritis of the thyroid cartilage. I therefore ordered mercury and potassium iodide, the latter in doses of 30 grains three times a day well diluted with water, and warned him to come to hospital at once should the dyspnoea get worse.

Under this treatment the dysphagia improved, but the tumour did not alter appreciably in size, and the patient reported several attacks of dyspnoea; the last of these was so severe that he was admitted to the hospital on the night of August 28th, and tracheotomy performed. I then gave intramuscular injections of benzoate of mercury on alternate days in doses of $\frac{1}{2}$ to $\frac{1}{4}$ grain, and at the same time I clipped away at several sittings a considerable part of the growth projecting into the larynx; in this way the dyspnoea was relieved so that he would wear a plug continually in his tracheotomy tube, but the main mass of the tumour appeared slightly larger and the swelling in the neck over the thyroid cartilage was more apparent; antisyphilitic treatment was, therefore, omitted. Microscopical examination of the fragments clipped away

showed only the normal tissue in a state of chronic inflammation, and there was no sign either of tubercle or of new growth. The patient was shown at the British Laryngological Association in November, and opinions were expressed suggesting perichondritis of the thyroid cartilage, malignant disease, and tuberculosis. My own opinion was in favour of perichondritis, possibly tuberculous in origin, as a primary form of tuberculous perichondritis of the thyroid cartilage is well recognized.

On December 5th I cut down on the external swelling in the neck, which was now tense and fluctuating; I found a large cavity beneath the perichondrium communicating, by a hole in the right thyroid ala large enough to admit the finger, with a similar cavity within the larynx. The entire cavity was filled with pale friable material resembling granulation tissue, but there was no pus; the cavity was thoroughly evacuated and scraped, and a tube inserted.

In a few days I removed both drainage tube and tracheotomy tube, and both wounds healed rapidly; there was now no dyspnoea, but considerable swelling was still visible with the laryngoscope.

Examination of the material from the cavity showed that it was almost entirely composed of masses and columns of epithelial cells without cell nests. As the case was now definitely one of epithelioma, and the patient was anxious for operation, I decided to remove the right half of the larynx, the growth being limited to that side. Total laryngectomy has a lower mortality, but appeared to me to be inadvisable in so young a patient, as it would leave him incapable of earning a living.

Accordingly I operated on January 28th, 1907, and, after a

Fig. 1.—Laryngoscopic appearance in September, 1906.

low tracheotomy, removed the right half of the larynx with the epiglottis. The operation was rendered difficult by the size of the tumour in the neck and the scars of the former tracheotomy and exploratory incisions, but the patient bore it well; his condition remained satisfactory until the sixth day, when there was a sudden rise of temperature, and he died on the eighth day of pneumonia.

Two features in this case are of special interest. The first is the age of the patient—namely, 27. Of 50 cases reported by Butlin,¹ only 1 occurred below the age of 28, and that was a remarkable case of epithelioma in a boy aged 3; there was, however, a somewhat large proportion—namely, 4 cases—between the ages of 28 and 30. The other point is of great importance in relation to the question of the intralaryngeal removal of portions of growth for examination. I refer to the deep situation of the neoplasm, which penetrated the thyroid cartilage without reaching the surface of the laryngeal lumen. A very considerable portion of the mass which projected into the larynx was clipped away to relieve the dyspnoea; nevertheless, microscopical examination showed that only normal tissues were included in the section, and no sign of malignant growth, or, indeed, of any neoplasm, could be detected.

REFERENCE.

- ¹ *Malignant Disease of the Larynx*, 1883.

A PROPOSAL that women should be eligible for appointment on the medical staff of lazarettos and hospitals and as provincial medical officers passed both chambers of the Swedish Legislature on February 13th.

SARATOFF has been definitively chosen as the seat of the new Russian University which is to replace that of Warsaw. The statutes will shortly be submitted to the Duma for approval.

MEMORANDA: MEDICAL, SURGICAL, OBSTETRICAL.

WANDERING SPLEEN.

THE patient in the following case, a servant girl, aged 21, stated that three months previously she had noticed a swelling in her abdomen. At first confined to the right iliac region, it rapidly increased in size, and a fortnight later she began to suffer considerable pain in the abdomen and back. She continued in service, and although growing paler and thinner and almost constantly suffering, she was able to do her work up till a week before consulting me. The sickness then became much more severe and persistent, all food being almost immediately vomited.

State on Examination.

The abdomen had the appearance of a six months pregnancy. On palpation the swelling was found to be easily movable, and it was easy to pass the fingers down behind it from above. On the upper margin a sulcus could be felt like the notch in a spleen. The girl denied all possibility of pregnancy, and except that the areolae were of a somewhat dark colour, the breasts were normal and no colostrum was present. Menstruation had been regular, the last period having ended fourteen days previously. The temperature was normal, the pulse weak and rapid. On vaginal examination a mass could be felt in the right fornix, and the uterus was apparently quite separate from it and of normal size. Dr. Fenn also saw her, and we made the diagnosis of an ovarian tumour with a twisted pedicle, and decided to send her to the infirmary, whither she was removed the next day.

Operation.

For the notes of the case after admission to hospital I am indebted to Dr. Brown and the house-surgeons. Shortly after admission the temperature rose to 101° and the pulse to 120, being very feeble. She looked very collapsed, and it was decided to operate. On opening the abdomen the mass was found to be a large and congested spleen with a long pedicle, which had become twisted. It was replaced in position and the wound sewn up.

RESULT.

The wound healed by first intention, but five days later signs of thrombosis developed in the veins of the left leg. This gradually disappeared, and a month later she was able to get up. At the end of a week, however, she collapsed suddenly, and died within six hours. At the *post-mortem* examination the spleen, still considerably enlarged, was found to be firmly adherent to the peritoneum and in good position. The cause of death was thrombosis of the mesenteric veins. The extreme degree of mobility of the spleen, together with the fact that a wrong diagnosis of ovarian tumour with twisted pedicle was made, seems to me to render the case worth publishing.

Southport.

ARTHUR J. LEWIS, M.D. Edin.

DELAYED CHLOROFORM POISONING.

ON reading reports of delayed chloroform poisoning one is apt to find in it an explanation for all deaths following operation where the actual cause is not clear. Two deaths which occurred recently with me were sufficiently obscure to make me wonder if they were not due to acetone poisoning, and seem worthy of record.

CASE I was a woman aged 66, on whom I operated for strangulated umbilical hernia on December 16th, 1906, and who died on the 22nd of the same month without apparent cause. At the operation the bowel was found to be congested, but not in dangerous condition; there was also a considerable mass of adherent omentum which had to be removed; but she seemed to recover from the operation very well, and on the 20th had a temperature of 100.6° and a pulse of 96. There was only very slight vomiting and the bowels had moved well several times. During the next two days, however, she gradually got worse, coma setting in and vomiting becoming very severe; latterly the vomited matter consisted almost wholly of blood. There was never any abdominal distension or sign of peritonitis.

No *post-mortem* examination was permitted, and the cause of death was supposed to have been spreading thrombosis of the mesenteric vessels.

CASE II was a man, aged 40, suffering from a suppurating ear with a sinus discharging behind the ear accompanied by rigors and a temperature running as high as 105°. I cleared out the mastoid on January 26th, but found very little pus. Two days later a severe hæmatemesis occurred and jaundice appeared. As the rigors still continued I operated again, opening up the