ease; whilst, on the other hand, if there be such a tendency, it will be more quickly brought into action if the supposed benign growth be subjected to prolonged and repeated irritation.

If this be true, the whole question of intra-laryngeal interference in the case of growths turns, as it ought, upon the early differential diagnosis between benign and malignant laryngeal neoplasms. Now this is frequently a question of very great difficulty, and one in which even the most experienced laryngoscopist is not exempt from occasional mistakes. It is impossible to enter, in the space of a letter, fully into all the points which must here be taken into consideration. There are, however, a number of symptoms, none of them decisive in itself, but each of some significance, which will, especially when several of them occur simultaneously, raise at once the suspicion of malignancy in the mind of an experienced observer. Speaking from a rather considerable experience of both benign and malignant laryngeal neoplasms, I should say: if, in the case of a person who has passed the age of 35, a small warty growth makes its appearance on one of the vocal cords, causing, at a very early period of its existence, intense hoarseness, or even aphonia; if the vocal cord to which it is attached at an early period becomes congested, and still more if its mobility should become defective; if there be signs of irritation in the neighbourhood; if the neoplasm, after partial or total destruction or removal, reappears very soon again, and grows rapidly—these are circumstances which ought to warn the observer to be on his guard. The absence of constitutional symptoms does not in the least exclude malignancy. It is characteristic of intrinsic laryngeal cancer that often enough it causes only in later stages pain, dyspnœa, dysphagia, swelling of neighbouring lymphatic glands, cachexia, etc.

What is to be done under these circumstances? From the general considerations developed above it will be seen that, if my views are correct, it would be the worst possible fault of art to irritate the suspected neoplasm by continued cauterisation or similar methods, for should there be really a tendency to transformation into cancer—in most cases, however, as will be shown hereafter, there is primarily malignant disease—this tendency would simply be intensified by such proceedings. It is under these circumstances that the exploratory intra-laryngeal removal and microscopic examination of a small fragment of the growth come into play. Should the latter show evidence of epithelioma, scirrhus, sarcoma, etc., the diagnosis is of course settled.

But here let me again raise my voice, as I did in a paper read in November of last year before the Clinical Society, in warning against the fatal mistake of drawing from the negative result of the microscopic examination the inverse conclusion that the growth was not malignant, and that now a non-discriminating surgical interference in the patient's larynx was quite justifiable. Thrice even during last year have I had the opportunity of seeing the utter fallacy of such a conclusion. In the first case, the one reported before the Clinical Society, the examination made by Mr. Shattock and myself of the first piece removed from the suspected case showed the characteristics of an apparently innocent papilloma, whilst the examination of the second fragment, which was removed only five days after the first, so that nobody will think here of a transformation having taken place in the meantime, revealed that we had in fact to deal with a cornifying epithelioma. In the second case in point of time, which my friend, Mr. Butlin, brought before the Clinical Society, and which I had the opportunity of seeing repeatedly with him, the results of the microscopic examination were at first very doubtful, and by no means characteristic of malignant disease, and only the clinical features of the growth from the first raised Mr. Butlin's suspicion, a suspicion which was later confirmed by the more decisive evidence afforded by the examination of a fragment subsequently removed. The most convincing instance, however, and one that really teaches much in this whole question, has since occurred in my practice. I recently removed a warty growth, being, with its base of healthy tissue, one-sixth and one-seventh of an inch in longitudinal and transverse diameters, from a vocal cord. My friend, Mr. Shattock, kindly made transverse sections through the whole growth and its base. If one of these sections be gently moved along under the microscope, it is seen that about three-fourths of the specimen show nothing but the common characters of inflammatory tissue—namely, an enormous number of small round cells; then there occur, scattered in the midst of this inflammatory tissue, some small epithelial proliferations, and here and there a few cell-nests; and if the slide be again shifted a little, we find ourselves suddenly in the middle of the most typical cornifying epithelioma that could be seen.

The practical importance of this is obvious. Supposing I had left the last small portion of the growth, that is the part which yielded these decisive results, in the larynx—and need I say that it was great good luck that I removed it in one piece with the rest?—the dictum of the pathological expert could only have been innocent inflammatory new growth. Supposing now I had (what I certainly should not have done under any circumstances), trusting to the microscopic result, began cauterising and otherwise irritating the base of the growth, supposing that it had reappeared, that I had again removed a fragment, and that this time the expert had found evidence of epitheliomatous disease, what would have been the verdict?

According to your leader, I see only one reply, namely, that I had by my continued irritation caused an originally innocent growth to undergo malignant degeneration. And yet this growth was malignant before it ever was touched.

Here, then, Sir, is the salient point of view, from which this letter is written. I wish to defend my specialty against unjust charges, and on the other hand to assign to accessory means of investigation, however valuable in themselves, their proper position.

With regard to the first point, I believe that probably in all, or at any rate nearly all, the cases in which a malignant degeneration is said to have taken place after, or rather in consequence of, intra-laryngeal interference, the disease was malignant from the very first, and was only not recognised as such. With regard to the second, I am certainly grateful for the help which the microscope has often given me in difficult and doubtful cases, but I do not expect it to do impossibilities. The pathologist can only give an opinion on the fragment that has been submitted to him, and not on the disease from which the patient suffers, unless he detects in that fragment positive evidence of malignant new growth. Considering the fortuitous character of the removal, the fact that growths need not at all be uniform in their structure, that papillomatous excrescences sometimes spring from an epitheliomatous basis, etc., the piece removed may be, and often is, quite inconclusive as to the true character of the malady. It would be a grave fault to disregard, under such circumstances, all one's well-founded clinical apprehensions. The question is parallel to that of the examination of the sputum in suspected phthisis for bacilli. If they are found, well and good; the diagnosis is settled; just as little, however, as the physician after one negative examination of the sputum would doubt his own diagnosis, which he has founded upon a number of other well-marked clinical symptoms, is the laryngologist entitled to dismiss, after one negative examination of a particle of the suspected growth, all those fears which preceded the examination. Here is the point where judgment and caution are required. In many cases the proper course, it appears to me, under such circumstances, consists—unless the character of the growth declares itself in the meantime by other symptoms—in the cautious repetition (if necessary, several times) of the exploratory removal and of the microscopic examination. No dogmatic rule, however, can be laid down in this respect. Each case must be judged on its own merits, and it ought never to be forgotten that time is precious in these cases, and that, by waiting too long, the chances of a real cure by radical operation may be irretrievably lost.

The questions here involved are too manifold and too numerous to be discussed in the space of this letter, which has, I am afraid, already attained an excessive length. I trust, however, that the interest which, from a clinical, pathological, and therapeutical point of view, is attached to the whole subject will serve as an excuse for troubling you with the foregoing remarks.—I am, etc.,

Wimpole Street, W. FELIX SEMON, M.D., F.R.C.P.Lond.

SIR,—The interest which I have for some years taken in the subject of laryngeal carcinoma emboldens me to ask to be allowed to comment shortly on some of the statements in your very interesting article in the JOURNAL of May 28th, on the "Illness of the Crown Prince." I do not know whence the opinion is derived that benign growths of the larynx are peculiarly prone to become malignant. So far as I am aware, there is no evidence to prove that this is so; on the contrary, there is a great deal of evidence to prove that they rarely become malignant, even under what may be regarded as great provocation. May I venture to suggest that your author takes an exaggerated view of the difficulty of removing successfully pedicled papillomata of the larynx, and of the necessity of cauterising the stump? My own experience of such matters is very inferior to that of some of my friends who devote themselves solely to laryngology, but it is sufficient to enable me to take a much more hopeful view of the intra-laryngeal method than would be gathered from your article. But the chief points to which I would allude are the results of the microscopic examination of a fragment removed with the forceps, and the manner in which our journals (particularly some of the daily journals) have spoken of the triumph of British over German laryngeal surgery.

Since I directed attention to the importance of the removal and careful microscopic examination of fragments of questionable laryngeal growths in 1883 (*Malignant Disease of the Larynx*, p. 26 and p. 43), I have enjoyed numerous opportunities of examining such fragments, both in my own practice and in that of others. And I have learned how misleading and dangerous it is to rely on the examination of a single fragment, unless the appearances are pathognomonic of such a disease as squamous-celled carcinoma (epithelioma). If the structure of the fragment is of doubtful import, or such as one might find in inflamed tissue, it is essential, before a decided opinion can be expressed, that a second or even a third fragment should be removed and examined. One or two cases recently reported have shown the immense importance of this caution, and the blunders which must have resulted had it been neglected.

In the case of the Crown Prince, I understand that the fragment which was removed was very small, and was removed with difficulty on account of the surrounding swelling. I have every respect for the marvellous manipulative skill of Dr. Morell Mackenzie, but I also know how impossible it is under such circumstances to select with anything approaching certainty such a fragment as is best fitted for examination. We all of us admit the superiority of Professor Virchow in microscopic anatomy; but, after all, he can only express an opinion on the structure of what has been submitted to him for examination.

The question is at present in a very unsettled condition, and some, if not many, of us here feel the gravest apprehensions regarding the real nature of the ailment of the Prince. The occurrences of the past few days do not afford the least proof that Dr. Mackenzie is right and the German physicians are wrong, and I do hope that our journals, whether lay or medical, will refrain from any expressions of triumph until we are in a position to know that Dr. Mackenzie has really "well upheld the credit of English medicine abroad."—I am, etc.,

HENRY T. BUTLIN.

82, Harley Street, W.

RIGHT UPPER CANINE TOOTH REMOVED FROM THE LEFT ORBIT OF A CHILD.

SIR,—Permit me to thank Mr. Storer Bennett for his courteous criticisms upon the case which appeared in the JOURNAL of April 23rd. In my paper I clearly expressed the opinion that the tooth was a supernumerary right upper canine, but Mr. Storer Bennett questions the correctness of my conclusion, and considers that it ought to be described "as a supernumerary tooth, resembling a right upper canine." Now, there is a great deal of difference between mere accidental resemblance and identity of conformation. The tooth presents the special characters of a right upper canine belonging to the temporary set, and appears to be a well-developed tooth for a child 2 years of age. It has been forwarded to the Curator of the Museum of the Royal College of Surgeons, and I hope Mr. Storer Bennett will kindly examine it for himself, and then record his opinion.

With reference to my explanation of the curious eruption of a right canine tooth in the left orbit, I cannot admit that your correspondent has quite exploded it by his letter. It still appears to me that this tooth, during the early stages of growth, must have occupied the right maxilla. A well made supernumerary tooth presents special characters which at once affiliate it to one of the normal forms, and strongly suggest its original site in the primitive dental groove. During the follicular stage, each papilla assumes a shape which actually corresponds to the form of the coming tooth, and certainly this definite shape has a formative relation to the position of the papilla on the rudimentary jaw. For my own part, I see no reason to doubt that supernumerary teeth, which can be fairly classified as molars, canines, or incisors, have passed through the regular evolutionary changes within their special follicles, just like their normal associates.

In conclusion, I still regard the theory of "crossed displacement" as a very probable explanation of my case; at the same time, I beg to assure Mr. Storer Bennett that I am ready to cast it to the winds of Heaven as soon as he has kindly provided me with something better, and something more consistent with the known facts of dental development.—I am, etc.,

J WARD COUSINS.

Portsmouth, May 19th, 1887.

A PHILANTHROPIC PROFESSION AND A NIGGARDLY PUBLIC.

SIR,—It is not usual to discuss in the public press a confidential communication. Your correspondent, "M.D.," appears to think otherwise, as in his letter with the above heading, which appeared in the JOURNAL of May 14th, he criticises a scheme sketched out in a circular marked "private" and which must have been shown to him in confidence.

He, however, totally misinterprets the aim of the proposed association, which is not designed to reduce the guinea fees of eminent specialists to a fixed charge of five shillings a visit, but in great part to relieve the overcrowded out-patient wards of our hospitals of that portion of the *habitués* who are able to make a small payment instead of accepting advice gratis. The staff will not consist of gentlemen at the head of the profession, but of younger men of perhaps equal competence, who are working their way to that position by the long and meritorious labours that "M.D." describes. The remarks of your correspondent as to the gratuitous work of eminent specialists do not therefore apply.

Under the present system, patients of small means suffering from diseases of the eye, ear, etc., have but two alternatives; namely, either to go to eminent specialists, whose fees are usually two guineas for the first visit and one guinea afterwards (younger men having to charge practically the same under existing ideas as to professional etiquette), or to attend at the hospitals, where they pay nothing. A large number, being unable to afford the former, pocket their pride, and adopt the latter course. How this arrangement benefits the profession I fail to see. It must be remembered that the bulk of the gratuitous labour to which "M.D." alludes is done by the junior members of the hospital staffs, and not by the gentlemen who "have arrived at the period when guineas flow in." During the long years of probation, when these useful coins are few and far between, I cannot but think that the younger men would not be injured by receiving a certain number of "fixed fees of 5s. a visit," instead of treating probably the same patients for no fee at all. I fancy that when the scheme is published, it will be seen that the "vicarious philanthropy" about which "M.D." is so much exercised is not an element in the question, and that the benefits of the association will be equally divided between the needy portion of the public and the junior members of the profession who have taken up special branches.

"M.D." seems to think that it is the natural function of men working at special branches to pass through "years of patient and anxious labour," uncheered by fees of either five shillings, or one guinea, and that having reached the happy "period when guineas flow in," they should rest, and be contented, while doing what they can to prevent any change in the system. The younger members of the profession, however, will probably think differently, and not regard the efforts of the "peers, members of parliament, bishops, authors, and others," with the contempt he displays.

It may, nevertheless, be a satisfaction to him to know that the plan will not in any way affect his *clientèle*, as under the rules, only the class a little above the very poor, such as clerks, governesses, etc., will be able to attend the institution. That they will prefer to do so, rather than obtain charitable treatment at hospitals, which is at present practically their only resource, is, I think, certain. Consequently, this "niggardly" class will not be making a fresh call on the philanthropy of the profession, but taking a decided step in the other direction.—I am, etc.,

EDWIN H. BAVERSTOCK, Hon. Secretary.

36, Queen Square, London, W.C.

ON THE TREATMENT OF ANEURYSM BY IODIDE OF POTASSIUM.

SIR,—At p. 930 of the JOURNAL of April 30th Dr. Suckling, of Birmingham, states that he treated his cases of aneurysm according to "Tufnell's plan," along with iodide of potassium "in large doses, commencing with ten grains and increasing to a dose of a drachm or more, according to tolerance and effects;" and he adds that "in two or three cases the iodide seemed to do harm, the pulse becoming very quick." Had Dr. Suckling been fully cognisant of all the facts bearing on the treatment of aneurysm by iodide of potassium, he would have known that this quickening of the pulse is due to an overdose, and is one of the things to be guarded against. A full statement of these facts is to be found in the *Ed. Med. Journ.* for June, 1876, p. 1142; in the JOURNAL for April, 1879, p. 511; in the second edition of my *Clinical Lectures on Diseases of the Heart and Aorta*, 1882, p. 453; and in the *Lancet* for February, 1886, p. 356. With your permission I shall restate these facts concisely, for the instruction of those whose treatment fails through ignorance, and the information of those others who, even in the present day, continue to practise the unscientific and hazardous plan of filling the sac with iron wire, apparently unaware that we now have a perfectly reliable method of treating aneurysms, the success of which is entirely commensurate with the earliness of our diagnosis and our acquaintance with the principles on which the treatment is based.

As recumbency reduces the heart's pulsations from six to more beats