A CLINICAL LECTURE

ON A

SERIES OF 46 CASES OF REMOVAL OF ONE-HALF OR THE WHOLE OF THE TONGUE,

WITH ONE FATAL RESULT.

Delivered at St. Bartholomew's Hospital.

By HENRY T. BUTLIN, F.R.C.S., D.C.L.,
Surgeon to the Hospital.

[THE first part of the lecture was devoted to a demonstration of Whitehead's method of removal of the tongue with scissors, and operations for the removal of glands and ligature of the lingual artery. The lecturer stated that all his operations had been performed by Whitehead's method, and that the lingual artery had been tied in those cases in which the disease was situated wholly at the base of the tongue, and in those in which the situation of diseased or suspected glands was such that the same incision was suitable for ligature of the artery. He strongly recommended that such wounds should be drained for a week or ten days, especially when the submaxillary salivary gland had been removed, for the discharges proceeding from the wound in the mouth sometimes sink down into the deeper wound, and occasion troublesome inflammation of it. He drew the attention of the students to the ordinary causes of death after operations on the tongue, particularly to general sepsis, and septic affections of the lungs, which form the very large majority of causes of death after these operations. The knowledge of the causes of death naturally leads to the consideration of the measures which should be taken to prevent them.]

The after-treatment of operations on the tongue should be chiefly directed to (1) maintaining the wound in the mouth as aseptic as possible; (2) diminishing the tendency of the wound discharges to pass down the air passages; (3) preventing food from passing down the trachea into the lungs.

The first indication is, I believe, better fulfilled by the frequent use of powdered iodoform to the mouth wound than by any other means. As soon as the operation is over, and before the patient is put back to bed, the surface of the fresh wound is covered with powdered iodoform. And, for a week or ten days, iodoform is blown on to the surface of the wound by means of a proper insufflator. For this purpose, Kabierske's insufflator is the best instrument. Powder must not be ladled into the wound with a spoon, but must be blown directly into the cavity, so as just to cover the raw surface. I have never seen any symptoms which could be attributed to iodoform when it has been applied in this manner, and I know of no dressing which maintains the wound in such a healthy condition. In addition, the patient may use a mouthwash of Condy's fluid or weak carbolic solution to help to cleanse the interior of the mouth of the fluids which collect there.

The second indication requires that the patient's head should be kept low, and that he should lie on one side. I only allow one small pillow, and insist that he should lie well over on the side from which the greatest amount of tongue has been removed. The discharges then have a tendency to sink into the cheek, and are frequently washed out or allowed to run out, and there is thus the least possible inclination of discharges to sink down towards the back of the mouth and larynx.

The feeding of these patients needs very great attention. When only half of the tongue—whether a lateral half or the front half—or two-thirds has been removed, liquids can generally easily be taken on the day following the operation from a feeder with a spout, provided a piece of india-rubber tubing, 3 or 4 inches long, be fixed on to the spout. If the right half of the tongue has been removed, the patient should lie over on the left side during feeding, so that the food is kept as far as possible away from the wound, and passes over the parts which have been least interfered with.

When the whole of the tongue has been removed the difficulty of swallowing is much greater, and many days may elapse before the patient acquires the knack of swallowing liquids without permitting a small quantity to pass down the air tubes. During the first forty-eight hours these patients are fed through the rectum with nutrient enemata. At the end of that period I allow the patient to make a first attempt to swallow a little liquid, and water is chosen for the experiment, because the entrance of a little water into the trachea is seldom followed by any serious consequences. Milk and beef-tea are more dangerous; they hang about the air tubes, are difficult to get rid of, and are very prone to undergo rapid decomposition, and occasion the much-dreaded swallowing pneumonia (*Schluck-pneumonie*). If the experiment is successful other liquids may be tried, and the problem of feeding is really overcome. But if there is any difficulty I feed the patient as long as may be necessary through a tube. I believe that no instrument is so good for this purpose as a black bulbous catheter, about No. 9 or 10, attached to a long piece of india-rubber tubing, to the other end of which a small glass funnel is fixed.

The throat is first sprayed with a 3 or 4 per cent. solution of cocaine; the tubing is clamped with forceps just above the attachment of the catheter, and the funnel and tubing are filled down to the clamp forceps with warm food. The catheter is very gently passed down the pharynx, and hitches at the posterior border of the larynx. The patient is directed to swallow, and as he does so the catheter is easily passed on into the œsophagus. For the moment discomfort is created, and the patient often struggles. He is directed to close his mouth, and no attempt is made to pass the catheter farther down for half a minute or longer. Then it is slowly and gently passed down to a distance of about 11 inches from the teeth. When the annoyance of the presence of the catheter has ceased, the clamp is removed and the food is allowed to run slowly down into the stomach. If there is an inclination to regurgitation or to cough, the descent of liquid is instantly arrested by pressing on the tubing with the finger and thumb, and the nurse lowers the funnel until the dangerous moment has passed. By attention to these details a pint or a pint and a-half of liquid may easily be introduced into the stomach without danger. Before removing the catheter the funnel is raised high up, so as to get rid of the contents of the tube; and during the actual removal of the catheter the tubing is kept tightly pressed between the finger and thumb in order to prevent the entrance of even a few drops into the larynx. When the feeding is carefully carried out according to these directions, I have known patients so satisfied with it that they have sometimes insisted on being fed through a tube for a much longer period than I have deemed necessary.

Results.—I do not know whether it is to the great care which has been bestowed on these measures, or whether it is due to a long spell of good fortune that I have removed at least half the tongue in forty-six consecutive cases with one fatal result. The great majority of the operations were, of course, uncomplicated, that is, they were not complicated by the removal of lymphatic glands or of ligature of the lingual artery. But they were performed on persons varying in age from 33 to 75 years, and nineteen of them were performed on patients over 60 years of age. Some of the patients were suffering from organic disease of internal organs, and some of the operations were very severe. They may be thus classified:

1. Uncomplicated operations, 30: removal of one lateral half of the tongue, 13; removal of anterior half or two-thirds, 12 (in several of these the floor of the mouth was at the same time freely dealt with); removal of the whole tongue, 5.

These uncomplicated operations were recovered from in almost every instance without any drawback. One old man, aged 72, suffered from retention of urine a few days after the operation, due to enlargement of the prostate, and I was obliged to tap the bladder above the pubes and insert a tube; but his progress to good recovery was not interrupted by this accident.

Another patient, 46 years old, had an attack of secondary

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hæmorrhage from the right lingual artery eleven days after the removal of the whole tongue. An anæsthetic was administered and the artery tied in the floor of the mouth, after which he made a steady recovery.

In an old man, aged 72, severe bleeding took place on the day of the operation, not from the tongue but apparently from the back of the throat. I thought he must have died of this; but after some time the hæmorrhage ceased and he slowly recovered, but his recovery was seriously retarded by the loss of blood.

2. Complicated operations, 16: removal of half of the tongue and lymphatic glands, 2; removal of the whole of the tongue and lymphatic glands, 1; removal of half of the tongue, ligature of the lingual artery in the neck, removal of glands, etc., 10; removal of the whole tongue, ligature of the lingual artery in the neck, etc., 3.

These complicated operations were for the most part recovered from with greater difficulty than the uncomplicated operations. Infiltration took place from the wound in the mouth into the deeper wound in several of them, and, in one case in which this occurred, the patient was for two or three weeks seriously ill. Since then I have almost invariably drained the lower wound for the first few days after the operation, a precaution which I had seldom previously taken.

In one of these patients, 51 years old, hæmorrhage occurred six days after the operation from a deep cavity which had been made in the floor of the mouth, and recurred during three or four days. It was ultimately arrested by thoroughly clearing out the wound to the bottom, and plugging it with iodoform gauze. And in a man, aged 49, secondary hæmorrhage set in from the wound in the neck nine days after the operation. The hæmorrhage was arrested also by plugging, and the patient slowly recovered.

A patient, aged 45 years, was seized with a rigor on his return to the ward immediately after the operation, and for five days in succession his temperature was between 101° and 102°. I was naturally anxious on his account, examined the wound in the mouth carefully day by day, and had the external wound dressed much more frequently than I should otherwise have done. But the most careful examination failed to discover sufficient cause for his condition, and I could not but observe that he did not seem really very ill. On the sixth day he was attacked with acute gout in the great toe (he had been subject to gout), when his temperature fell to normal, and remained there until his discharge from the hospital.

The fatal case was that of a man, aged 71, who suffered from an epithelioma of the anterior portion of the left half of the tongue, and associated enlarged glands. I removed the left half of the tongue, the enlarged glands, and tied the lingual artery in the neck. The operation was performed on September 18th, 1891. In the course of a day or two the wound in the neck was foul, apparently from the sinking down of discharges into it from the mouth; it had not been drained. The patient had rigors and high temperature. He appeared to improve for a while after the condition of the wound had been bettered, but he finally died on October 22nd, five weeks after the operation. There was no *post-mortem* examination.[1]

I have thought this series of cases worthy of publication on account of the almost complete absence of general septic poisoning and of septic affection of the lungs. At first I thought that my success was but a part of the general success which at the present time attends these operations, but hospital statistics and tables show that this is not the case, and that the percentage of deaths after such operations as I have put together above is still considerable, and that nearly all the deaths are due either to general or to pulmonary sepsis. Such septic conditions are by no means limited to the larger operations or to those in which the entire tongue has been removed. But I regard the complicated operations as more dangerous than those which are not complicated by any external wound, and I would rather remove the whole tongue than one-half of the tongue, and at the same time perform a severe operation on the side of the neck.

So far as I can judge, the manner of performing the operation has less to do with the recovery of the patient than the after-treatment. I greatly prefer Whitehead's method of removing the tongue with scissors to any other method, and have exclusively employed it for six or seven years. But other surgeons still prefer to use the *écraseur*, and remove the whole or large portions of the tongue with it very satisfactorily.

No special care was taken to select the forty-six patients on whom these operations were performed. In every case in which it appeared likely that an operation would benefit the individual and prevent recurrence in the mouth it was undertaken, even if he was in a bad state of health. For the sufferings endured by those persons who die of actual cancer of the tongue moved me to extend the operation, even for the sake of palliation, to persons on whom I should not otherwise choose to operate.

[1] At the time this lecture was delivered I believed that I had had a series of 45 cases without a death, for I had overlooked this case. I performed the operation during the long vacation for one of my colleagues, and only took charge of the patient until his return to town at the end of September. The man was not in Mr. Smith's ward, to which I was at that time assistant surgeon, and I really did not know of his death, for his case is not entered in the registration book in which the cases under the care of Mr. Smith and myself are placed. Fortunately, before I sent the lecture for publication, my attention was called to the case, for the fatal result of which I am, of course, wholly responsible.

A CLINICAL LECTURE

ON

TWO CASES OF LUPUS TREATED BY THYROID EXTRACT.

Delivered at the Edinburgh Royal Infirmary.

BY BYROM BRAMWELL, M.D., F.R.C.P.EDIN.,
Assistant Physician to the Edinburgh Royal Infirmary.

[WITH SPECIAL PLATE.]

TO-DAY I propose to bring before your notice two cases of lupus which have been treated and materially benefited by the internal administration of thyroid extract, and by this treatment alone.

I have already explained my reasons for employing the thyroid treatment in cases of psoriasis. The desquamation and the remarkable improvement in the nutrition of the skin which the remedy produced in the first case of myxœdema, which I had the opportunity of treating by thyroid feeding, suggested to me that the remedy would probably be beneficial in some skin diseases. The rapid and marked improvement which occurred in the first case of psoriasis in which I employed the thyroid extract confirmed this opinion, and led me to suggest that it would probably be useful in ichthyosis, exfoliative dermatitis, and perhaps in other forms of skin disease. Now, just at the time that I was making my first experiment in psoriasis, this girl, M. M., was sent into my ward by Drs. Allan Jamieson and Norman Walker, suffering from lupus, in order that she might have her face scraped; and, after observing the case for a time, I determined, before anything was done to the face, to try the effect of the thyroid treatment.

I was anxious to give the remedy a trial in lupus for two reasons:—

1. As an experiment. Having observed the benefit which seemed to be produced in the course of a few days in psoriasis, I was anxious to see whether it might not possibly produce some improvement in lupus. But I must confess that this, the purely experimental reason, did not hold out to my mind any reasonable hope or expectation of success. Psoriasis is one thing, lupus is another and quite a different thing. Lupus is one of the most intractable and incurable of all skin diseases. The mere fact that the remedy was useful in psoriasis—a disease which often spontaneously subsides, and which, in individual cases, is beneficially influenced by many different forms of treatment—did not, to my mind, afford any adequate reason for supposing that it would be beneficial in lupus.

2. But I had another and, as I thought, a more satisfactory and promising reason for hoping that the thyroid extract

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