Clinical Lecture
ON
ACUTE LARYNGITIS.

GIVEN AT
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BY

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[THE case referred to by Dr. Chambers, is the first (that of Maria F.) related in Mr. Young's report from St. Mary's Hospital, at p. 168.]

Inflammatory laryngitis (or rather glottitis) is a disease in which the power we wield of saving existence is most strikingly exhibited. What a paltry scrap of flesh is damaged! Yet how frightful the results are to witness! The question of life or death is a question of an eighth of an inch more or less diameter in a tube! If the same amount of inflammation were in your finger, or at the end of your nose, any old woman would laugh at you for going to a doctor about it; if it were in your digestive canal, you would perhaps stay away from lecture, and take some slops, but you would not care to make an accurate diagnosis of its whereabouts. Catarrhal inflammation may even attack the lower part of the larynx itself pretty severely, and yet "nursery" practice be all that is required. The girl in bed number 7 (admitted at the same time as this one), had lost her voice from the tumefaction of the vocal cords, yet I did not think it worth while to treat her further than by keeping her in bed, with hot water inhalations and ammoniated salines. But let inflammation sink through the mucous membrane of the glottis to its submucous tissue, let that become anasarcous, and you see what a piteous call for your active interference! I say you "see" advisedly; because, though the patient has all the appearance of screaming loudly, and mayhap is trying to do so, no cry reaches your ears. It matters not if the inflammation be violent or weak, be rapid or slow—directly it has caused the edges of the glottis to swell to the point of not admitting as much air as the lungs want—instantly that it has reached this point, life is in imminent danger. It matters not what was the former state of the patient—the present moment is a present and pressing peril—a Hercules or a Lazarus equally hovers on the edge of the grave.

In point of fact, the importance of acute laryngitis depends, not on the *degree* of injury to life, but on its *localisation*. And, hence, the value of remedies is proportioned closely to the special definiteness of their action on the part affected. There may be, perhaps, at the druggist's, excellent remedies for inflammation, which would act most powerfully all over the body of your patient—all over the body of an animal three times her size; but you do not *want* just now to act all over her body, only on that little spot which stands between her and life. Do not run the chance of acting deleteriously on the whole person for the sake of a possible benefit to such a minute portion of it. Do not ransack your brains for that which is the extremest remedy for this extremely dangerous inflammation; but for that which will get nearest to the seat of peril. When this woman came into the ward, she was, as is described in the report, blue in the face, speechless, incapable of swallowing and breathing without labour and noise. It was very obvious that something must be done to relieve her without delay. But her skin was cold, her pulse was weak and not quick, and she was exhausted by abstinence and bodily exertion. Therefore, though I anticipated tracheotomy would have to be practised, I thought it as well to try other measures first, especially as there are other measures equally local and equally important without being so alarming. I got her, therefore, warm in bed, gave her some teaspoonfuls of hot beef-tea and wine, made the air damp and soft round the mouth with hot steam, and put four leeches on the outside of the trachea. There was a certain amount of relief from this, and the purple hue of the face faded during the afternoon. But the next evening it came again; and Mr. Young carried out the provisional order for performing tracheotomy. Then the relief was immediate, the lividity of countenance vanished; she shortly fell asleep, and continued afterwards to breathe through the tube till such time as the swelling of the glottis subsided enough for her to respire in the natural way; then the tube was removed.

Tracheotomy is an alarming operation to hear of or look at, but is, in reality, not a dangerous one. Bungling suicides often saw open the trachea by cutting their throats right in front; yet, if they miss the great vessels, they fail to kill themselves. And if a wound, under circumstances of such violence, is not fatal, how is it likely to be so when made with the deliberate caution of a surgeon? In point of fact, I cannot find on record any instance of the operation being fatal. Patients, of course, often die after it, because laryngitis is so often complicated with extensive pneumonia, croup, diphtheritis; but I cannot find anything indicating that the operation has ever hastened the death; nay, in most even of these, it seems to have postponed the unfortunate termination. Do not, therefore, alarm the patient's friends by speaking of it as "a last hope," "a final resource," or by any other twaddling expression. The effect of such conduct is that they beg you to postpone it a little and a little longer, till the time has passed for its complete success. Each minute the throat is becoming more swelled and filled with black blood, and there is more likelihood of the surgeon's hand being stayed by troublesome hæmorrhage. Each minute congestive pneumonia is becoming more and more probable; more and more incurable, if already existing. In fact, the operation is as the stiff leap to the timid sportsman, "the more you look at it, the less you'll like it."

The only reason for delay is that of which you saw an instance in the present patient; namely, a possibility that the excessive urgency of the symptoms may be due to some easily obviated external cause, such as cold, weariness, nervous excitement, hysteria, or the like. It was not unlikely that a patient, chilled with coming to the hospital and sitting in the waiting-room, might appear worse than she really was, and that warmth, stimulus, and rest, might alleviate the pressing danger. It did so

to a certain extent; but not so far as to prevent a relapse.

This is not a place to speak much about the surgical part of the business. I will merely say what the physician requires of the operator. His requirements are :—1. That blood shall not be allowed to get into the trachea (to secure which the use of a simple scalpel, and the waiting for all serious bleeding to have ceased before the cartilages are cut, are the best means). 2. That the opening shall be large enough to admit a sufficient body of air; that is to say, it must be capable of being stretched to nearly the diameter of the trachea. 3. That the instrument inserted should be capable of being kept clean by a nurse, and not easily jerked out by spasmodic movements on the part of the patient. (The ordinary curved double cannula seems to me the best.)

So far, then, for restoring the deficiencies of the respiratory functions.

But other functions require care also. You will observe that half a pint of warm beef-tea is ordered to be thrown up into the colon by enema every three hours from the first admission of the patient. These patients are usually suffering as much from want of food as from want of air. The deficiency, indeed, does not kill them so rapidly as the impediment to respiration; nor does it make itself so conspicuous; and, for that very reason, is apt to be forgotten. But observe the convulsive motions of a patient with laryngitis on trying to swallow, and you will not be surprised that they resist all attempts at feeding by the mouth, and that nurses have no heart to force them. The attempt is another name for strangulation. Yet if they get no nourishment, they are hourly becoming less able to bear up against the depressing influence of the devitalised blood, less able to renew the injured larynx. This is a matter of great moment, not only as regards the present retention of life, but as regards the later prospects of the patient. For the last hundred years, people have been writing a great deal, more or less sensible, about laryngitis; but I do not think anyone has noticed this important part of the treatment since Van Swieten a hundred years ago. (*Commentary on Boerhaave*, vol. viii, sect. 813, *ad fin.*) It seems not improbable, from the details given, that many of those whose immediate danger has been happily postponed by the operation, have died of starvation through the neglect of this simple measure.

In all cases where you desire to administer nutriment in enema, it is safer to prevent it from running off before it is absorbed by adding a few drops of an opiate. This was done at first in our patient's case; but it was not necessary to continue it, as no fæces were passed *per anum* for three days.

When the powers of life have been so reduced by the deficiency of the respiration that the mucous membrane of the intestinal canal rejects the food undigested, you mix pepsine with it; and you may appropriately administer tincture of bark and port wine. Both were ordered on this girl's card; but little of them were given, as, by forty-eight hours after the operation, her pulse had got full and natural. Remember always, as I told you with regard to low fever, wine is an adjunct or help to restorative treatment; but if made to take its place, is hurtful.

When the patient begins to take food again by the mouth, you will not rarely find that solids of certain kinds are easier swallowed than complete liquids. This happens in all kinds of dysphagia; in fact, the embracing of a gulp of fluid by the semi-voluntary pharyngeal muscles is a greater effort, and more apt to cause spasm, than is the case with a more resisting mass. You can try this any day in your own throats. But you must select as the solid you administer some one which slips down easily, such as the oysters which have been ordered for this girl.

I feel you expect me to say something about two drugs which have been strongly recommended in acute laryngitis—antimony and mercury. I must confess I have never been able to trace any advantage from their use, either in cases which have recovered, or which have died. I no longer use them, and do not recommend them to you. The action of these metals is to increase destructive metamorphosis, and to lower the force of the heart. By such means they certainly do appear to me to have a controlling power over inflammation. But it is a power exercised slowly, and at the expense of depressing the general vitality rapidly; so that they are peculiarly unsuitable for cases where an effect is desired to be quickly produced; for, if enough of them is given to stop inflammatory action in the short time allowed, a serious lowering of the functions ensues, extremely dangerous to patients who have already sustained the shock of being half stifled. And this depression is the more decided from the limited extent of the inflamed spot, and the limited inflammatory reaction on the system; for the poisonous actions of antimony and mercury are the stronger in inverse proportion to the amount of tissue inflamed. Give them to a healthy man—to a man with a cold in his head, or an inflamed corn—and they pull him down most wonderfully; but give them to a patient with double pneumonia or peritonitis, and he hardly feels their effects. In laryngitis, therefore, *more* than in most inflammations, these drugs are likely to have a deleterious action, and *less* than in most inflammations a beneficial action.

What I would have you keep in mind, in your treatment of laryngitis, is as follows :

1. If the external and obvious conditions of the patient be such that some part of the symptoms may be due to those conditions, remove them. Warm the surface of the body; saturate with hot steam the air inspired; put on leeches, and hot fomentation to the throat. In special favourable cases, bleed.

2. If benefit do not quickly follow, perform tracheotomy, or get it performed.

3. If a relapse occur after temporary benefit, every minute that the operation is delayed is a minute lost.

4. Food must be sedulously administered, if not by mouth, by rectum. This is especially necessary if leeches are applied, more especially if you decide to bleed, and still more specially than ever if mercury or antimony have been thrown in.

5. Let the restored air of respiration be moist and warm; and take care that there is enough of it, by inserting a full sized double cannula in the operation, and sedulously watching the orifice day and night, lest it be blocked up by mucus.

As a contrast to a disease in the larynx inducing

such serious danger by its locality, but rapidly recovered from by reason of the slight morbid alteration which has taken place, I show you here a larynx taken this week from the body of a man who died of pulmonary consumption. See how extensively it is disorganised. The mucous membrane covering all the upper part is white, thick, and ragged; just below the vocal cords on the right side, there is a ragged deep ulcer, which has bared the arytenoid cartilages, and caused them to become necrosed by killing the perichondrium; a piece of the necrosed cartilages projects into the bottom of the cavity. There is another superficial ulcer in a corresponding place on the opposite side. Yet here the symptoms referrible to the larynx were of the most minor importance. The man's voice was indeed hoarse and weak, but not more so than you find in most sufferers dying with a very large vomica in one lung and the other filled with crude tubercles, which we found in this autopsy. There was a considerable secretion of pus also, and pain in the larynx when pressed; but no difficulty of breathing, in whatever position the patient lay. Consequently, no local applications were made to the organ. There was no demand for local medication, and certainly it would have been useless to the prolongation of life. The deficiency calling for restorative treatment was the important one of chronically deficient nutriment to the whole system. The larynx was ulcerated and degenerated, for the same reason that the kidneys were shrunken and granular, and that the whole person was emaciated to a skeleton: sufficient aliment was not absorbed to compensate waste. A despairing effort was made to supply this by endeavouring to restore digestive and absorbent powers to the alimentary canal by means of quinine and iron, and to supply muscle and fat with meat and cod-oil. But in vain. Sentence of death had long before gone forth; and it was difficult to see that it was in any degree delayed by treatment, however appropriate. My object in quoting this case now is not by it to commend the remedial agents employed, but to draw your attention to the rule, that the *immediate* danger of diseases is mainly traceable to their locality; the *final* danger, to the extent and degree of the pathological changes.

I would therefore lay it down as a rule that, in cases where the danger is immediate, the attention of the medical attendant should be directed to locally active remedies; where it is more remote, it should be directed to those of general agency. Thus in acute laryngitis you are to think of the larynx alone, to the temporary neglect of other parts; in chronic laryngitis, of the general nutrition, in preference to the local injury.

GRINDING. The tutor 'crams' his pupil, not with knowledge, but with promising bits of information adroitly selected, and teaches him how to reproduce them by the most rapid process and in the most specious shape. He carefully studies the papers that are set, divines, if he can, the theories or tastes of the Examiners, makes 'shots' at the subjects most likely to 'pay,' and discovers or constructs short cuts to the knowledge required. The proficiency obtained under such a system is not likely to be genuine, but whether it be real or simulated signifies little, so long as the object is gained. If the pupil appears in the list of the successful candidates, he is satisfied, and his tutor too.

Lectures

ON THE

DIAGNOSIS AND TREATMENT OF DISEASES OF WOMEN.

DELIVERED AT ST. MARY'S HOSPITAL MEDICAL SCHOOL.

BY

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DISORDERS OF MICTURITION. (*Continued.*)

GENTLEMEN,—We have now considered the cases in which micturition is difficult, and those in which it is painful. The next class of cases are those in which

c. Micturition is frequent. There is, perhaps, no one diseased condition of the vagina, uterus, bladder, or adjacent organs, which may not, at one time or other, give rise to frequency of micturition, to say nothing of the varying conditions of the urine which may occasion the same phenomenon. Frequency of micturition can hardly, then, be considered as characteristic of the presence of any one diseased or altered condition.

Frequent micturition is often an early sign of pregnancy. During the first two months of gestation in primiparæ it is very generally present. Towards the latter end of pregnancy also, it is pretty frequently observed. In hysteria, frequent micturition is often present during the attacks.

Displacements of the uterus may occasion frequent micturition; but more often difficulty and pain during micturition are produced thereby. In retroflexion of the uterus the micturition was most frequent during the night in two cases observed by Ashwell. In prolapsus uteri, there is frequency of micturition, especially during its early stages; it is diminished by the horizontal posture. *Ovarian* or other pelvic *tumours* occasion frequent micturition, owing to pressure on the bladder before remarked. Urinary difficulties are more frequently present during the early than the later stages of these tumours; when larger, they rise out of the pelvis, and the patient suffers less. One of the most important causes of frequent micturition is retroflexion of the *gravid uterus*, a condition in which urinary difficulties are rarely absent. There may be difficulty alone; but more generally difficulty and frequency of micturition are noticed; the latter may alone be observed. *Organic affections* of the uterus, as cancer, fibroid tumour, polypus uteri, or simple hypertrophy, or an inflammatory or hyperæsthetic condition of the organ, may, each of them, give rise to frequent micturition. Cancer would be recognised, after its very earliest stage, by the other symptoms present; fibroid tumour and hypertrophy might be unaccompanied by other symptoms; in polypus, menorrhagia is not often absent. Tenderness and pain are the characteristic symptoms of the inflamed or irritable uterus. Pressure on the bladder, and consequent frequent micturition, may be produced by abscess in the cellular tissue between the bladder and vagina, or by effusion of blood into the peritoneal cavity around the uterus in peri-uterine hæmatocele.