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A CASE OF LARYNGEAL GROWTHS; TRACHEOTOMY; THYROTOMY AND REMOVAL OF GROWTHS; RECOVERY.

The operations which are performed for intra-laryngeal growths are (*a*) intra-laryngeal removal by means of forceps from the mouth, aided by the laryngoscopic mirror, or (*b*) extra-laryngeal. (1) After thyrotomy, as in the case which Dr. Whittle records below; (2) supra-thyroid laryngotomy, by means of incision through the thyro-hyoid membrane; or (3) the infra thyroid laryngotomy, removal through the tracheotomy wound. These methods were carried out in the years 1833, 1853 and 1863 respectively. The first is specially adapted for the removal of the benign growths met with in children, where it is often impossible to employ the laryngoscopic mirror and forceps with success; also where the growths are multiple. It is recommended that tracheotomy be performed for a fortnight at least before the operation, in order that the patient may become used to the tube, and that no operation be performed until the patient is suffering from dyspnœa or dysphagia. The results of the operation, when successful, show 14·58 per cent. of recoveries followed with perfect voice and respiration; Bruns gave the following as the result of his investigations. In eighteen the voice again became normal or nearly so; in twenty instances it was completely lost in six, and reduced to nearly complete aphonia or extreme hoarseness in the others. But in a very large percentage the operation is followed by obstruction to the respiration, necessitating the use of a cannula. This in many instances appears to depend upon cicatricial contraction and narrowing of the larynx, which hardly any mechanical treatment is able to overcome, few patients possessing sufficient perseverance to attend long enough for its full trial. Oertel and Paul Bruns make three varieties of papillomata, and give the prognosis according to each. In a large majority there will be recurrences, especially in children, and operation at a later date will be again required. Published statistics are very misleading, few failures finding their way into the medical journals. Stoerk says that the best method is that which does not subject the diseased larynx to any great irritation; irritating applications are apt to encourage recurrences. Some of these are due to imperfect removal of the growths. From the description of the growth in this case, it probably belongs to the second of the three varieties mentioned by the authorities quoted, one of the characters of which is its slow recurrence, a variety of the growth usually met with in adults.

A female child, aged three years, was sent to the hospital by Mr. Graham, of Storrington, with the history of laryngeal obstruction, which had existed from early infancy, and had gradually increased; the dyspnœa had, indeed, occasionally been critical. Attempts were made with and without chloroform to view the larynx, but they were unsuccessful. Tracheotomy was performed by Dr. Whittle on Aug. 5th, 1886; thyrotomy was deferred in compliance with the parents' wishes. The child improved in health, but could not dispense with the tube.

On May 17th, 1887, the larynx was opened. An incision was made from the lower border of the hyoid to the upper border of the cricoid cartilage. The incision was deepened till the thyroid notch above and the crico-thyroid membrane below were exposed. The point of a scalpel was introduced through the membrane and the lower half of the thyroid divided. This not exposing the cavity of the larynx, the section of the thyroid was completed by a probe-pointed bistoury.