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INTUBATION OF THE LARYNX IN DIPHTHERITIC LARYNGITIS.

BY DR. L. L. PALMER, SURGEON, EYE, EAR, THROAT, AND NOSE.

YOUR late invitation, Mr. President, to give a paper to-night on some surgical subject and the short time at my disposal, led me to choose Intubation of the Larynx as easy for myself, and, I trust, of interest to this association. Easy, because I shall give only the result of my own experience and the detail of such cases as present symptoms of importance; and interesting, inasmuch as it opens up the much-vexed question of surgical interference in stenosis of the larynx in membranous croup—a question that has had, and still continues to have arrayed on either side, those who oppose and those who ardently support surgical interference.

I may say that my experience in *tracheotomy* and my additional experience in *intubation* confirm the soundness of judgment in advocating surgical interference—either tracheotomy or intubation—in wisely chosen cases of croup, where all other means have failed and a fatal result is anticipated unless relieved.

To be brief and confine my remarks to clinical experience, I will avoid all bibliography of the subject, even what *Hippocrates*, *Galen*, *Paracelsus* and O'Dwyre have said about intubation. Nor will I dwell on the technique of the operation, which is by no means unimportant, as all this is matter to be found in literature.

I will premise by saying that every case that I report to-night is one of true diphtheria, manifested first in the pharynx and extending to the larynx.

My first four cases, aged five, two, five and eleven years, terminated fatally in from two to five days after the tube was inserted, and all of them died from extension of the disease into the bronchi. This was diagnosed by auscultation and verified in three of the four cases by a post mortem.

In *every case* the tube gave relief to the dyspnœa and death was easy.

My fifth case recovered. A little girl, aged five years, had been ill with sore throat for three days, with small diphtheritic patches on the tonsils. Dyspnœa had continued for twenty-fours, gradually increasing. When I was called I found her struggling for breath; cyanosed; marked recession of chest walls; respiratory murmur inappreciable. As this condition was not a spasm, but the culmination of a gradually increasing dyspnœa, there was every indication of an early and fatal issue if not relieved. This was the opinion of Drs. Lowe and Archibald; it was my opinion. I introduced the tube suitable for her size with immediate relief. Auscultation now reveals a full, free, soft respiratory murmur, interrupted, however, with coarse rales which soon disappeared. This tube was retained five days, when I removed it, after which it was not required. She made a slow but steady recovery.