

in the rima glottidis, as shown in Figure 5. When the cords were approximated, the neoplasm turned upwards on the superior surface of the left cord. Several vascular points were visible over the surface of the growth even after the appliance of cocaine. At subsequent visits on October 31st, November 5th and 7th, the patient's chief anxiety was to be relieved of the severe pain which she said was increasing rapidly. A 20 per cent. solution of cocaine was applied to the larynx on November 7th, and the growth removed by Mackenzie's antero-posterior laryngeal forceps. The next morning the voice was almost normal in character, and the pains and scratchy sensations in the throat had disappeared. When the patient last visited the hospital, November 30th, it was difficult to tell which vocal cord had been the seat of the growth.

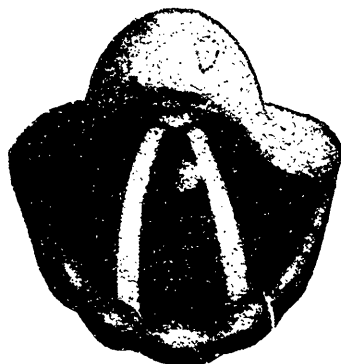


FIG. 5.

Fibroma of the Vocal Cord.

The remarkable tolerance which may be established in the larynx and the oro-pharynx when the encroachment is slow and unaccompanied by pain, is well illustrated in a résumé of some of these cases. Of course much depends on the size, shape and situation of a neoplasm. If the initial development implicates the cords, ventricular bands, or either commissure on a plane with the cords, the voice is at once impaired from their fixation or prevention of coaptation. If the anterior commissure is implicated, the smallest growth may give early evidence of its presence; on the other hand, the upper part of the inter-arytenoid space and the arytenoid cartilages will tolerate neoplasms of considerable size. One of the patients recently at the clinic had several large condylomata in the superior part of the inter-arytenoid space, without producing any change in the vocal sound or respiration. Extrinsic parts of the larynx are more tolerant, especially if the growth begins in the upper part of the epiglottis. The tolerance to these