ŒSOPHAGUS.

Emanuel, J. G.—*Cancer of the Œsophagus without Obstruction.* "Lancet," October 18, 1902.

In this paper are described six cases of cancer of the œsophagus without obstruction which occurred at the City of London Hospital for Diseases of the Chest, in the years 1897 to 1899 inclusive. In all these cases the common symptom of cancer of the œsophagus, dysphagia, was either altogether absent or else it was obscured by other more prominent symptoms. In three of the cases the symptoms for the relief of which the patient sought admission to the hospital were laryngeal (hoarseness or aphonia), and in two of these pulmonary symptoms (cough and expectoration) were present as well. In a fourth case the patient was admitted on account of shortness of breath, cough, and expectoration, and the pleural cavity had to be aspirated immediately after admission. Hæmoptysis accounted for the admission of another case, and in only one was there vomiting which was apparently due to a simple gastritis and which was certainly not accompanied by any difficulty in swallowing. Even in those cases in which the history brought out some trouble in deglutition the difficulty was not one associated with trying to get food through a stenosed œsophagus, but was caused by the œsophageal growth perforating either the trachea, the left bronchus, or the lung itself, and bringing on a reflex spasm of coughing immediately after taking food. This paroxysm was sometimes so violent that the food was returned through the nose as well as through the mouth. It is very important to recognise this form of dysphagia, this reflex paroxysm of cough immediately after swallowing. It differs from the ordinary form of dysphagia, by which, in cancer of the œsophagus at all events is meant difficulty of getting food through a narrowed tube, and by this symptom some stricture of the œsophagus is indicated. But "cough immediately after swallowing" signifies a communication between the œsophagus and the air-passages; and the importance of recognising this symptom is obvious, for although the patient may succeed in getting part of the food, enough to maintain life, past the growth into the stomach, some will find its way into the air-passages and sooner or later set up an inhalation broncho-pneumonia. And patients in whom this symptom is present should be advised against taking food through the mouth, and should be fed by nutrient enemata, an œsophageal tube, or by means of a gastrostomy.

Of the following series, in Cases 3 and 6 the growth was in the upper part of the œsophagus, and had caused perforation of the trachea; in Cases 2, 4, and 5 the growth was opposite to the bifurcation of the trachea, and had perforated the left bronchus; while in Case 1 the growth was at the lower end of the œsophagus, and had perforated the lung itself. It follows from this that in all the cases, excepting Case 1, the malignant disease was situated mainly in the anterior wall of the œsophagus. In three (Cases 3, 5, and 6) death was caused finally by inhalation of food into the air-passages, which set up a septic broncho-pneumonia in two of the cases, and a septic bronchitis in the third. In Case 1 death occurred from a pneumothorax, in Case 2 from a pyoneumothorax, and in Case 4 from hæmorrhage into the left bronchus.

The series illustrates well the frequency with which laryngeal

paralysis forms an early symptom of œsophageal growth. In three cases the evidence of laryngeal palsy was found during life, in one case it was evident at the autopsy; and in the remaining two the involvement of the recurrent laryngeal nerves was "probable."

Five of the cases were in men between the ages of fifty-one and fifty-five years, and one only in a woman aged thirty-three years.

The full notes of these six cases are well worthy of study, and an excellent summary of them is given in a table.

StClair Thomson.

THYROID AND TRACHEA.

Gaudier and Chevalier.—*Two Cases of Thyroid Tumour at the Base of the Tongue.* "L'Écho Méd. du Nord," August 24, 1902.

The first case was a woman, aged twenty-one, who complained of a slight difficulty in swallowing and in speaking. Her voice was nasal and more or less rough. She attributed all her troubles to a tumour at the back of the tongue. Two years earlier the tumour had been operated on in Paris with punch-forceps and galvano-cautery; the symptoms were relieved for about a year and a half, but then returned. On examination with a laryngeal mirror a round tumour, about the size of a walnut, was found behind the papillæ circumvallatæ. It was in the middle line, and pushed the epiglottis back a little. The mucous membrane covering it was apparently normal, was not fixed down to the tumour, and contained a fine superficial network of veins. The tumour was fixed in its deeper parts to the muscles of the tongue, did not fluctuate, but was almost soft on palpation. Otherwise the mouth was normal; tonsils not enlarged; no enlarged glands. From the neck no very definite information as to the tumour could be gained; the mass could be indistinctly made out in the suprahyoid region. General health was good; no goitre; blood and urine normal.

The diagnosis of the nature of the tumour was far from easy. It was evidently not a malignant growth. It was not fluctuant, and in appearance, etc., differed from a cyst. It was not in the usual position of a lipoma of the tongue. Fibroma of the tongue, whether pure or mixed with fat, cartilage, etc., is a very rare tumour, and has only been recorded in males. Hypertrophy of the lingual tonsil, angioma, and gumma could all be definitely excluded. The diagnosis made was "lipoma," or "lipo-sarcoma."

Operation.—Chloroform was administered, the patient being in Rose's position, the mouth widely opened by a Doyen's gag, and the tongue drawn well forward. The whole operation was carried out through the mouth. The first step was to pass a strong silk thread round beneath the tumour, in the muscular tissue of the tongue, which could be used to draw forward the base of the tongue, and also to stop hæmorrhage as soon as the tumour was removed. Next an incision was made along the top of the tumour in its long axis. No definite line of demarcation between tumour and tongue tissue could be found, therefore a free oval incision was made in what appeared to be healthy tissue all round the tumour, and the tumour removed. The silk thread was at once tied, and so the wound closed and hæmorrhage stopped. Two or three superficial stitches completely closed the wound. Recovery uneventful.