Medical Matters.

THYROTOMY IN POST-DIPHTHERITIC STENOSIS.

Dr. H. F. Parker, late House Physician to the Wolverhampton and Staffordshire General Hospital, reports an interesting case in the *St. Bartholomew's Hospital Journal*, illustrating some of the difficulties that are liable to be encountered in the after-treatment of a case of diphtheria where tracheotomy or intubation has been performed. A girl of eleven was admitted last August to the above hospital suffering from a severe attack of diphtheria, with no evidence of laryngeal obstruction. She was injected with the anti-diphtheritic serum of the Jenner Institute, receiving 38,000 units between August 4th and August 12th. As her condition, in spite of the treatment, became worse, as a last resort tracheotomy was performed on August 14th to relieve the exhaustion caused by obstruction to respiration owing to the swelling of the fauces. Two days later the tube was removed for four hours, and on August 19th was left out entirely.

The patient then rapidly improved in general health, but two weeks later began to have great dyspnœa with recession of the chest walls during sleep, and this became so serious that, after an ineffectual attempt to intubate had been made, it was found necessary on September 4th to re-open the tracheotomy wound and insert a tube. Twelve days later intubation was again tried unsuccessfully, and, as the failure was apparently due to some stenosis of the larynx, the stricture was dilated under an anæsthetic and a vulcanite intubation tube inserted. A fortnight later, the patient having first been anæsthetised, the tube was removed, but, upon her recovering consciousness, spasm of the glottis ensued and a tracheotomy tube was again introduced. The dilatation of the stricture having been repeated on more than one occasion with similar result, the larynx was opened by prolonging the old tracheotomy incision, when it was found that there was considerable stenosis opposite the cricoid cartilage, with much swelling of the mucous membrane close to the vocal cords, and some cicatrisation at the upper aperture of the larynx. The obstructing tissue and a considerable portion of the vocal cords were cut away and a long rubber tube, which fitted the trachea tightly, was inserted and brought out through the mouth. Some recurrence of dyspnœa necessitated a return to the tracheotomy tube, but ultimately, after a stay of five months in the hospital, the patient was discharged cured. The wound was then healed, respiration was perfect, and phonation remarkably good, consisting of a loud and somewhat raucous whisper.

The case, says Dr. Parker, presents many features of interest. In the first place the child received no anti-toxin until seen at the end of a week from the commencement of the illness, and, though it cannot be said that visible improvement was caused by its administration, it is possible this may have turned the scale in favour of her recovery. Secondly, the stenosis did not occur until a fortnight after the tracheotomy tube had been left out, and, further, the stenosis was not a consequence of the division of the cricoid at the time that tracheotomy was performed.

Thirdly, intubation alone failed to effect a cure. Though ultimately success by this method might have been attained, it was considered best to proceed at once with the more radical operation. Lastly, the idea of passing a rubber tube from the mouth to the lower part of the trachea is a new one, and was found a distinct advantage, enabling the parts to regain their natural relations to some extent.

GRIPPAL PNEUMONIA.

Dr. Watkins, in the *Journal of the American Medical Association*, briefly describes the types of pneumonia complicating la grippe, and summarises that the typical grippal pneumonia differs from the ordinary form: (1) By the slow insidious invasion. (2) By the predominance of bronchitis. (3) The rather low, often remittent, temperature. (4) The tendency to heart failure and cyanosis. (5) The frequent absence of rusty sputum. (6) Absence of critical defervescence and strong tendency to delayed resolution. (7) A tendency to wander from one lobe to another and thus involve the apex. (8) Decided fatality and infectiousness to a curiously limited degree. He advises for these cases heart tonics, the early use of stimulants, alcohol, carbonate of ammonia instead of the usual cough mixture expectorants; codein and heroin in elixir; terpin hydrate for cough; caution in the use of morphin, and no antipyretics of a depressing character.

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