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LARYNGEAL PARALYSES IN GOITRE.

THE abstract of a paper on this subject by Dr. Eugène Félix, of Bucharest, on another page of this journal [1] will be found to afford most interesting reading, particularly with regard to the occurrence of paralysis of the recurrent laryngeal nerve after operation. Unfortunately in a good many of the cases collected by Dr. Félix this point was not laryngoscopically investigated beforehand. In the reports of 3000 cases of operation laryngeal paralysis was noted in nearly 200, or between 6 and 7 per cent. It is interesting and disquieting to learn that the paralysis may make its appearance some months after the operation. On the other hand, a paralysis occurring at the time of the operation may be due simply to traumatic disturbance from manipulation, or to chemical irritation by antiseptics such as carbolic acid, and may pass off with comparative rapidity. Again, laryngeal paralysis due to the pressure of a goitre is frequently, but by no means invariably, cured by the operation.

Mr. James Berry, in his recent communication to the Surgical Section of the Royal Society of Medicine, reported 274 further cases, and referred particularly to the question of concomitant recurrent laryngeal paralysis.

A number of these presented dysphonia or aphonia as pre-

[1] Page 126.

operative conditions, but in only one was there definite recurrent paralysis. Operation made no difference in this case. In two cases the recurrent laryngeal was injured by the operative measures. In one of these a portion of the nerve involved in a "hard papilliferous tumour believed to be malignant" was intentionally removed, but recovery of the voice, to an "almost normal" condition, was found to have taken place when the case was examined several months later. In the second case mild suppuration, following the enucleation of a cystic adenoma, was followed by paralysis of one cord.

In the series operated on by this writer it will be observed that the percentage of cases in which the recurrent nerve was injured during operation was very low. The larynx was examined with the mirror, both before and after operation, in all cases.

CONTRIBUTION TO THE PATHOLOGY AND THERAPY OF SUBMUCOUS INFLAMMATION OF THE LARYNX (LARYNGITIS SUBMUCOSA ACUTA).

By Dr. John Sendziak,
Warsaw, Poland.

A paper read in the Oto-laryngological Section of the Tenth Congress of Polish Physicians and Naturalists, held at Lemberg, July 23, 1907.

Gentlemen,—The first mention of œdema of the larynx we find in Hippocrates, to whom also was known erysipelatous inflammation of the upper air-passages. But we owe the first exact paper—clinical and anatomical—on the subject of œdema of the larynx of inflammatory origin to the contemporaneous physicians of the eighteenth century, Boerhave, Van Swieten and Bichat. Darluc has also described œdema of the larynx of infectious (erysipelatous) origin.

Bayle, in the beginning of the nineteenth century, however, was the real scientific creator of this œdema of the larynx. This author included in the term "œdema glottidis" laryngeal œdema of inflammatory origin as well as phlegmon of the larynx. In the year 1825 Bouilland employed the term "laryngitis phlegmonosa," and Cruveilhier in the year 1832 "laryngitis submucosa." This convenient term is at present mostly employed. In the year 1852 Sestier enlarged Bayle's theory of œdemas of the larynx, having