

# Laryngeal Phthisis.

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2) Stop the cough. By that I do not mean cough of pulmonary origin, but cough which results as a reflex action from the nose and throat. Take for example atrophic rhinitis. Most of the patients suffering from this affliction have wide nasal passages, and yet they feel that they cannot get any air through them. The reason for this is that the mucous membrane of the nose is dried out, or covered with scabs and crusts. The air spaces are large enough but the air itself cannot be "assimilated." I might compare this condition to that of a patient suffering from cholera. He is craving for water, but no sooner drinks it than it leaves the system again without being absorbed. So it is with the inhaled air in atrophic rhinitis. Observations in the University Clinic at Kiel fully corroborated the results of my own experiments on this subject. In many patients the characteristic hacking cough, described in all text-books as a premonitory or incipient stage of tuberculosis, has its source in the pharynx, being caused by the dry secretion of atrophic rhinitis getting down into this region from the nose; or you may simply find post-nasal catarrh. If one treats this nasopharyngeal catarrh according to the customary methods, one will be sure to eliminate the cough originating in the above manner. In this way we have accomplished a great deal already, for here is a chance of arresting the disease in the beginning. *Principiis obsta* is an old rule which should be followed. On the other hand, one will benefit the patient by restoring the nasal mucosa to a normal condition, so that the inhaled air can be warmed and moistened and thus rendered fit for breathing purposes.

But it is in the pharynx that the most frequent source of a cough is found, and one that can be easily removed in the majority of cases by regular topical application. We find here post-nasal catarrh, with its sticky, tenacious secretion, often originating in the accessory sinuses, and also granulations and diseased tonsils. In catarrhal cases mild applications several times a time week will positively remove the cough. These are the

typical cases, where you find that characteristic hacking cough, and with but a few slight rales over the lungs. Nobody could ever convince me that these few rales have any connection with the cough. Morphine will do great harm at this stage, but rational treatment of the pharynx will eliminate the great danger of a permanent cough.

Another prominent source of the cough is in the larynx. In that organ the aberrations from the normal are so numerous that they cannot all be enumerated here. We see a general hyperæmia, injection, injection of certain portions of the larynx, massive infiltrations of the cords, interarytenoid outgrowths, œdematous perichondritis of the arytenoids or the epiglottis, ulcerations on any part of the larynx, etc. The last-mentioned will be discussed in the next paragraph. All the others, from a simple laryngitis to the most complicated forms of laryngeal tuberculosis, can at least be relieved by regular, painstaking and untiring efforts on the part of the attending laryngologist and his assistants. The latter are mentioned because in a hospital or sanatorium much can be done by simple applications that any young man on the staff can easily master. The visiting physician, as a rule, has no time for such daily or thrice-weekly work. Formerly the infiltrations of the vocal cords and ventricular bands were removed by operative means (Krause's and Heryng's double curette, etc.). In those days I operated frequently, sometimes with a good result, but more often without any benefit or even a detrimental effect. (Subsequent or immediate pulmonary hæmorrhage, flaring up of quiescent areas, etc.). Nowadays I remove such infiltrations only when they are large enough to cause a stenosis, or a cough that cannot be got rid of by any other means. I prefer to do such operations under suspension laryngoscopy, provided there are no cavities in the lungs, or any other condition that might bring on a hæmorrhage. Simple infiltrations that cause no irritation are best left alone. The hoarseness caused by them improves spontaneously when the patient gets better. If it should persist, nevertheless, there is plenty of time to operate afterwards.

(3) Remove the dysphagia. Unless a stenosis is present or imminent, it is comparatively easy to treat an early case of laryngeal phthisis, but the

sufferings of the patient and our own troubles commence as soon as the tissues break down and ulceration sets in. Then in many instances dysphagia develops and no end of other difficulties. These pitiable people to whom even the swallowing of their saliva, or the mere thought of the ingestion of food causes a shudder, suffer really the tortures of Tantalus, since, in spite of a good appetite and a bounteous table, they are unable to eat, and prefer rather to experience hunger and thirst.

It is a source of satisfaction that just here the greatest advance has been made, but there are still many questions to be settled. First of all there is need of greater progress in the treatment of the pulmonary affection. That part of our therapy has not advanced satisfactorily. Many a case has been observed by me in which the larynx improved steadily under proper treatment, while at the same time the lungs steadily became worse. But let us return to the ulcerative processes in the larynx, and ask how are they best treated? As far back as January, 1899, in a paper read before the New York Academy of Medicine, I advocated orthoform as the main drug to be used because it is analgesic and non-poisonous. It is not an anæsthetic like cocaine, which is an advantage, but it

produces analgesia, *i.e.*, freedom from pain lasting from an hour or so to three or four days and more. It has no toxic effect and may be used even several times a day. (I speak only of its application to the denuded mucous membrane and do not recommend its use on the skin.)

In the above-mentioned paper (1899) I said that whoever does not try orthoform in these cases, after everything else has failed, does an injustice to his patients. Now, after so many years I can only add: Whoever has tried orthoform in some desperate cases and has witnessed the gratitude of the patients after they were enabled to take some nourishment, will never give it up again. Of course, orthoform has only a local effect, and does not cure any pulmonary complication or general toxæmia. I have used an emulsion, to which lately was added the ethyl esters of chaulmoogra oil (chaulmestrol). My formula for this emulsion now is:—Orthoform, 6.00; menthol, 1.0 to 6.0; formaldehyde, 5.0; aquae ad., 60.0; m.f. emulsio. This emulsion is injected by means of an ordinary laryngeal syringe so that it forms a coating over the ulcerated area, which previously has been cleansed. It is not the quantity of the emulsion used that counts, but the amount that adheres to the surface and is absorbed.