Spasm at the Entrance to the Œsophagus.

By A. Brown Kelly, M.D.

A variety of dysphagia is not infrequently met with in middle-aged women which may have been present for years, is referred to the level of the larynx, and is so pronounced that even a small fragment of food becomes impacted and causes complete occlusion. As a rule, this affection is diagnosed as spasm of the upper end of the gullet and, without endoscopic examination, is treated and benefited by the passage of a bougie; the subjects are considered to be neurotic.

It is doubtful whether our conception of this disease is correct. In view of the steady persistence of the dysphagia for years, the immediate and striking benefit following the use of a bougie, and the fact that a membranous diaphragm has been met with at the entrance to the œsophagus in a few cases, are we justified without an inspection of the parts in excluding the possible presence of an organic stricture—e.g., resulting from the union of adjacent surfaces? Further, are the patients neurotic or have they become nervous solely in connexion with deglutition? Hysterical dysphagia differs from the affection under consideration and is not taken into account.

In order to determine the local condition at fault an examination was made under chloroform of the entrance to the œsophagus in a number of patients suffering from the above-mentioned symptoms in pronounced form. The obstruction was found, in accordance with the generally accepted view, to be caused by strong spasmodic closure at the entrance to the gullet. The majority of the patients, on the other hand, were not at all neurotic.

The causes of the affection will be discussed.

A Clinical Type of Dysphagia.

By D. R. Paterson, M.D.

Dysphagia in women frequently associated with a condition of the mouth cavity due to atrophic changes in the mucosa and aggravating the difficulty in swallowing. Changes also seen in the lower pharynx and of importance in direct examination. Condition accompanied by marked anæmia and loss of flesh.

DISCUSSION.

Dr. F. DE HAVILLAND HALL: There is a cause of spasm of the œsophagus which I have not seen mentioned, but which I noted some twenty years ago in the case of two doctors who consulted me. They were both habituated to morphia to a great extent, and on giving up the drug they were quite unable to swallow solid food. In both cases a large-sized bougie passed quite easily into the stomach, but with no alleviation. One of the patients passed out of my knowledge without my being able to learn anything of his subsequent history, but the other gradually improved and was able to take a fair amount of food. He lived on milk for over a year, the milk being gradually thickened. Unfortunately, he returned to his morphia, and on relinquishing it he again found inability to swallow. Eventually he made a perfect recovery, but as I have been unable to find his name in the *Medical Directory* for the past two years, I assume he is now dead. The cessation of the habit by the withdrawal of the accustomed stimulant much reduced the nervous system, and rendered the men liable to spasm.

Sir W. MILLIGAN: The moral of these two interesting communications is that in all cases of middle-aged people who suffer from dysphagia a direct examination of the œsophagus should be made. The number of women who suffer from dysphagia, when the disease is just at the commencement of the œsophagus, is remarkable, and I think that my statistics correspond to those of Dr. Kelly: 70 to 75 per cent. of the women suffering from disease of the food passage have it in that particular situation. The blind bougie method should be put aside; the examination should be direct. It has always seemed to me that possibly trauma is a very considerable ætiological factor. From the number of times in which it is possible to get some little erosion of the œsophagus owing to swallowing something very hard, such as a spicule of bone, it is not to be wondered at that these disturbances are not uncommon. I look upon it in much the same way as I do fissure of the rectum or anus. Trauma is an ætiological factor which we should not dismiss too lightly. Then again, how many of those cases of spasmodic dysphagia, if followed out over years, have been found to develop malignancy? I can only recall one case in which malignancy developed. One loses sight of these cases, of course, but I do remember one case, a woman, aged about 45, who had this particular type of spasmodic dysphagia, and the only thing to be seen was just an annular tumefaction at the commencement of the œsophagus. It was not infiltrated, nor even hard, but that woman, two years afterwards, did develop a definite malignant growth in the lower end of the hypopharynx. For that reason only one ought to make a direct examination. The dysphagia may be a passing phase or it may be the commencement of organic disease, and it is well to know what it is at the earliest possible moment.

Dr. W. HILL: Though the titles of these two thoughtful papers are far from identical, yet the authors traverse very much the same anatomical area. They both include obstruction at or near the upper end of the gullet.

Dr. Kelly definitely calls his paper "Spasm at the Entrance to the Œsophagus," but it was evident to everyone that he was dealing very little with spasm of the œsophagus itself, but almost wholly with obstruction of an indefinite pathology at the lower end of the pharynx. Dr. Paterson was fairly definite in localizing the obstruction producing dysphagia to the neighbourhood of the inferior constrictor. I have an idea, often expressed here, that members of this Section, especially those who are not very conversant with œsophageal disease, are obsessed with the idea of primary spasm as an explanation of dysphagia in certain cases. On the other hand, I have the reputation of being "spasm-blind." I am extremely familiar with the spasm in the lower pharynx especially, and also in the gullet, as a secondary symptom, but primary spasm I have looked for in vain, except on one occasion. I am not unacquainted with the question of dysphagia behind the cricoid, say in the lower pharynx, but I do not know that I have ever seen a case in which I was able to satisfy myself that it was purely a primary spasm. I am very familiar with the class of cases which to Dr. Paterson has alluded—e.g., the case of a woman with stomatitis—and Dr. Kelly has alluded to something very similar. In my own cases, parallel to those alluded to by the readers of the papers, the first thing I do with a woman who cannot swallow, and in which there appears to be obstruction in this area, is to ask her to swallow before me, giving her a biscuit or something of the kind. Instead of showing the typical phenomena of spasm, she almost invariably makes no effort to swallow. The last act of pharyngeal swallowing and the first act of œsophageal swallowing consists in pulling the larynx upwards and forwards by the muscles connecting it with the terminal hyoid bone and tongue. Any man in this room can, if he likes, determine whether the patient does move the larynx forward. If there is any spasm the effort will be evident, the muscles will be seen to contract, and if the larynx does not come forward then it is due either to spasmodic or organic stricture. In the class of cases discussed here in which there is no stricture to speak of, I have no doubt that if members will only study this question they will see that this effort to pull the larynx forwards and upwards away from the vertebral column does not take place. We have inertia—i.e., paresis. We are all agreed that there are a certain number of cases which may be properly called functional or neurotic, but they show paresis rather than spasm. Bougieing is a very useful treatment in these cases whether we do not find stomatitis or whether we do. It stimulates; it is a method of massage. In a certain number of cases, however, we do get actual tumefaction, and evident narrowing. I think we should separate those cases which show definite narrowing owing to slight inflammatory and other organic causes from the smaller group of those which are unequivocally functional and of the nature of paretic rather than spasmodic neuroses.

Dr. DAN MCKENZIE: Dr. Hill has been accustomed to give us definite facts and opinions on this point, but now they have become rather less definite, until now I believe, in his heart of hearts, he thinks that spasmodic stricture does, after all, exist. I suggest that what he means by primary spasm is a

spasm induced by the higher nerve centres, while a secondary spasm is one that is induced by the local centres.—[Dr. Hill: No.]—To come to practical matters, in the cases I have reported there was no obvious local lesion, no tumefaction, and yet there was definite stricture visible on direct inspection. One saw that the calibre of the gullet was narrowed down to an opening 3 to 5 mm., having an appearance which could be easily overlooked. The two patients had both been suffering from the effects of this spasm for very many years. One of them had never been able to finish a meal in her life. She was ashamed to eat out of her own house, as some of the food stuck at every meal and had to be regurgitated. I saw this spasm with the œsophagoscope; it was also seen to occur by X-ray examination, yet the moment I passed the bougie it disappeared, and the patient has been all right ever since. If that was not a functional spasm I do not know what it was. I had two cases within a short time, under almost precisely the same conditions, and both showed the same good effect of treatment.

Mr. R. A. WORTHINGTON: The statement that all cases of dysphagia should have an endoscope passed is perhaps going rather too far, but every case of dysphagia in which it is thought necessary to pass a bougie should have an endoscope passed first. I would make an absolute rule against blind bougieing until an endoscope has been passed. I would not have any particular regard for the age of the patient. I remember a few years ago being consulted by a young lady aged 27, suffering from symptoms of dysphagia, and I regarded it as probably a functional condition, but I said that I would advise examination if under treatment she did not improve in two or three weeks. She did not improve, and as is often the way in those cases she went up to London, which was quite unnecessary! and there, I learned afterwards, she had been œsophagoscoped and that an epithelioma had been found. That in a young woman aged 27! So I thought after that that I would not be influenced by considerations of age. One of the symptoms which I have always regarded as of extreme value as making it practically certain that there is a real obstruction in the œsophagus, and that it is not a purely nervous dysphagia, is the presence of froth in the throat. Where there is any froth—that is, unswallowed saliva—I always advise an examination. Many of these cases are what I still venture to call spasmodic, and in spite of much instruction on the subject from my friend, Dr. Hill, I had one such case, not very long ago, of a woman who had had dysphagia for about five years, and she was of the kind who perhaps would be regarded as typical, a rather thin, nervous woman, aged 36 or so. The presence of froth made me diagnose a definite and more or less constant block. I œsophagoscoped her, and found that the œsophagus contained curds of milk. The estimation of dilatation of the œsophagus is often exceedingly difficult unless it is a very marked condition. I passed the bougie in this case through the endoscope, and at the cardia I had some resistance, which suddenly gave, and then the bougie—a full-sized one—passed easily. I could see nothing abnormal around the wall. That I regard as a case of spasm. If the whole of the œsophagus had been in the condition that

Dr. Hill describes as paresis, then I should not have had the feeling of resistance to the bougie at the lower end. The woman has completely recovered her powers of swallowing after that single examination.

Dr. PATERSON (in reply) : I suggest that we should examine a series of cases where the difficulty is a paretic one. The only one I have had an opportunity of examining was a case of myasthenia gravis, and there the tube went in easily.

An Operation for the Complete Removal of the Soft Palate (Staphylectomy).

By DAN MCKENZIE, M.D.

IT is claimed for the procedure about to be described that by a combination of the use of diathermy and the cold snare the entire soft palate can be removed with little or no loss of blood.

Indication : Malignant disease (epithelioma or sarcoma) of the soft palate, especially when it occurs on the posterior aspect where the new growth cannot easily be excised as an island of tissue.

Contra-indications: If the disease has spread so as to involve the bone of the palate the removal of the soft palate alone would be an incomplete operation.

By using diathermy in making the section it is possible to cut through the tissue of the growth without any risk of disseminating living cancer cells as the tissues in contact with the diathermy terminal are destroyed.

Operation : The anæsthetic may be given by the mouth as hæmorrhage is minimal.

Technique: (1) By means of a diathermy knife terminal a transverse incision is made ¼ in. behind the posterior edge of the bony palate and is carried right through the soft palate to its posterior surface. The incision extends from the level of the alveolar process on one side to the same level on the other side.

(2) Using the diathermy knife again two incisions are carried, one on either side of the base of the uvula, from the highest point of the arch of the velum palati to join the first incision, and the middle of the soft palate, including the uvula, thus isolated is removed.

(3) The lateral portions of the soft palate left are removed by means of Lermoyez' tonsil snare applied close to the lateral wall of the palate (the cold snare is here employed, being gradually tightened) in preference to diathermy, in order to minimize the risk of secondary