

COHEN (J. Solis)

Multiple papillomata  
in a child. x x x x x





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**MULTIPLE PAPILLOMATA IN A CHILD:**

*Tracheotomy at Four Years of Age; Retention of Canula  
Thirteen Years; Evulsion of Multiple Laryngeal and  
Pharyngeal Neoplasms; Closure of the Tracheal  
Fistule by a Cutaneous Flap; Recurrent or  
Repullulant Growth at the Anterior  
Commissure of the Glottis.*

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THIS instructive and long-time neglected case was sent to my clinic in April, 1892, by Dr. Harter, of Maytown, Pa.

The patient, a girl seventeen years of age, but less fully developed than many a child of fourteen or even less, was completely aphonic, and was wearing a child's tracheotomy-tube.

Her story was that at four years of age, after suffering frequently with what was supposed to be croup, tumors in the larynx were diagnosticated by the late Dr. John Atlee, of Lancaster, Pa., than whom there have rarely been better surgeons. Dr. Atlee performed tracheotomy and inserted a double canula. This appliance was used for eleven years without any withdrawal of the outer tube by her attendants, when it was found to have become corroded. Then a new canula was inserted and this second one had not been removed up to the time the patient was brought to me. On removing it I found it so corroded that I deemed it imprudent to replace it, and therefore substituted another.

Laryngoscopic inspection revealed multiple neoplasms



filling the upper portion of the larynx and extending along the laryngeal face of the epiglottis almost to its very tip. There were likewise a few multiple neoplasms at the base of the tongue, and along the pharyngo-epiglottic and glosso-pharyngeal folds.

The patient was admitted to the hospital, where my clinical aids, with some assistance from me, removed in a number of sittings all the morbid growths, chiefly with forceps; about a month being consumed in the procedures, and the voice returning in a satisfactory manner both for conversation and for singing.

After waiting for a few weeks, without noting any evidence of recurrence or repullulation, I removed the canula definitely at the end of June, and sent the patient home with directions to report in October, when my clinical services at the hospital would be resumed.

When she returned there was still no evidence of recurrence. The fistule in the neck, however, was as large as ever, and I determined to close it with a cutaneous flap. So on October 7th, before my clinical class, I dissected out the cicatricial tissue around the fistula, so as to leave an oval section in the integument, with bevelled edges from without inward. A flap of integument was then raised from over the sternum, and so bevelled on the edges that when the flap was turned up, skin-surface inward, its edges would fit into the bevelled seat prepared for it around the fistula, somewhat like a stone is set in a piece of jewelry. The parts were carefully stitched as far around to the pedicle of the flap as possible. The fat of the flap was then snipped away with scissors, and the raw flap was dressed with sulphuric ether so as to dissolve any remaining fat during the healing process. The wound in the tissue from which the flap had been raised, and which had gaped widely by retraction during the fitting of the flap in its new and reversed position, was drawn together with sutures, except a triangular portion superiorly and just beneath

the pedicle of the inversion, and which had to be left to heal by granulation.

The flap adhered well and thoroughly to the parts to which it had been stitched, and there was no necessity to release the pedicle to fill in the gap in the healthy tissues. Nature's unaided efforts were sufficient to cause absorption of the exuberant duplicature at the pedicle, and to gradually skin the raw surface of the flap with cicatricial tissue, so that there was no further occasion for professional supervision at the end of a month, when the patient was dismissed with instructions to report at the end of a year, or sooner, should anything untoward occur.

On October 17, 1893, the patient reported at the clinic very much improved in appearance, and with a clear voice of greatly increased volume. She had gained ten pounds in weight. The cicatricial tissue over and around the position of the fistula was in excellent condition, and except for a glossy aspect was not notably distinguishable from normal integument.

On examining the larynx, I detected a small, red, pedunculated pyramidal growth, about the size of a small pea, at the anterior commissure of the glottis and hanging below the vocal bands so that it did not interfere sufficiently with phonation to produce hoarseness. The voice, indeed, was shrill rather than deep. Whether this was a recurrent growth, or a repullulation from fragments left in extracting the growths the year previously, cannot be determined. It might be of either, but was probably of the latter character. It had occasioned no symptoms whatever indicative of laryngeal disorder. This little growth was readily removed with forceps.





