CHAPTER VIII

DISEASES OF THE MOUTH AND PHARYNX

Examination of the condition of the mouth is very frequently made, and often proves of great value. The internist sees in a herpes labialis a confirmation of his diagnosis of typhus; the surgeon regards an edematous upper lip seriously when called on to decide whether or not a child has a scrofulous diathesis. The gums are to be examined in all cases of suspected stomatitis, scurvy, and anæmia. Such an examination once saved me from a serious mistake. A child with hare-lip was to be operated upon. I examined the gums and saw by their condition that two teeth were about to appear; I therefore advised the parents to bring the child at some later date. During the period of teething the child was seized with convulsions. When I was informed of this, I considered it advisable to wait until the child was still older. The parents, however, went to another surgeon, but concealed the condition. The surgeon operated on the hare-lip; during the following night convulsions occurred, and by the next day the child was a corpse. The whole mucous membrane of mouth and pharynx must be carefully examined if syphilis is suspected, for the epithelium of the tongue often betrays the disease in spite of the obstinate denials of the patient. "*Labia custodiunt scientiam lingua loquitur*

judicium." In practice the physician must act with circumspection if he finds the signs of syphilis. If they are noticed, it is unnecessary to tell the patient, for a false imputation may convert a hot-headed patient into a harmful enemy.

Hardness of hearing can frequently be cured by tonsillotomy; therefore, in this condition one must never fail to examine the mouth. In swelling of the cervical lymph glands, as we will see later, careful examination of the mouth will often demonstrate the local point of infection. Such examples are very numerous. The coated surface of the tongue requires at least cursory mention. We must agree with Strohmeyer, that the world-wide custom of inspecting the tongue at each visit should not be abandoned; for, in one case in a hundred, or oftener, it leads to the discovery of some disturbance. For a surgeon, it is true, it is more important to examine and to be able to judge the condition of the wound. Yet it is a satisfaction to see the abnormal conditions of the tongue, such as dryness or coating, disappear in conjunction with the improved condition of the wound, of the findings shown by the thermometer, and the composition of the urine. In those cases of erysipelas which are ushered in by so-called gastric disturbances, by nausea, and heavy brown coating of the tongue, v. Dumreicher prescribed an emetic as a matter of routine. I can give the assurance that in all such cases the patient was greatly relieved. In these days of laparotomy we always examine the tongue after operation; it tells us a great deal.

When we turn to the diagnosis of local conditions, we first of all think of the common *ulcerations* of the mouth.

A practical classification of ulcers of the mouth consists in dividing them into fetid and non-fetid cases; for fœtor ex ore is so noticeable a symptom that it at once turns the thoughts of the physician into certain channels.

An equally practical classification is regional. Secondary syphilitic ulcerations appear on the palate, likewise diphtheritic gangrene; scorbutic ulcerations and cancrum oris on the gums; noma and malignant pustule on the cheek; carbuncle only on the lip; aphthæ scattered upon the mucous membrane of the cheek, floor of the mouth, and gums.

But it is still more practical to divide the ulcers, according to their chief symptoms, into certain groups, because these symptoms at once exclude ulcerations belonging to other varieties.

If, in the course of a scarlatina, a white membrane appears on the tonsils, palate, fauces, and uvula, and on the third or fourth day becomes gangrenous, accompanied by an extremely fetid odour, marked swelling of the cervical glands, and severe constitutional symptoms, the condition must be DIPHTHERIA. The same disease may be primary, without scarlet fever.

The milder form of the disease, *diphtheritic tonsilitis*, which produces milder general symptoms, is characterized by small white patches on the tonsils. These two conditions must not be confounded with that form of angina known as FOLLICULAR ANGINA, or herpes of the tonsils. The constitutional symptoms may correspond and the swelling of the glands also, but the appearance of the tonsils can be similar only at the onset. In follicular angina the tonsils are swollen, reddened, and studded with numerous yellowish dots. Strohmeyer

says: "The tonsils look like the star-studded heaven." These yellow plugs consist of pus, mucus, and bacteria which block the lacunæ of the tonsils. They correspond in size, number, and regularity of distribution to the situation of the lacunæ, and therefore appear only on the tonsils, and are strictly limited to the lacunar openings. Croupous membranes, however, have no definite distribution or size. It is decisive if they occur on the fauces, soft palate, and uvula.

Another group, which can not be brought into any relation with the other ulcerative processes, is characterized by a large, very tense infiltration of the surrounding parts, and usually appears as a gangrenous condition of the cheek in the neighbourhood of the corner of the mouth. The widely distributed, boardlike infiltration is apt to call up the picture of anthrax. But this disease need not be discussed here, for it can never be properly counted among the ulcerations of the oral cavity. It arises in the skin, and then spreads to the subcutaneous tissues, but as it never perforates, it causes no ulcer inside the mouth. Malignant pustule, likewise, which appears on the exposed portions of the skin, can not be discussed here, although, in passing, we may state that the disease begins with rapid pustulation and formation of scabs, which are depressed. The area is odourless and surrounded by a circle of vesicles. The condition is followed by swelling, which, however, does not lead to perforation.

The diseases referred to are noma and advanced cases of mercurial stomatitis. These begin in the mouth, and may lead to great destruction of the soft parts of the cheek, of the gums, and bones. They are distinguished from one another in the following manner:

Noma appears only in children, and then only after severe, debilitating diseases—following small-pox, scarlatina, typhus, cholera, etc. The word *after* is to be emphasized, for, in other words, noma appears only during convalescence, and then suddenly, extending below to the upper or even lower lip, and reaching above to the lower eyelid. The cheek is swollen, waxy, pale in colour, and shining like a fatty surface. On the inner side of the cheek is a small gangrenous ulcer, corresponding to which there is a hard spot of infiltration in the outer swelling. A rapid gangrenous destruction of the whole thickness of the cheek starts from the ulcer and extends to the gums, and even to the alveolar processes, so that a large hole, which communicates with the mouth itself, is formed. *Mercurial Stomatitis* is recognised by the absence of an antecedent severe disease, by the positive knowledge that mercury has been taken in large quantities, and especially by the fact that the skin remains intact, while it may be destroyed in a short time, even in two or three days, in noma. Noma in most cases is a fatal disease. The patient's strength fails; delirium, profuse diarrhœa, and œdema of the feet precede death. Mercurial stomatitis, on the other hand, is a very slowly progressing affection, and only exceptionally does it prove fatal.

Two other conditions have common characteristics and a superficial resemblance. These are scorbutic affections of the gums and aphthous stomatitis. Both processes run an afebrile course, begin in the gums, cause a foul odour, swelling, softening and pain of the gums, and loosening of the teeth. But they are readily differentiated. In SCURVY the gums are dark, bluish, and greatly swollen. They rise above the crowns

of the teeth and bleed spontaneously or on the slightest pressure. The rest of the body shows signs of scurvy. In *stomatitis* the gums are reddened, and bordered by a markedly yellowish edge, consisting of a softened pulp, which ulcerates and exposes the roots of the teeth. An exact impression of this yellow edge is found on the mucous membrane of the cheek corresponding to both the upper and the lower jaw. The mucous membrane of the cheeks and the lips are swollen, the tongue is coated. The affection rapidly disappears on using potassium chlorate, sometimes within two to three days.

Very small ulcers, with sharply demarcated edges and yellowish base, are seen, especially in the mouths of women. They often recur regularly at the menstrual period, and may lead to the suspicion of venereal disease. This suspicion is all the more readily accepted by the inexperienced if the same condition is found on the genitals, as occasionally may happen. Under these circumstances we must be politic and circumspect. The small ulcers may well be innocent *Aphthous* spots. They are recognised by their extreme sensitiveness, which annoys the patient in speaking, chewing, and laughing. They are further characterized by their bright-red border, and especially by the fact that they disappear in the course of a few days, without treatment.

Children also suffer from infected ulcers under and at the tip of the tongue. They may appear suspicious, for, in addition to their lardaceous base, the edges may be infiltrated, and healing proceed very slowly. In spite of this, they are innocent, and related to the process of dentition.

On the tongue two pathological conditions are of interest: 1, ulcerations; 2, tumours.

ULCERS of the tongue are of manifold nature. Their diagnosis furnishes one of the most difficult chapters of surgery. The ulcers appearing on the tongue are traumatic, syphilitic, carcinomatous, tuberculous, and lupoid; the majority, therefore, are symptomatic. Consequently, in most instances, the diagnostician will be obliged to look for and rely upon distant landmarks.

A tuberculous ulcer is suspected if the individual is of tubercular habitus. It is not true, however, that, as was believed until recently, the patient must be in an advanced state of phthisis. Chvostek has observed a primary, tuberculous ulcer of the tongue. We think of carcinoma if the individual has reached a ripe or advanced age, though it may make its appearance at an earlier period. Syphilis must be thought of in each case, as this disease spares no time of life. It is unnecessary to attempt to obtain an extensive variety of symptoms in each case in order to establish a diagnosis. A case was sent to us for operation with the diagnosis of cancer. The ulceration, which was extensive, involving the tip and part of the left edge of the tongue, was recognised by most of those present as non-malignant, for the simple reason that the ulcer had existed for years without impairing the movements of the tongue, without perceptible swelling of the glands of the neck, and without cachexia. A markedly indurated base, and a single hard and enlarged lymph gland occurring in an individual of advanced age will cause everybody to suspect carcinoma, and that only. A smaller ulcer, near the tip of the tongue, situated opposite a rough, carious tooth, will usually prove to be traumatic.

Upon what landmarks, in the diagnosis of these conditions, can we rely?

1. *Situation.* An ulcer on the dorsum will, as a rule, not be of traumatic nature unless some peculiar trauma has occurred. This can be learned from the history; or some particular local cause may be found, such as a necrotic piece of bone on the hard palate, or some misplaced tooth (situated behind the upper row of teeth), with tartar or carious irregularities upon its surface. An ulcer of the dorsum near the base of the tongue will rarely be syphilitic. These ulcerations are usually placed near the tip, or at the frenum; in other words, anteriorly.

2. *Extent of the ulcer.* An ulcer which spreads far and wide along the floor of the mouth and to the gums will hardly be of traumatic or tuberculous origin; more likely it will be syphilitic, and most probably carcinomatous. Tuberculous ulcers are always small; a very large ulceration will therefore not be tuberculous.

3. *Character of the edges.* Cancer has a very hard edge; the syphilitic ulcer a softer, very sharp border; the tuberculous, a sinuous, dentated, undermined border. Traumatic ulcers possess a hardened, painful edge only after very prolonged irritation.

4. *Character of the base.* The base of a traumatic ulceration, after removing irritating agencies, rapidly becomes a clean, granulating surface. Syphilitic ulcers possess a lardaceous base, which clears up on using potassium iodide. Cancer often contains epithelial pearls, which can be squeezed out by pressure. Tuberculous ulcers have a roughened base, and sometimes show small grayish nodules scattered here and there. Lupus is characterized by small bright-red nodules, composed of papillæ, which bleed readily. They are situated at

the edges of the small ulcers, which are formed by the breaking down of nodules.

Circumscribed NODES in the substance of the tongue are even harder to diagnose than the above conditions. A hard, sharply circumscribed node embedded in the substance of the muscles, and covered by the normal mucous membrane, may be an abscess, a gumma, or a cancerous node. We must not expect to find fluctuation plainly marked. A circumscribed *abscess*—fluctuation, as was just stated, can rarely be felt if the abscess is deeply situated—is very painful. The pain is increased as the tension increases. The mass usually attains the size of an almond. A cancerous nodule is only slightly sensitive; only exceptionally does it become painful. These signs, however, are insufficient; other guides must be found. Age has a decided value: if the individual is young, cancer is excluded. In middle and advanced age any of the mentioned conditions may be present. Complete examination of the patient must be undertaken. Signs of lues elsewhere on the body are in favour of a gumma. If no lues is present, the rapidity with which the node developed is of great importance. An abscess forms in eight to fourteen days; a cancerous node requires a longer time to grow to a corresponding size. A small, round, hard, painless lymphatic gland in the neck points to cancer.

Other rarer tumours appear on the tongue: tubercles, actinomycotic foci, lipomata, or fibromata. Fibromata are always situated superficially. They are flat, small (about a square centimetre in extent), and exist for years. A lipoma is elastic, and likewise requires years to develop. Tubercles are found only in connection with tuberculosis of other organs (lung, bones, or

joints), and eventually ulcerate. I refer here to the rare cases of larger nodes, not to the more commonly met with tubercular ulcers of the tongue which were previously discussed. An isolated focus of actinomycosis can be recognised only by exclusion. The first case which was diagnosed at our clinic was recognised in the following way: The individual was young (no carcinoma) and healthy (no tuberculosis or syphilis), and the node had existed some time (no abscess).

As cancer of the tongue very rarely occurs in females, this is to be remembered in diagnosing tumours of the tongue.

If a tumour of the tongue ulcerates, we are dealing with cancer, tuberculosis, or syphilis. By bearing this in mind no great difficulty should be encountered in arriving at a correct diagnosis.