CLINICAL RECORDS

UNILATERAL ATROPHIC RHINITIS

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ATROPHIC RHINITIS is now a relatively rare condition, and so experience of treating it is necessarily limited. Some cases are amenable to medical treatment, but when this fails, various surgical methods of relief have been devised; all have their disadvantages (Taylor and Young, 1961). The occasion was taken, therefore, when a case of unilateral atrophic rhinitis was seen recently in out-patients, to try out a new method developed by Young (1966).

Case Report

Mrs. R., aged 27, was first seen on *30 September 1965*, with a long history of right-sided nasal obstruction. There had always been a nasal discharge, which was at first watery, but it was becoming green, and she had, for some time, been aware of an unpleasant smell. As a child, a diagnosis of allergic rhinitis had been made, and she had noted that both the obstruction and discharge were worse in summer.

On examination, the septum was found to be deflected to the right. The left nasal cavity was very large, with an atrophic mucosa covered with foul crusts. This crusting was also present in the post-nasal space and spreading down the posterior pharyngeal wall, which was very dry and glazed. There was a little mucopus from the right middle meatus, but the sinus X-ray was quite clear.

Treatment was started with nasal sniffs using normal saline, followed by a glucose and glycerine spray, and this did improve her nose after a month or two. However, the tendency to produce foul crusts remained and she requested further help. After discussion with Mr. Austin Young, she was put down on the waiting list for a plastic operation to close off the left nostril. This was done on *10 August 1966*, under general anaesthesia. An incision was made round the muco-cutaneous junction inside the left nostril, and the skin was reflected forwards by scissor dissection. After controlling the bleeding, the edges of the skin were approximated with interrupted silk sutures. She was put on to a course of penicillin. The stitches were removed on the seventh day, and she went home. There was a small leak at the lower end of the scar for a few days, but this finally healed, and when she was seen on the *8 September*, the left nostril was firmly closed off. The right side of her nose was producing a little thin discharge which was not offensive and she was getting enough air down the one side to be comfortable. Examination of the post-nasal space showed that all the crusting had completely vanished, the mucosa within the left side of the nose was a normal colour and the posterior pharyngeal wall was now moist

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and normal in appearance. The patient was very pleased indeed with the results and with the disappearance of the smell, and was quite happy to accept her blocked left nostril indefinitely. The closure was not visible unless a speculum was used.

Comment

The object of surgical treatment is to narrow the air-way and reduce the flow of air through the nose. When one side is already narrowed by a deflected septum, but provides an adequate air-way, it seems a rational step to close the side which is too large, and the operation to do this is easy.

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