SOCIETIES' PROCEEDINGS

ROYAL SOCIETY OF MEDICINE—SECTION OF LARYNGOLOGY.

President—Dr A. Logan Turner.

April 3, 1925.

Discussion on Paroxysmal Rhinorrhœa — Introductory Papers by Drs John Freeman, A. Brown Kelly, James Adam, and Margaret Tod (pp. 561 to 585), *Journal of Laryngology and Otology*, No. ix., vol. xl., September 1925.

Dr Millais Culpin said the psychologist rarely saw these cases primarily for the conditions which had been described in the discussion, but he was accustomed to seeing them in persons who came for other reasons. He, therefore, gave consideration to such conditions as rhinorrhoea, Raynaud's fingers, or colitis, as forming part of one big picture. He was disposed to criticise Dr Freeman's contention that a larger number of these sensitised persons were not nervous, but were stolid, steady-going folk. The psychologist could not accept that generalisation, because many people with nervous symptoms succeeded in hiding them, and only by making a skilled examination could one be certain whether the patient was or was not nervous.

He recalled the case of a lady who suffered from asthma when she was in the presence of sheep, or attempted to ride a bicycle, or when her husband, a medical man, was at a confinement. A full examination of the patient linked up those three peculiarities under one psychological cause.

To the psychologist this particular group of disorders was very interesting. If he could explain why a serum injected produced certain reactions in one person and not in others, he would also be able to explain many other happenings. His own view was that these conditions were parallel to phobias; what would produce in one person asthma or hay-fever would cause a phobia in the other. One patient was laid up for three weeks after contact with a cat, which produced an absolute panic. He (the speaker) thanked Dr Freeman for his references to the psychological side of the subject.

Sir James Dundas-Grant referred members to an article which he wrote in *The Practitioner*, in 1913, on nasal disease in relation to asthma. His number of cures was much the same as those shown in Dr Tod's tables. In a typical series, 18·2 per cent. were cured, 45 per cent. improved, no improvement resulting in 20 per cent. In his (the speaker's) work on this subject he had been much influenced by the experiments of Dixon and Brodie. They found that the dilator nerves for the bronchial muscles were derived from the sympathetic, though they passed through the trunk of the vagus. This accounted for the beneficial effect of adrenalin. Experimenting on decerebrate rabbits, they found that when they could not get a reflex

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contraction of the bronchial muscle from stimulation of any other sensory nerve, they got it from the nasal mucous membrane, and particularly the upper and back part of the septum. In patients with asthma one could often find a small swelling of the middle turbinate body which came into contact with the upper and posterior part of the septum, especially if there were variations of pressure. A nose might be full of polypi without causing asthma, but a small mobile polypus might cause it. In regard to vasomotor rhinitis, he would add to what previous speakers had said, that there was sometimes a tendency to urticaria and chilblains, and to bruising readily on slight provocation, conditions indicating a deficiency of calcium in the blood. Hence the importance in these cases of giving calcium and sometimes magnesia.

Mr FRANK COKE said that he agreed with Dr Freeman that those patients suffering from paroxysmal sneezing, hay-fever, and asthma were in no way more neurotic than normal people.

With regard to judging the effects of nasal operations, naturally one did not see the successes of the nasal surgeons; only in cases of failure did the patients come for further advice. He (the speaker) had found that cauterisation of the septum and turbinals was a procedure of considerable value. Very successful results in curing asthma often followed the removal of septic tonsils; especially was this so in children.

It was a question whether too much attention was not being paid to the nose itself and too little to the system as a whole. Every case of hay-fever gave the dermal reaction on every portion of the skin, showing that the whole body was affected, thus arguing against the presence of a neurosis in these cases. He had recently seen a doctor who overdosed himself with pollaccine, given hypodermically; this was at once followed by an attack of hay-fever, asthma, and a profuse urticarial rash.

Lumière had recently shown that anaphylaxis was due to a colloidal change taking place in the blood, of the nature of precipitation and flocculation of the particles. If that were so, the condition of the blood was of more importance than the local nasal troubles. M'Donagh suggested that the condensation of these colloidal particles led to the flocculation. If an ordinary case of rhinitis were treated, on his suggestion, by manganese butyrate, a cure would probably result.

In all these nasal conditions a larger view should be taken, and every effort should be made to trace the cause of the complaint by means of the dermal reactions and the full examination accorded to cases of asthma with such successful results.

Mr C. A. PARKER said that one cause of paroxysmal sneezing and rhinorrhœa which was not commonly recognised was mahogany dust. At High Wycombe there were many cabinet-makers, and many of them when they were sand-papering the mahogany suffered from profuse rhinorrhœa. The onset in that case suggested a purely mechanical cause. He understood the same happened to workers in some other kinds of wood.

Mr W. STUART-LOW said he did not consider that local treatment at this discussion had been sufficiently enlarged upon. In the acute stage, namely, the stage at which patients most frequently appealed to the specialist, when there was often such a profuse watery discharge that as

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many as a dozen handkerchiefs in the course of half an hour became saturated with serous fluid—what he had found most effective was a solution of cocain of a strength of 10 per cent. applied quite freely in the nose. The interior of the nose should be swabbed with this solution, which he found more advantageous if used as warm as could be comfortably borne. This was the best means of getting rid of the excessive vascularity and hyperæsthesia of the mucous lining. Having accomplished this he found that the best applications to act as a protective against cold air and dust, which were very aggravating to so sensitive a surface, were those of an oily nature, such as plain parolein, applied by means of an anterior nasal atomiser.

In most cases of rhinorrhœa there was an anatomical abnormality in the interior of the nose causing a disturbance in its functions; and in some cases he had found high up in the ethmoid region an œdematous spot which, if punctured, bled freely: this indicated a collection of purulent matter in the underlying cells, from which pus discharged and caused such irritation as to precipitate an attack of rhinorrhœa.

The only remedy in such cases consisted in the ablation, more or less, of the middle turbinal. Sometimes the interior of the nose was so sensitive that perfectly pure non-bacterial dust would induce a severe attack, as in the case of a lady patient of his who was always affected by the dust from the Penmaenmawr slate quarries.

Where a deviation of the septum existed it was essential that a complete resection should be carried out, and, if the ethmoidal portion of the septum were out of place, it was imperative that it should be thoroughly removed.

This was well illustrated by a case he had seen and operated upon, in which the lower half of the septum had been resected at a former operation by an expert operator, but the upper part left. The rhinorrhœa was not remedied until a complete resection had been done, because this mechanical displacement kept up a chronic congestion in the upper region of the nose.

Very frequently the inferior turbinal was the offending body, it being firmly enlarged and pressing on the septum, causing obstruction and congestion; such a turbinal was not susceptible to the galvano-cautery. The best procedure for this condition was the performance of the operation introduced by himself (Mr Stuart-Low), namely, submucous turbinectomy, which consisted in ablating, more or less, the bony framework of the turbinal, preserving the soft structures, and so effectively removing the mechanical obstruction in the inferior meatus.

Dr LOGAN TURNER (President) said he felt somewhat disappointed that none of the speakers had discussed the endocrine aspect of the subject, as work had been done in that connection. He agreed with Dr Freeman that we were not dealing with a nasal disease, and that it was necessary to look further than the nasal cavities for the cause in many of the cases. Dr Brown Kelly had rightly emphasised that it was not necessary that there should be sneezing, discharge, and obstruction in every case; only one or two of the three symptoms might be present.

Dr BROWN KELLY (in reply) said complaint had been made that the causes and treatment had not been referred to; but it was mainly with the causes that all the openers had dealt, and when the cause in a particular case was determined, the line of treatment became evident.

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If he had had time he would have referred to what might be termed false sensitisations. In these cases sneezing was excited by flour, fine dust from hay, flowers, etc. No specific protein sensitisation existed, but only temporary hyperæsthesia, which made the patient susceptible to various mechanical irritants.

It had been suggested that cases of vasomotor rhinitis could best be investigated by team work. He (the speaker) had had several of his patients very thoroughly overhauled by physicians, radiologists, and other specialists without their being able to elucidate the presence of any abnormal condition beyond a neurosis. With regard to the endocrines it was perhaps as well that this subject had not been introduced into the discussion as there was still so much speculation attached to it.

Dr JAMES ADAM (in reply) said he thought members would find the questions which had not been replied to in this discussion were very fully answered in the articles which had appeared in the *American Journal of Clinical Medicine*, by Drs Haseltine and La Forge; a symposium on the subject was to appear in the June number of *American Medicine*.

With regard to endocrine disturbance, this was due to the toxæmia, which affected the endocrine glands in the same way as it affected the skin and the vagus. Doses of any dust frequently repeated would start asthma in a toxæmic subject.

He had been very pleased to hear Mr Coke's reference to the work of Lumière, who had been engaged upon the nature of anaphylaxis for years; it was most valuable work. To asthmatic patients he (the speaker) gave a mercurial once a week for years, as it helped one to deal with the toxæmia. Golf was a most effective medicine for these people; it was preferable to injections.

THE SCOTTISH SOCIETY OF OTOLOGY AND LARYNGOLOGY

TWENTY-FIRST MEETING, ROYAL INFIRMARY, EDINBURGH.

President—Dr W. S. SYME.

May 23, 1925.

Acute Middle Ear Suppuration (right); Extradural Abscess; Temporal Lobe Abscess; Ventricular Meningitis; Death—Dr J. S. FRASER.—Male, aged 27, had tonsillitis (20.12.23) followed by pain in right ear and discharge. Two days before admission (4.1.24) discharge ceased. Severe frontal headache and vomiting, with irritability; sudden loss of speech, though patient understood what was said to him. (Patient is right-handed.)

Examination revealed no rigidity of neck; no Kernig; pupils equal and reacted to light; no paralysis of eye muscles; no aphasia; hand grasps equal; no pointing error; no spontaneous nystagmus; no

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