BRITISH MEDICAL ASSOCIATION.

Meeting at Brighton, July, 1913.

SECTION OF LARYNGOLOGY, RHINOLOGY, AND OTOLOGY.

A. J. HUTCHISON, M.A., M.B. (*Brighton*), *President, in the Chair.*

Abstract Report by MR. HAROLD L. WHALE.

The PRESIDENT, in opening, assumed responsibility for the choice of subject, "The Care of Patients after Nasal Operations," and quoted, in justification, two cases, one of tonsils and adenoids, in which operation was followed by pericarditis and multiple arthritis; the other of posterior turbinotomy, followed by abscess of the lung.

A temporary subacute otitis media is common, and graver issues include sinusitis, meningitis, and suppurative cervical adenitis.

Discussion on the Technique and After-treatment of the Radical Mastoid Operation.

I.—**William Milligan, M.D.** (Manchester), said that pre-operative labyrinthine tests should be routine. It is better not to operate at all than to perform *only* the radical operation where the functions of the labyrinth are actively impaired. Ruttin's test—that in a healed labyrinthitis after-nystagmus lasts as long towards the diseased as towards the sound side, but that both these are of shorter duration than normal—is useful to distinguish this condition from a latent diffuse serous labyrinthitis.

In operating on females, instead of shaving the scalp widely, the hair may be plastered down with collodion. To close off the Eustachian tube the galvano-cautery may be used, under direct vision through a Yankauer's speculum.

In contra-distinction to an ordinary skin-flap, the new periosteal flaps are more likely to slough. The gouge, worked by hand alone, especially in infantile bones with dense cortices, is inferior to the gouge and hammer, supplemented by the burr.

Scraping away the mucosa over the promontory, and so replacing the former with cicatricial tissue, is deprecated unless all hearing had previously been lost.

The first packing may be left in for four days. Later, to encourage epidermisation of the cavity, "cell-proliferants" such as scarlet-red, skin-grafting, or blood-clot dressing may be adopted.

Dr. DUNDAS GRANT referred to the occasional formation of a web over the antrum during healing. What is the relative frequency of post-operative meningitis?

Dr. WILLIAM HILL advocated a light packing with plain gauze and insisted on the thorough removal of granulations from the tympanic orifice of the Eustachian tube, and recommended painting the meatus with iodine immediately after operation.

Sir ROBERT WOODS approved of immediate grafting. The use of hydrogen peroxide risks the spread of sepsis.

https://doi.org/10.1017/S1755146300190900 Published online by Cambridge University Press

Dr. JOBSON HORNE urged simplicity in technique and after-treatment.

Dr. NEIL MACLAY urged the necessity of dealing with the Eustachian orifice.

Dr. WATSON-WILLIAMS preserves the tympanic mucosa in cases with fair hearing-power, and has had fairly good results with the double skin-flap.

Dr. WYLIE said it is important, although difficult, to make the patient lie on the diseased side after operation for purposes of drainage. Granulations could be treated by the cautery or trichloracetic acid.

Dr. W. S. SYME prefers to close the Eustachian tube not only at its tympanic, but also at its pharyngeal end.

Mr. E. D. DAVIS, in urging the importance of examining the labyrinth before operation, quoted a case of subdural abscess and another of diffuse meningitis subsequent to operation.

The PRESIDENT had had good results with allontoin in cases which were slow to granulate.

Dr. MILLIGAN replied.

Discussion on After-treatment and Complications of Operations on the Nose and Naso-pharynx.

Mr. Herbert Tilley said the galvano-cautery should never be used in nasal fossæ so narrow that adhesions might form. Before an anterior turbinectomy the vestibule might be painted with iodine.

In the dangerous bleeding sometimes following posterior turbinectomy morphine, hypodermically, is useful. When, after a submucous resection of the septum, this remains lax and vibrates with respiration, a large hole may be deliberately cut in the septum. The nozzle of any syringe used should be sufficiently narrow for an easy return-current of lotion. After ethmoidal curettage two of his earlier cases had developed an orbital abscess.

After a Caldwell-Luc operation the most dreaded complication is a crust forming a complete cast of the antrum, for which he applies strong silver nitrate solution.

After washing out a frontal sinus the cavity should always be blown out with warm air.

After adenoid curettage hæmorrhage is usually due to the remains of a tag. An important item in after-treatment, where the chest has become deformed, is breathing exercises.

Sir Robert Woods preferred cocaine to any general anæsthetic; before cocainisation, a full meal tends to the avoidance of syncope. For bleeding, calcium lactate is useful, or if from venous engorgement, digitalis.

After turbinectomy, pharyngitis sicca is not a complication, but a natural result, and the operation should be avoided.

Dr. W. H. KELSON urged the routine examination of the urine in all patients of middle age, thus forewarning the surgeon of the likelihood of bleeding or sepsis.

Dr. JOBSON HORNE preferred to keep the patients in bed or their rooms for a few days after an operation.

Dr. SOMERVILLE HASTINGS advocated the use of sodium salicylate or aspirin.

Dr. WATSON WILLIAMS preferred his method of frontal sinus opera-

https://doi.org/10.1017/S1755146300190900 Published online by Cambridge University Press

tion to that of Killian, because an aberrant infected cell is less likely to escape notice.

Mr. Mayo Collier deprecated extensive post-operative douching. The stream of respired air was the best antiseptic and styptic.

Mr. W. S. Syme, at the conclusion of a maxillary antrum operation, sprays through the cannula with cocaine and adrenalin.

Prof. Wheelock paints the operation area, after cocainisation, with argyrol.

Dr. Killen, for septal operations, uses *injections* of novocain.

Mr. Herbert Tilley and Sir R. Woods replied.

Rhinoscleroma.—Owen Richards.—Rhinoscleroma is neither an English nor a tropical disease. It is common in Egypt. The nose, while increasing vastly in bulk, retains its form. The lachrymal ducts and Eustachian orifices may become blocked. The jaws and face appear able to resist.

An organism has been isolated from a culture in which it is mixed with *Diplococcus catarrhalis* and diphtheroid organisms; the tube containing the emulsion requires prolonged agitation, because the growth is so viscid. A vaccine had been made and so far proved useless.

Dr. William Hill inquired whether gamma radiation had been tried for this condition.

Suggestive Points of Analogy between Otosclerosis and Arthritis Deformans.—John O'Malley, F.R.C.S.—Otosclerosis is stapedio-vestibular osteo-arthritis. In the morbid changes of chronic hyperplastic otitis media there are two outstanding features—simultaneous and alternating hypertrophy and atrophy, both of these being active processes. The essential underlying pathogenic factor must be nutritional.

The Anatomy and Comparative Anatomy of the Palatine Tonsil and its rôle in the Economy of Man.—H. Seccombe Hett, F.R.C.S.—Carnivores have projecting tonsils; herbivorous animals' tonsils are submerged. The human tonsil is a mixture of these two.

The normal human tonsil begins to atrophy at five years of age, and, being fully atrophied before adult life, cannot have a function in adults.

Mr. H. G. Butterfield: The perivascular lymphatics at the hilum of a tonsil associated with cervical adenitis are found full of micro-organisms.

Mr. E. D. Davis referred to the defensive *rôle* of the tonsils.

Dr. Jobson Horne considered the tonsils to be the first line of defence.

Mr. O'Malley asked whether Mr. Hett had found cervical adenitis after enucleation of tonsils.

Demonstration.

Tracheal Administration of Anæsthetics.—Dr. William Hill showed his gum-elastic intra-tracheal catheter. A rubber shoulder 3 in. from the end rests on the ventricular bands, preventing the ingress of blood into the larynx. This avoids laryngotomy, tracheotomy, or Kuhn's cumbersome apparatus.

Dr. G. Barton approved of this apparatus, quoting a case where its use might have avoided death from asphyxia.

Dr. E. D. Davis also had used a catheter passed through the nose into the trachea.

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