SOME DETAILS IN EUSTACHIAN CATHETERIZATION.*

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It is not merely flattering to the vanity, but favourable to the interests of the practitioner, to succeed in passing the Eustachian catheter up a nostril through which others have been unable to do it. I have no doubt that every aurist of experience has some dodges of his own which help him through difficulties into which others have fallen. No doubt in some cases in which I have failed others have succeeded, but in some, if only a few, the converse has been the case.

In those cases the difficulty which has baffled the operator who has unsuccessfully preceded me has been the steering of the catheter past some deformity of the septum, whether a deflection or thickening. In most cases the obstruction has been a ridge of some sort running obliquely upwards and backwards, but sometimes a so-called scoliosis, bulging low down in front so as to come close up to the outer wall of the nose and almost obliterate the visible opening of the cavity. In many of these cases discomfort and disappointment have resulted from the operator not having made a preliminary rhinoscopic inspection of the nares, and I would lay down as a rule that the Eustachian catheter should never be employed without such an examination having been made. As a rule, the application of a weak solution of cocaine, either by a spray or brush, facilitates the catheterization by diminishing the patient's sensitiveness and reducing the vascular turgescence of the mucous membrane. In some cases the passage of the catheter through the nose is greatly facilitated if the nasal speculum is used at the same time, the sense of touch being greatly assisted by the sense of sight. In some instances this help must be dispensed with for reasons which will be given later on.

In the case of an oblique ascending ridge on the side of the septum, it may be taken as a general rule that the catheter should be introduced with its beak pointing towards the septum and underneath the ridge, then when it is in this way pushed back as far as it will go the point should be turned downwards and outwards underneath the inferior turbinated body and upwards into the hollow, and then upwards and outwards into the vault of the inferior meatus. It is sometimes necessary to withdraw the catheter slightly before engaging its point under the inferior turbinal; the instrument is then pushed steadily backwards until it is felt to be

* Paper communicated to the Meeting of the British Medical Association, August, 1901.

https://doi.org/10.1017/S1755146300169963 Published online by Cambridge University Press

free in the naso-pharynx, when it can be turned downwards and hooked over the back of the soft palate. In some cases, where the septal ridge diminishes rapidly and considerably towards its posterior part, the beak of the catheter need not be turned under the turbinal at all, but kept pointing upwards under the septal crest until the naso-pharynx is reached. This proceeding is greatly facilitated if the point of the nose is pressed forcibly upwards.

When the inferior turbinal projects considerably, and the septal spur is not very great, it is sometimes advantageous to pass the catheter above the turbinal till its tip, pointing downwards, reaches the naso-pharynx, when, by a little steady downward pressure, the stem of the catheter may be forced down between the turbinal and the crest on to the floor of the meatus. When the septal projection extends outwards so far in the inferior meatus as nearly to occlude the orifice, the nasal speculum must be removed, so that the tip of the nose may be forcibly pressed towards the opposite side of the face. The point of the catheter is then introduced under the septal projection, the stem being directed towards the opposite side of the face, pressing the tip of the nose with it. This will often permit of the catheter, lying, as it were, on its side on the floor of the nose, being pushed in till its angle approaches the middle part of the inferior meatus, where the passage widens out considerably. By a little gentle *tâtonnement* the operator will find whether the point of the instrument should be turned upwards or downwards, so as to be coaxed through into the naso-pharynx with the least difficulty. In another class of case there is a projection from the septum at the junction of its posterior and middle third, presenting a somewhat arched shape on inspection. When this is present, the passage of a sufficiently curved catheter is quite impossible as long as the usual rule is followed of turning the beak downwards and pushing it along the floor of the nose. The catheter must, on the other hand, be placed with the back of its beak on the floor of the nose after the manner of the head of a golf-club; and to allow this position to be maintained while the catheter is pushed sufficiently far back for its tip to get in the arch-like projection, it is necessary for the tip of the nose to be tilted upwards and to the opposite side. In this case also the nasal speculum must be removed. The writer believes that by carrying out these rules he has obtained success in passing the catheter in cases in which he did not expect it, but he doubts not that others have had the same results by following them intentionally or unwittingly. In any case, he would strongly commend them to the consideration of those who think their success in Eustachian catheterization still leaves something to be desired.

https://doi.org/10.1017/S1755146300169963 Published online by Cambridge University Press

I have made no reference here to the usual rules for the passage of the Eustachian catheter, which are or ought to be familiar to all who use the instrument, or to its use through the opposite nostril, in case the nostril of the affected side is obstructed. Ardent nasal operators recommend that when an obstruction exists such as prevents the introduction of a Eustachian catheter this fact is sufficient to justify the removal of the said obstruction; but we must reflect that the passage of the Eustachian catheter may be impeded by an obstruction which merely produces a tortuosity rather than a stenosis of the passage, and does not prevent the free admission of air to the naso-pharynx and Eustachian tube, although it interferes with vision and the passage of a Eustachian catheter. The obstructions, as seen through the rhinoscope, are thus, so far as aeration is concerned, even more apparent than real. I make bold to say that an application of the rules I have laid down will greatly diminish the number of cases in which the passage of the Eustachian catheter is impossible, apart, however, from the question of the injurious influence of this obstruction on the organs situated behind it.

I have not touched the question of the indications for the use of the catheter rather than the Politzer bag, but I will assume that all are convinced that in many cases such indications exist.

I need hardly remind my hearers of the occasional occurrence of complete congenital or acquired occlusion of one, or it may be both, posterior nares, which is sometimes only detected when an attempt is made to pass the Eustachian catheter. In all my cases of this anomaly I have found the nasal cavity of the affected side filled up with a white glutinous secretion resembling the starchy paste used by a laundress.

I may be reproached for dwelling with unnecessary insistence upon what are mere minor details, possibly beneath the consideration of such an assemblage as the present, but I may remind you that it has been said that he who would command success must have an almost ignominious love of detail, and of no one, I believe, is this more true than of the specialist and of those who would wish to do like him.

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