

The four soldiers whose photographs illustrate this paper have been provided with the oculo-palpebral prosthesis through the generosity of some of the ladies visiting the hospital. I am much indebted to them and also to Mr. John Trotter, of 40, Gordon-street, Glasgow, who has taken great pains in the construction of the eblepharon, and the photographs show that his mechanical and artistic skill have been rewarded by satisfactory results. The immobility of the prosthesis is its most serious drawback, but that is a disadvantage which is also present in many cases where an artificial eye is worn in the socket. It is important that all cicatricial contraction is as far as possible completed before the eblepharon is adjusted, for if any further shrinking occurs a readjustment of the prosthesis is necessary.

CASE 1.—Private —, aged 26, was severely wounded on the left side of the face by a bullet on July 10th, 1916. He was admitted to the 3rd Scottish General Hospital on August 5th. The left eye had been enucleated and a deep adherent cicatrix extended from the inner third of the lower eyelid downwards and outwards one and a half inches across the malar bone. Both upper and lower eyelids were adherent to the tissues of the orbit and pulled backwards by cicatricial contraction. The scar from the lower lid on to the face being very unsightly, was cut out on Sept. 2nd and the edges of the wound were carefully sutured. Captain John Morton, R.A.M.C. (T.), assisted me at the operation, which, however, was not so successful as it promised to be at the time, owing to the occurrence of secondary hæmorrhage two days afterwards. The pressure of the effused blood caused some of the stitches to give way, and the result after healing was completed is well shown in the photograph. The right eye is healthy and vision equals 6/12, measured by Snellen's test-types. The prosthesis was adjusted in October and the man was discharged on Nov. 11th, 1916. (Fig. 1.)

CASE 2.—Rifleman —, aged 20, was wounded by shrapnel on July 2nd, 1916. The bullet struck the left side of the nose, shattering the nasal bones, tearing the right cheek, and damaging the right eye so severely that it had to be enucleated. He was treated for four days at No. 1 Stationary Hospital, Rouen, and then taken to the 3rd Scottish General Hospital, where he was first under the care of Lieutenant-Colonel T. Kennedy Dalziel, R.A.M.C. (T.), who treated the fracture of the nose. He was transferred to the ophthalmic department on Sept. 6th. At that time a suppurating wound extended across the cheek, and the right lower eyelid was completely everted. There was a copious discharge of pus from the orbit, and the upper lid was dragged into the socket and partially adherent to the underlying tissues. Antiseptic dressings were applied, and on Sept. 30th a plastic operation was performed to remedy the deformity of the lower lid. By the end of October the appearances were as represented in the photograph. The left eye is healthy in structure and function, and vision equals 6/9, measured by Snellen's test-types. An oculo-palpebral prosthesis was adjusted and the man was discharged on Nov. 11th. (Fig. 2.)

CASE 3.—Private —, aged 35, was severely injured on the right side of the head by the explosion of a rifle grenade at Souchez on August 14th, 1916. He was taken to a base hospital, where the right eye was removed, and was admitted to the 3rd Scottish General Hospital on August 20th. The right orbit was septic, the lower lid was torn and sloughing, and communicating with the socket there was a large suppurating wound in front of the right ear. Major J. W. Downie, R.A.M.C. (T.), examined the sinuses in connexion with the orbit and reported that they were not implicated. Antiseptic dressings were applied and the suppuration gradually diminished. On August 31st the patient complained of difficulty in opening his mouth, but there was no trouble in swallowing. Antitetanic serum was injected on three different occasions, but there was never any sign of tetanus. The wounds healed slowly, the difficulty in opening the mouth persisted, and considerable swelling of the face remained over the right superior maxilla. Massage and passive movements were applied to the face and lower jaw, and the swelling and stiffness gradually lessened. By the end of December the wounds had healed, but the orbit was so contracted that an artificial eye could not be worn. An oculo-palpebral prosthesis was supplied, and the man was discharged on Jan. 6th, 1917. (Fig. 3.)

CASE 4.—Lance-Corporal —, aged 25, was severely wounded on the left side of the head by the bursting of a shell near Ginchey on Oct. 22nd, 1916. He says he was taken to the 1st Australian Hospital at Rouen, where the left eye was enucleated and an "abscess" of the orbit evacuated and drained. On Nov. 3rd he was admitted to the 3rd Scottish General Hospital. The orbit was sloughing and a deep suppurating wound extended from it outwards to the cheek and upwards on the forehead, where a large area of the frontal bone was exposed. There was also a deep wound of the left parietal region. The wounds and the orbit

were kept clean and treated with antiseptic dressings, and antitetanic serum was injected on three different occasions. Healing was slow but uninterrupted in its progress, and by the beginning of January, 1917, cicatrization was almost complete. The eyelids were drawn backwards and had become firmly adherent to the tissues of the orbit, and the wounds of the forehead and face were represented by deep adherent cicatrices. An oculo-palpebral prosthesis was adjusted and the man was discharged. The right eye is healthy and vision equals 6/6, measured by Snellen's test-types. (Fig. 4.)

Glasgow.

THE SURGICAL CORRECTION, WITHOUT CICATRIX, OF UNLOVELY NOSES.

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To rectify, or correct, unlovely noses and to render them acceptable to the æsthetic sense by means of a surgical operation and without leaving any cicatrix appears at first sight paradoxical, in that every surgical operation involves a scar. This kind of operation therefore encounters a certain incredulity, not merely among persons unfamiliar with surgery, but even amongst a number of colleagues. The following letter sent to me last year by the chief of the Medical Clinic at the Faculty of Medicine in Toulouse is sufficient evidence of this.

With the Forces, June, 1916.

On my speaking with colleagues at the field hospital of your nasal corrections without scar they gave expression to a certain doubt. Being desirous of convincing them I should be obliged if you would send me photographs of the cases that we have had the opportunity of operating upon together.

D. PUJOL.

This kind of plastic surgery being quite a novelty, such scepticism is scarcely surprising. In France we have to reach the point of correcting any and every case of nasal deformity by operating in the endonasal passage, and it is thus that the cutaneous covering shows not the slightest trace of a scar. By nasal deformity we understand any exaggerated development of the nose in length or breadth, any protuberance or deviation, an exaggerated point, or too broad or too long an extremity. If rhinoscopy is practised after rectification doubt may often arise whether the bistoury has actually been used, for the incision in the mucosa leaves no visible trace; nor is this surprising to rhinologists, who are well aware that after submucous resection of the nasal septum with consecutive suture the area of incision is identical afterwards with other parts of the mucosa not touched by the bistoury.

Rhinoplastic operations belong not only to the æsthetic but to the psychic sphere. The majority of those upon whom we operated did not desire a well-formed nose for elegance, or for purity of line, but rather a nose "like everyone else," one which "does not attract attention." As we expressed it in a communication to the Academy of Medicine in Paris on Feb. 23rd, 1917, the mentality of Cyrano was not created entirely by the imagination of a poet, but was the fruit of keen observation. It would carry us too far to quote the various complaints we have received from patients thus afflicted. Some speak of the prejudice occasioned by this unlovely feature, others of moral suffering or of the pleasantries of which they are the victims. "If there is anything to be done," wrote one of them to us after having described the shape of his nose, "I shall owe you a thousand thanks if you will let me know of it, for it is a source of suffering to me." It is necessary to have seen the emotional gesture with which the patient hurries to the glass at the termination of the operation, and his look of satisfaction on grasping the result, to be entitled to state that it is with them more than the satisfaction of vanity; it is actual moral salvation.

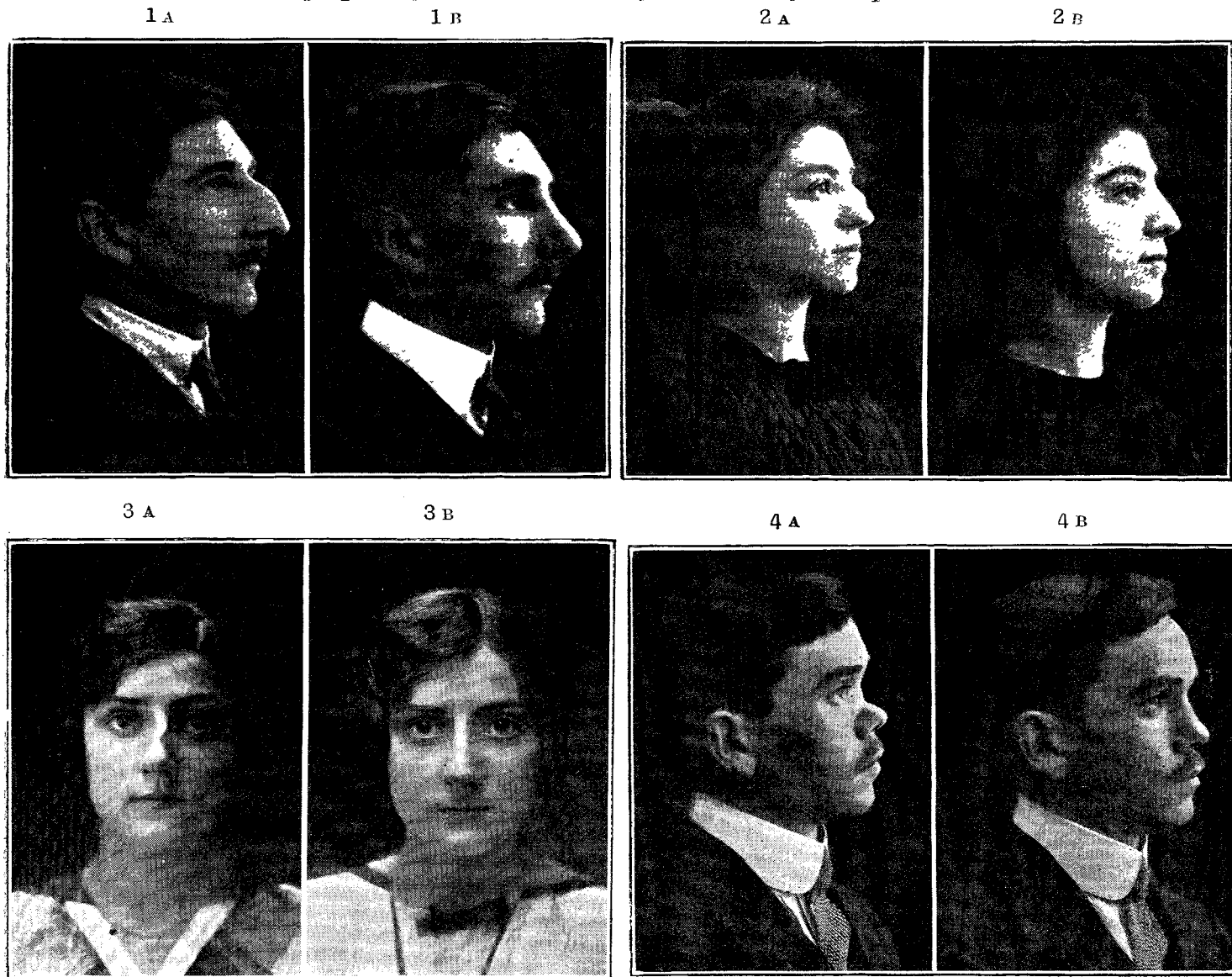
It is generally at puberty that the nose, which presented till then a normal aspect, changes in character, if it may be so expressed. The nose may develop largely in height, producing an exaggerated curvature (Fig. 1 A), or it may be only the medial portion that develops, thus resulting in the hump-backed nose. (Fig. 2 A.) In other cases the abnormal enlargement affects the length instead of the height, giving rise to various forms of pointed nose; in one type the nasal point is unable to bend over towards the chin, in another

bending abruptly towards it. In convex noses, with or without protuberance, and in unduly long noses, the two lateral portions of the nasal projection are symmetrical. In crooked noses these lateral parts are unsymmetrical, one developing more than the other; the result is a nose deviating from the middle line. Of the crooked nose thus formed, the fault may rest with the cartilaginous portion alone (Fig. 3A) or with both cartilage and bone. Noses may, of course, deviate from the straight line, not only as a result of asymmetrical development, but from traumatism.

Finally, in certain cases, an arrest of development may occur at the level of the bony framework, affecting the nasal bones as well as the ascending rami of the maxilla. These bony parts may fall in as a result of acquired syphilis. Traumatism may also result in a similar subsidence. Whatever the origin may be the result is a saddle-shaped

diminished either with the bistoury or the scissors; and if occasion requires, so that the nostril may not remain too wide as a result of this operation, a portion of cartilage is removed from the ala. When, on the other hand, the tip of the nose is prolonged downwards the length of the septum is diminished by the removal of a triangular segment, and the point of the nose raised by means of sutures. When the point itself projects above the general nasal profile it is brought back into line by an operation on the alar cartilage. Deviating noses are also corrected by way of the endonasal passage. If the deviation concerns only the cartilaginous portion, one or several small prismatic segments of mucosa and of cartilage are removed from the convex side of the septum. The remaining portions are carefully sutured, thus rendering the septum perfectly straight. (Fig. 3B.) If the whole nose deviates the frontal processes of the maxilla are

Photographs of Cases taken Before and After Operation.



nose (Fig. 4A). Other less common nasal deformities occur, but the foregoing will serve as a general outline. All varieties of unlovely nose can be corrected by intranasal operation without, that is, incising the cutaneous covering.

Operation.

This is always performed under local anaesthesia produced by an injection of cocaine-adrenalin. The mucosa is incised at the desired points; through the incision so made the skin is separated from the bony and cartilaginous framework, and the convexity or protuberance removed with a hand-saw. In certain cases an electric burr is employed. Finally, the skin is allowed to apply itself again to the underlying framework. (Figs. 1B and 2B.)

In pointed noses, when the tip does not descend properly towards the chin, the height of the nasal septum is

separated obliquely on each side with a saw from the body of the bone and the nasal bones are disarticulated from the frontal. The nose is kept in proper position by a dressing until completely consolidated. Saddle noses are corrected by a bone graft obtained from the crest of the tibia, of size corresponding to the thickness and length required. (Fig. 4B.) When the depression is slight it is readily remedied by an injection of solid paraffin, fusible at 60°C. In certain cases a small thing suffices to give to the physiognomy a more æsthetic appearance, such as the removal of a slight protuberance and raising the point of the nose.

Such are the outlines of the operative technique, and if a comparison is made of the photographs of patients before and after surgical intervention the results obtained may easily be estimated. In conclusion, I repeat that in the operation by the endonasal route there is never any visible cicatrix.