

I have decided not simply to close the thorax in cases in which exploratory thoracotomy has shown the disease inextirpable, but to divide the esophagus in proper distance from the upper pole of the tumor and then transpose the oral stump extrathoracically, after closure of the distal part by inversion and suture (one personal observation so far).

From my experience gained in six cases of esophageal resection for advanced carcinoma I should advise to leave alone an infiltrating carcinoma behind the aortic arch which covers several inches of the tube, when performing thoracotomy on patients who show symptoms of *complete obstruction for some time* prior to operation. Attempts at removal will greatly weaken the resisting power of these reduced patients and eventually force the surgeon to continue radical work much against his wishes. On the other hand, palliative work—division of the esophagus above the stricture, closure of the distal end and extrathoracic transposition of the oral stump, as described before—do not tax the patient to any extent and will brighten the rest of his life.

It is, as a matter of course, impossible at the present moment to say which method of extrathoracic esophago-

of the esophagus, or localized right at the cardia itself (scirrhus) and immediate esophagogastrostomy does not appear feasible on account of the distance of the proximal end, the excellent plastic and well-nourished material of Jianu's tube makes one wonder whether or not the excised lower portion of the esophagus or cardia might be immediately replaced by this tube if brought up intrathoracically into the pleural cavity through the foramen esophageum of the diaphragm or alongside the cardia which had been closed by sutures after the resection (Fig. 23), its free opening to be united by end-to-end anastomosis with the oral stump of the esophagus which otherwise remains *in situ* undisturbed (Fig. 24).

CONCLUSION

As stated before, intrathoracic esophagoplasty, when properly worked out, would seem to be an ideal operation. If further observations in man, however, should prove that the transposed oral stump of the esophagus, no matter how long, has no tendency to become necrosed in its distal portion, but will live, as a rule, further experimental work for the perfection of intrathoracic esophagoplasty will be less urgent and extrathoracic esophagoplasty will become the operation of choice for resection of carcinoma in any part of the esophagus.

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A CASE OF RHINOPHYMA SUCCESSFULLY TREATED BY "DECORTICATION"

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For the following reasons and others, I report the following case of rhinophyma. The photographs of the patient were taken before and after the surgical intervention.

1. This chronic disease of the nose, although it is not painful and occurs almost invariably in males, who, as a rule, are less sensitive than females to facial disfigurement, always exposes its victims to ridicule, often makes employment difficult to obtain and not infrequently hampers a patient's whole career. Hebra gave the name of "rhinophyma" to this disease.

2. Owing to the fact, that in the treatment of this affection, medicinal and other non-operative measures never give satisfactory results, patients soon acquire the erroneous impression that cure is impossible.

3. Though Ollier long ago demonstrated that pound-nose (called by him *éléphantiasis des buveurs*) can be successfully treated by decortication of the nose, that is, by removing the diseased tissues, by the aid of the thermocautery or cutting instruments, surgeons in general seem to ignore the fact that this unsightly deformity can be corrected by an operation of great simplicity and of unfailing efficacy.

4. Complicated operative procedures have been devised for and recommended in the treatment of hammer-nose. Being based either on inadequate knowledge or faulty interpretation of the pathology of this condition all such operative measures should be discarded.

5. Some diversity of opinion exists as to the etiology and pathologic anatomy of rhinophyma. Coplin, who made the histologic examination of the tissues removed from Keen's¹ patient, diagnosed the condition from the pathologic point of view as a soft fibroma of the skin

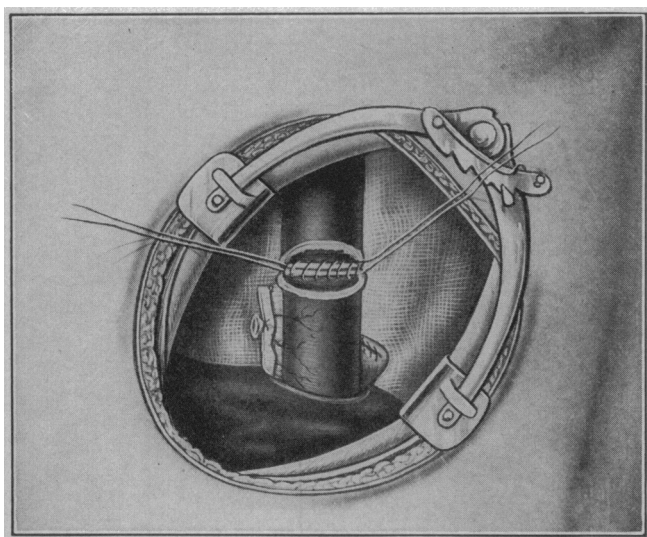


Fig. 24.—Inverted tip of Jianu tube released and cut off; redundant gastric mucosa clipped and both openings in process of end-to-end union by suture. There is splendid blood-supply up to the tip of the Jianu tube from the left inferior epiploic artery within the ligated major omentum, which latter always is to point toward the patient's right.

plasty will prove to be the preferable one. If the task of preventing regurgitation of stomach contents through the Jianu tube can be solved, then this method of gastrostomy and inferior esophagoplasty will be the operation of choice, principally on account of its simplicity and comparative absence of danger. If it will be shown, however, that this cannot be done and that the digestive effect of returning stomach juice will spoil plastic work that may become necessary later on, then the Wullstein-Roux method, or very likely Kelling-Vulliet's transposition of the excluded transverse colon will best be resorted to. At the present juncture it should be emphasized again that efforts of surgeons should be directed toward improving the functional working of Jianu's tube.

INTRATHORACIC ESOPHAGOPLASTY, EXPERIMENTAL

In cases in which examination previous to operation has shown the cancer to be located within the lower third

1. Keen, William H.: Rhinophyma, *Ann. Surg.*, 1904, **xxxix**, 685.

with distention of the acini and possibly a hyperplasia of sebaceous glands.

All observers are agreed that the diseased part presents an enormous hyperplasia of the connective tissue

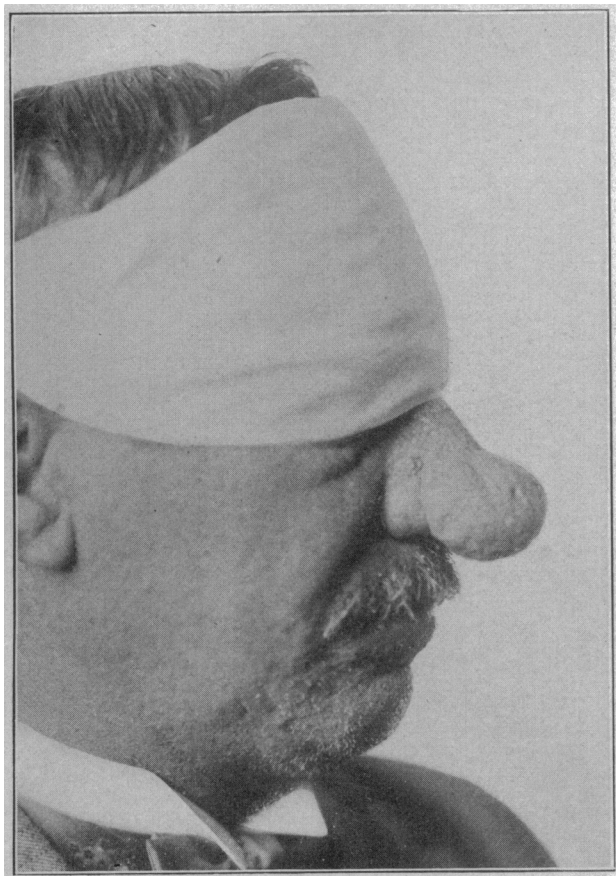


Fig. 1.—Case of rhinophyma before operation.

of the corium, a thickening, dilatation, tortuosity, a numerical increase of the cutaneous arteries, veins and capillaries and an increase and hypertrophy of the sebaceous glands, the excretory ducts of which show marked lengthening and dilatation. The latter is caused partly by the retained secretion, partly by the active hyperplasia of the glands.

History.—Mr. L., a Bohemian tailor, aged 48, married, was referred to me by Dr. Stulik for a nasal deformity which, according to the patient, made its appearance thirty-one years ago following an attack of chicken-pox. The patient eats lightly, drinks several glasses of beer daily, and does much walking. The family history is negative. The patient's health has always been good, and the physical examination, outside of the face and nose, is negative. The facial appearance frequently subjects him to embarrassment and mortification. Many physicians have treated the condition non-operatively with no improvement.

Examination.—The entire facial skin was seborrheic. The nose and the bordering cheek-areas were dusky red and presented a large number of thickened, dilated and tortuous cutaneous vessels, and many dilated, large, gaping sebaceous gland orifices, some of which were plugged with inspissated secretion. Many pustules, coexistent with acne rosacea, were on the cheek. The external portion of the nose was greatly hypertrophied; its tip consisted of a soft lemon-sized mass. The hypertrophy was limited to the superficial external portion and did not extend beyond the nasal orifice. The patient was sent to the hospital, was etherized, the eyes protected and the operative field (nose and cheeks) painted with tinc-

ture of iodine. Although decortication of the nose has been performed successfully under local anesthesia² (cocain, its synthetics, freezing mixtures, etc.), I prefer in these cases to use a general anesthetic.

Operation.—The index-finger of the left hand, introduced into one of the nostrils, stretched the soft tissues and held the thickness of the nose under control. This facilitated the modeling of the wings of the nose and guarded against the removal of too much tissue. The exuberant tissue masses on that side were then ablated with a sharp razor; the finger was introduced in the opposite naris and the same procedure repeated on the other side, care being taken during the entire operation not to injure the osteocartilaginous framework of the nose. The intent was to remove almost the entire diseased cutaneous portion of the nose, as the pathology of the disease is in this cutaneous covering. In rhinophyma, the nasal bones, the nasal cartilage, their fibrous covering and the endonasal lining show no apparent change and therefore should not be molested. To make the nose more presentable some paring was done here and there with scalpel and scissors, until the form of a normal nose was reached. It could easily be seen that the tissue removed contained degenerated and cystic sebaceous glands filled with epithelial debris and sebum. The operation somewhat resembles the whittling of a block of wood with a jack-knife.

Postoperative History.—The hemorrhage, profuse at first, was readily checked by compression with sterilized gauze. To prevent its recurrence, a hard-rubber nasal tube was introduced in each nostril, counter-pressure being thus secured from within against the pressure exerted from without by the gauze and bandage. The nasal tubes were removed in twenty-four hours. For the first forty-eight hours the postoperative treatment con-

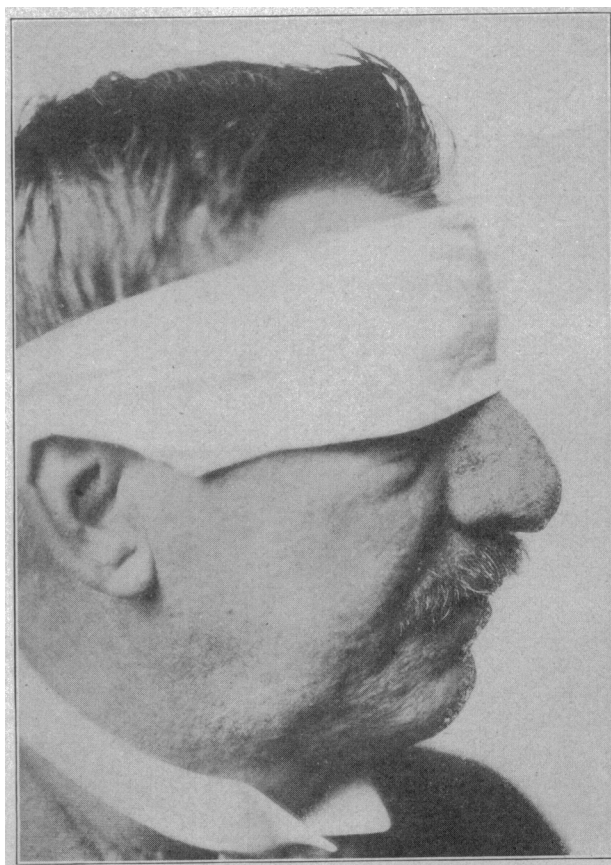


Fig. 2.—Appearance of patient after operation for rhinophyma.

sisted of hot boric compresses applied every two hours to the operative wound. After that time the part was dressed with calamine lotion. Recovery was uneventful. At the end of eight weeks the wound was completely epidermized.

2. Wood, James C.: Surg., Gynec. and Obst., 1912, xv, 622.

A number of points of interest are presented by this case of rhinophyma:

1. Its occurrence in a man whose occupation does not entail exposure to inclement weather, who is fairly moderate in his consumption of alcoholic beverages and who gives no history of gastric irritation or disturbance. The etiologic influence of alcohol is hard to determine; there are many alcoholics and but few cases of rhinophyma.

2. The fact that all but one of the patient's medical advisers (and he consulted a goodly number) seem to have been unaware of the relief which surgery offers in this condition.

3. The simplicity, safety, efficacy and short duration of the operative intervention, which consists in removing almost entirely the cutaneous covering of the nose, while carefully respecting its osteocartilaginous framework. A covering of greater or less thickness of the soft tissues must always be left. This direct operation is limited to the external superficial more or less modified parts. No complementary, autoplasmic or skin-grafting operation is performed.

4. The satisfactory result, which can be seen when the photograph taken immediately before the operation is compared with that taken shortly after the patient's discharge. The new complete skin-covering for the nose was derived from the dermal margins of the wound and from the epithelium of the abundant and deeplying remains of sebaceous glands.

In cosmetic surgery of the face I discard the thermocautery for the removal of exuberant tissues. It makes the employment of ether anesthesia dangerous. It has always seemed to me that the scar resulting from the cautery is less satisfactory from the esthetic point of view than the scar which results from cutting operations.

HAIR-BALLS OF THE STOMACH AND INTESTINE *

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The rarity of hair-ball coincident in the stomach and in the intestine has led me to report the following case, which also has an unusual symptomatology:

History.—The patient, H. C. A., aged 13, the daughter of a physician, with the exception of the usual diseases of childhood and a pneumonia at the age of 11, had always been in good health. When about 2 years of age she developed the habit of sucking her right thumb and at the same time twisting and pulling her hair with the left hand. At the age of 5, she was first noticed by her parents actually to put hair in her mouth and swallow it. This was observed occasionally in her up to her tenth year, but since that time it was thought that the habit had been discontinued and forgotten. She had always eaten heartily and digestion had been apparently normal until about one year prior to the present illness, when occasional attacks of stomach disturbance began, which were evidenced by stomach-ache, belching of gas, fetid breath, etc. These attacks, however, were not so frequent or so severe as to impress the parents as unusual.

Present Illness.—This began on the morning of July 19 with stomach-ache which was temporarily relieved by bowel action. Attacks of abdominal pain recurred during the day and night. She abstained from food during this time and there was no vomiting. Early the next morning, an attack of pain was

followed by vomiting of bile and a bowel movement. Castor oil was administered but was rejected. The father, while examining the abdomen at this time, discovered the presence of a large sausage-shaped tumor which occupied the area between the ensiform cartilage and the umbilicus and extended crosswise from the cardiac area of the stomach to the region of the pylorus. The tumor on palpation was movable and tender. Examination of the lower abdomen elicited some tenderness over the appendix but otherwise was negative. The nature of the mass was a matter of doubt until a tuft of hair vomited a few hours later recalled to the father's mind the habit of hair-eating, and at once suggested the diagnosis of hair accumulation in the stomach. Dr. L. F. O'Neill, of this city, who saw her in consultation, concurred in the diagnosis. Two more attacks of pain and vomiting occurred during the second night. There was no disturbance of temperature or pulse. I examined the patient for the first time on the morning of July 21, having been called with regard to an operation. The findings previously described, together with the history, seemed to make the diagnosis clear.

First Operation.—This was performed at the Auburn City Hospital, July 21. A midline incision above the umbilicus exposed the stomach, which was seen to be the container of the mass. An incision about 3 inches in length was then made through the anterior wall of the stomach near the cardiac end, and through this a mass of firmly packed hair mixed with food particles and mucus was extracted. The hair tumor, which completely filled the cavity of the stomach and had adapted its form to the contour of the greater and lesser curvatures, weighed on removal 15 ounces. It measured $7\frac{3}{4}$ inches in length, $2\frac{1}{2}$ inches in diameter, and 7 inches in circumference. The stomach incision was closed by three layers of continuous sutures, catgut in the mucous and muscular coats and linen in the peritoneal. The appendix was examined through the same incision, found to be thickened and injected, and was removed.

The patient, at the conclusion of the operation, was in good condition, and continued so for the next thirty-six hours. During this time two bowel movements occurred, one spontaneously and one by enema. About 6 p. m. July 22 she vomited nearly a quart of bile-stained fluid, and at 9:30 a like quantity of similar fluid. High enemas during the night resulted in free expulsion of gas with some fecal matter. No further vomiting occurred until 11:15 the morning of July 23, when, after the administration of 2 drams of calcined magnesia, she again vomited about a quart of bile-colored fluid. Castor oil was given an hour later and was retained for nearly six hours, when vomiting of about 8 ounces of bile-colored material mixed with oil occurred. After two further recurrences of vomiting and with distention of the abdomen beginning, it became evident that we had to deal with some form of ileus and that an exploration was indicated.

Second Operation.—The abdomen was opened through the original incision, at 5 a. m., July 24. As the patient seemed physically depressed an intravenous transfusion of normal saline solution was given during the operation. The seat of the gastrotomy was inspected and found satisfactory. No obstruction was found in the pylorus or duodenum, but a firm, movable mass was discovered in the ileum from which a firm mat of hair measuring 3 inches in length and completely occupying the lumen of the bowel was extracted after enterotomy.

Postoperative History.—The patient showed some evidences of shock, but reacted promptly. No further vomiting occurred. The bowels moved freely during the first twenty-four hours succeeding the operation. Liquid food was begun at the end of eighteen hours and was well borne. With the exception of some fat necrosis in the line of the incision, the convalescence was uneventful. She was removed from the hospital to her home on the eighth day following admission. Since recovery from the operation she has been free from stomach symptoms and has gained 10 pounds in weight.

The presence of a hair-ball, hair-tumor or trichobezoar, as it is variously termed, in the human stomach,

* Read by title before the Medical Association of Central New York, at Auburn, Oct. 30, 1913.