

EXTENSIVE KELOID OF MASTOID WOUND
CICATRIX.*

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The patient first presented himself at the clinic of Dr. Kenefick, at the eye and ear infirmary, about four weeks ago. At the time, as a matter of record, Dr. Dickson took a picture of the condition (Figure 1). The case was presented before the section to show the extensive keloid development, which seems to be quite unusual following a mastoid operation. There was no history of any keloid growth or hypertrophy of any scar tissue in the family.

The patient was twenty-seven years of age, born in Austria, and came to this country at the age of eighteen. He had had typhoid fever, but otherwise had always been well.

Two years ago, after acquiring a severe cold, the patient had a pain in his right ear, and for a short time there was a purulent otitis media. Three months later a mastoidectomy was performed at St. Mark's Hospital. After dressing the wound for about four months, the upper part healed, leaving a small wound open at the bottom, which soon healed. The tumor subsequently began to develop along the entire line of the incision. In the beginning there was an entire absence of sensation to touch, both of the ear and over the mastoid area, but during inclement weather there was a prickling and tingling sensation.

There were no scars upon the patient's body, but there were three or four on the fingers.

The tumor was two and one-half inches in length, one-half an inch wide at the base, and three-quarters of an inch wide at the top. The surface was slightly irregular; the consistence,

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firm. There was a sharp margin to the healthy skin, and no overlap at the base, excepting a small tip at the lower end.

About nine months ago the patient received a series of X-ray treatments, the duration of each being about two minutes. The last treatment was given six months ago.

It has been customary to divide keloids into two varieties—the false type, which occurs as the result of scratching, injury, burn, or syphilitic scar, and the true keloid, believed to originate in normal uninjured skin; but the case presented is apparently spontaneous, although it may be the result of a slight injury, as scratching, the occurrence of which is entirely forgotten. The tumor develops in those who show congenital or racial predisposition, and is especially prevalent among the negro race.

Workers agree that a keloid consists of horizontal strands of fibrous tissue which originate from the corium, the long axes of which lie parallel to the skin. The vessels are atrophic or completely absent. Hair follicles, glands and muscles are absent or pushed to the side of the growth. Keloids have no capsule, but merge imperceptibly into the surrounding connective tissue. They generally run a very long course; resolution is possible by simple absorption of fibrous tissue, but the tumor will most frequently recur after excision.

Successful treatment for the removal is not as satisfactory as may be desired. Surgical removal, preceded and followed by the X-ray, has given some good results. Electrolysis, cauterization and excision have been of little avail, as the growth has returned with renewed force and increased size. Partial success has been reported with hypodermic injections of fibrolysin (thiosanamin) and glycerin and water. Perhaps as good a therapeutic agent is the application of radium. A report of twelve cases by Dr. Frank Simpson of Chicago shows some good results. The dosage is determined by experience, and the most insistent keloids have been made to disappear by the more or less destructive action of the radium.



FIGURE 1.
Extensive keloid of mastoid wound
cicatrix.