

## AN UNESTABLISHED INCISION FOR THE RESECTION OF THE NASAL SEPTUM OR AN ALL-SKIN INCISION.\*

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I appreciate the honor your secretary has conferred upon me by the invitation to read a paper on the all-skin incision for the resection of the nasal septum, and I feel that I am assuming a great responsibility in accepting it, because of the technical perfection of the septum operation, both by American and European surgeons. Your society would not be interested in a discussion of the merits of ways of performing the submucous operation by American surgeons over German rhinologists. Neither would you be interested in a review of the classical operation nor the classifying of kinds of deviations, but I believe all of you will welcome any suggestion that will lessen or eliminate entirely the complications following resections made by any of the mucous membrane incisions.

In this short paper, I shall endeavor to point out the difference between mucous membrane incisions and the all-skin incision. I am familiar with the complications that may follow submucous resections, because I believe I have experienced practically all of them. Some operators seem to underestimate the difficulties of complete septum surgery, and many minimize the complications. With the advent of the submucous operation as developed by Freer and Killian—which had as its main objects the eradication of all obstruction, or rather restoration of nasal breathing—it might have been thought that a new era would have opened, as it did in the treatment of appendicitis by surgery. This has not been the case, and there are nasal surgeons treating nasal stenosis in the same antique way, by sprays, cautery, operations on the turbinates, and worst of all, by incomplete and ineffectual septal surgery.

I propose to discuss the various incisions from the standpoint of clinical results. The objections to the Hajek incision are that it does not give access to the deeper parts, especially to the bony parts, and being in the mucous membrane, on or near the free border of the septum, is followed by a prolonged scabbing. The objections to the Killian are the dangers of a permanent perforation when the cartilage is cut through, limited room for instrumentation, which

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leads to incomplete work, and a tendency, I might add a certainty, to scab formation. The Killian incision seems the most popular, and I am sure, the easiest. The Freer incision is the best planned and has the merit of being developed on sound surgical principles—free access. While this gives ample operative interference, yet in my experience, it is followed by extensive and prolonged scab formation. The genius and cleverness of Freer are evident in all his work and writings, but he is open to conviction. The possibility of dryness and scab forming following his incision has prompted him to make changes from the original incisions. The last operation I saw him do, he placed the vertical cut far back on the septum—near the middle turbinate. In St. Louis, in 1910, before the Section on Laryngology and Otology, I advocated, and at that time practiced in order to prevent scabbing, placing the vertical cut far back on the septum, but the horizontal cut was made in the muco-cutaneous structure. Freer and I had changed the vertical cut unknown to each other, but I had changed the horizontal cut nearer the skin in the free border. I felt I had the drawbacks of the operation sewed up in a sack. How quickly I was disillusioned! Wherever I cut the mucous membrane, scabbing and disagreeable feelings always followed. While I got perfect breathing, because I did not stop till I completely removed all of the obstruction, however far back it went, I was disappointed. The patients invariably complained of some disagreeable sensation, either dryness, scabbing or something else. They get the habit either of forcibly blowing out these crusts or removing them by picking with the finger or a toothpick. Personally, I do not know the discomforts of nasal stenosis, but I feel quite positive I should prefer to have the stenosis remain, rather than to have regrets from a septum operation. It strikes me that the scabbing would be just as annoying, or worse, than the stopping up.

As I have for a long time contended, I believe the initial incision is the key to a successful submucous operation. For I believe the patient's comfort and satisfaction after the operation depend upon the character and kind of initial incision.

It takes but a few words to describe the all-skin incision as I now place it. Beginning on the floor of the nose opposite the attachment of the inferior turbinate, the incision is carried forward to the tip of the nose, being sure all the while that the incision is in the cutaneous septum, and not in mucous membrane. In extreme anterior deflections, I have begun the incision near the junction of the inferior turbinate on the lateral wall. However, there is no crusting when the incision is started in the middle of the floor, provided that

you cut entirely within skin tissue. I use this method in all deflections, however deep in the nose they are located, when it is decided best to do the submucous resection. This may be thought unnecessary surgery, but my results justify me in this method of approaching the obstruction, and too, results justify the extra labor and time taken. As is well known, the dissection is much harder in this region than in mucous membrane, because of the fibrous nature of the tissues, and the tenacity with which they cling in this region. Too, there is more bleeding than in the purely mucous membrane cut. The thick skin covering the foremost, lower part of the septum, does not favor the penetration of cocain, so that little anesthesia is obtained by applying the drug to the surface. I have employed subcutaneous injections of a solution of cocain here, but of late have given them up, for they cause as much pain as the cut itself. It will soon be three years—to be exact, in August—since I began the use of the all-skin incision. In not a single case has there been a complaint of even dryness. The results have been so ideal that I am very enthusiastic and the submucous operation has been robbed of the terrors of scab forming. This incision does not and cannot deserve the name of buttonhole cut and, moreover, is sufficiently ample to carry the resection far back into the bony septum, even where the crista and vomer require extirpation along the nasal floor.

In order to be certain that I have not deceived myself in my enthusiasm over results of the cut thus placed, I have had my confrere, Dr. C. H. Johnson of our city, see a number of cases and he commented that it was practically impossible to find the line of incision. He also noted the freedom of complication of my cases.

I am herewith quoting a letter from him, which states in a few words all I claim for the all-skin incision:

Dr. C. E. Purcell, Paducah, Ky., Dear Dr.:

I wish to acknowledge a debt I have owed you for some time. You recall, don't you, showing me your latest incision in the submucous operation? It appealed to me at the time, and after using it, my first impression has changed to conviction. I now use it in every case and the end results are all that can be desired—no complaint from patients of any kind so far. The line of incision heals without the aid of sutures, and, best of all, no crusts or scabs form.

Yours truly,

C. H. JOHNSON.

Fraternity Building.