WHAT CONSTITUTES PROPER NASAL TREATMENT IN CHRONIC EAR DISEASES? *

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A patient, who recently had adhesions loosened in both ears under general anaesthesia, consulted me presenting letter from a prominent aurist, stating that with appropriate nasal treatment favorable results might be expected. This patient had also been treated some weeks in Vienna. Inspection revealed a septal spur too large to allow a catheter to pass. This case following several similar experiences suggested the title of this paper.

Universal as our literature is on the necessity of correcting nasal deformities, in practice the world over, today with the exception of comparatively few men, only the grossest deformities seem to receive attention no matter how severe the symptoms. Dr. E. Pyncheon's paper before this society last year (*LARYNGOSCOPE*, July, '03) probably describes an ideal nose as nearly accurate as our knowledge will permit. Such discussions must ultimately lead rhinologists to accept a somewhat uniform standard of practice, which will redound much to the credit of this branch of surgery, much more to our patients.

From observation, I believe when there is a catarrhal inflammation in the middle ear resulting from, or associated with a similar condition of naso-pharynx, nothing short of an anatomically and physiologically perfect nose will suffice to permanently check the condition, providing the patient continues to reside under the same environments, which most people will do. There is no deformity, however small, but to some extent influences respiration. This, while the patient is under observation in the office, may be unimportant, yet under less favorable conditions as sudden change of temperature, moisture, altitude, recumbent position, indigestion, etc., this trifling obstruction, for the time being becomes a decided one. Though the effect of such irritation be but temporary in the nose, its frequent occurrence sooner or later sets up changes in the ears which do not subside so readily, till one following another becomes a chronic, continuous irritation in itself.

A prominent factor but little dwelt upon in the etiology of otitis is:—if any nasal obstruction exists, during inspiration there is in

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direct proportion to the obstruction a negative pressure produced in the naso-pharynx. This produces rarefaction in the middle ear and collapsed ear drums. This same vacuum must produce a turgescient condition of the tubes, thus maintaining a pathological condition in the middle ear. That a lessened air pressure will produce this condition while there is no direct evidence of it in the respiration, may be demonstrated by the dullness of hearing produced in many while ascending considerable heights; many people especially after having their attention drawn to it will experience this condition in crossing the mountains on a train. Accustomed as I am to high altitudes, I always experience it when traveling. That this cannot be due to the change of pressure directly on the ear drums is shown by the fact, that if no other factor existed the pressure must be equal on both sides. The frequent cases of epistaxis and menorrhagia in those first moving to high altitudes prove the engorged condition of all mucous membranes. The changes in circulation alone are not sufficient to explain all the phenomena.

There remain few aurists who doubt or dispute the nose as an etiological factor in this condition; as practically all admit it, then how should it be treated. The excuse given for non-surgical interference is that many deformities produce no symptoms, which is true, but these people do not consult us for treatment. It is, therefore, of patients who have some symptoms, however mild, already existing of whom I speak; and I may add the milder the symptoms in the ear the more urgent and the better the results of immediate, thorough, radical treatment of the nasal condition. To quote from paper previously referred to, "As structural deformity of some kind will be found present in the noses of all, or nearly all who apply for relief from the nasal trouble, the rhinologist will do his patients the greatest amount of good by taking such steps as will cause the nasal passages to resume the conformation and patency of the ideal standard.

Probably the most frequent obstructions are septal spurs, usually small and opposite the anterior end of lower turbinate or may be situated any place. Small hypertrophies in this locality are so frequent they might almost be considered normal if it were not for the decided improvement often following their removal. Before adapting the method of retaining the mucous membrane, it was a question often whether to risk the removal of what on examination appears to be an inoffensive enlargement, but with this method though longer time is taken in operating, the reaction is so slight, pain so little, recovery so rapid and complete that there remains no reason for taking any chances of their producing further trouble.

One suggestion in regard to technic. After cleansing and cocainizing, the mucous membrane is elevated; a small spur may be quickly removed with Freer's sharp cutting spud or dissecting knife or a burr, the larger ones with saw, trephine or chisel; in any event the subsequent use of the burr will remove any ragged edge and make a smooth surface to which the mucous membrane adheres and heals more readily. In deflected septum, possibly the submucous dissection is the ideal method, and especially so if complicated by much hypertrophy. A modification of Gleason's operation in most of cases has given me such good results, I feel loath to abandon it. I continue both upper ends of the incision, cutting entirely through the cartilage if possible, protecting the skin by raising it with thumb and finger of other hand. This makes a longer flap and completely destroys its resiliency. I use no plugs for after treatment at all, finding them not only unnecessary as a rule but objectionable. For enlargement of middle turbinate, the scissor and snare, and for lower turbinate the saw and scissor, removing only sufficient of the edge as described by C. R. Holmes (*N. Y. Med. Journ.*, Sept., '00) will complete either operation from a fraction of to a few minutes' time, especially if a mechanical saw be used. The De Vilbiss saw is small enough to engage, and will easily remove any portion of the lower turbinate in a few seconds. With motor and mechanical saw, the time and consequent pain, hemorrhage and fatigue experienced in cutting thick or hard bone anywhere is eliminated, thus simplyfying the operation.

With skill and practice any of these deformities can be corrected in a strictly surgical manner in but a few minutes' time longer and with as little pain and discomfort as would require for a single application of any of the less radical remedies. The risk and disagreeable results immediately following is of course greater, but the use of an adrenalin and resorcin spray to control hemorrhage, immediate application of orthoform powder to relieve pain and some form of menthol spray is less objectionable than the necessity for frequent irritating applications that at best have but a temporary effect.

The time to operate in most of these cases is at once. Except where there is positive danger of infection, the patient who is operated on before leaving the chair fares infinitely better than the one who takes days, weeks and more likely years to consider some dreadful operation to be performed. Assuming the patient has come for treatment and circumstances will permit of avoiding heavy manual labor a day or two should it be necessary, a few words of assurance, careful application of the anæsthetic, a skilled manipulation of the instruments completes the worst feature of the case. The patient

gains confidence instead of fear and the after treatment or other operations are done without trouble or anxiety. Of course, in case of immediate operation there must be no possibility of a doubt as to the procedure. Where doubt exists, then the case must be first studied. I doubt the utility of prolonged preparatory treatment to render a surface aseptic that of necessity must constantly be exposed to new sources of infection every moment. Also, any after treatment which prohibits the free escape of secretions is to be avoided when possible. In cases where systemic reaction has followed in my practice it has much more frequently been when I have used packing.

When it is necessary to attack soft tissue only, punctures with cautery point are preferable to the use of acids as a rule, being more easily handled and less painful. In every case it is individuals with whom we have to deal, not isolated portions of anatomy, so there can be no positive rule to which there are not many exceptions.

In conclusion, would suggest that when nasal treatment is indicated as a remedy to lessen or check middle ear inflammations nothing short of anatomically and physiologically perfect nasal chambers be aimed at. That those methods of procedure be recommended that will accomplish the most thorough and permanent results in the least possible time with proportionally the least danger. That unless there are positive indications to the contrary immediate surgical treatment should be advised and operations be repeated as often as considered safe till no obstruction remains, irrespective of size or number of obstructions present.

The Treatment of Granular Pharyngitis and of Pharyngitis

Lateralis—J. HERZFELD—*Monatsschrift f. Ohrenheilkunde*—May, 1904.

The author has devised a forceps having an oval, fenestrated cutting extremity, for removing small masses of adenoid tissue, (granulations), from the walls of the pharynx.

YANKAUER.