SERIOUS SYMPTOMS ARISING FROM RETENTION OF NASAL DISCHARGE.

By Dr. Middlemass Hunt.

Miss H., aged twenty-three, was sent to me on Sept. 7 of this year as a probable case of malignant disease of the nose. The history she gave was that in November, 1890, she had a severe cold in the head with all the ordinary symptoms, except that there was an unusual amount of pain in the left eyeball and forehead, and that though the right nostril soon got well, the left continued to discharge a thin yellowish fluid which afterwards became thick and purulent, and had a very disagreeable odour. The left nostril gradually became more obstructed, and at last no air could be got through it. The pain in the eye, in the cheek, and across the forehead became also more severe, so that she could not sleep well at night, and could not read beyond a few minutes at a time. Pain was almost constantly present, and always got worse towards evening. For some months too the lachrymal duct had been obstructed, causing the tears to run over her cheek, and she had lost her sense of smell.

The appearance of the patient certainly gave one the impression that the case was a serious one. The left side of the face was swollen as a whole, and especially along the side of the nose; the left eye appeared to protrude, and had a dark discolouration under it, which had been noticed by her friends for two months previously. The entrance of the left naris
was filled by what looked like a large pale growth. The patient was very anaemic and thin, having lost much flesh since the commencement of her illness.

The supposed nasal growth was easily pushed aside with a probe, as it was only a fold of hypertrophied oedematous mucous membrane, springing from the external wall just below the anterior end of the middle turbinate. It formed a very effective valve to prevent the escape of the stinking mass of putty-like or cheesy material which filled every part of the nasal cavity beyond. The smell was most offensive, and made the business of scooping out the collected secretion extremely unpleasant. After thoroughly clearing the cavity, which I did not finish in one sitting, and the free use of an antiseptic nasal wash, all the symptoms disappeared and the discharge ceased. I also destroyed the fold of mucous membrane which had caused the obstruction by repeated applications of the galvanic cautery.

The above case corresponds in almost every particular with the following one which had come under my notice a year previously.

Mrs. G., a widow, aged fifty-five, was sent to me in August, 1890, suffering from right-sided nasal obstruction, with slight, but very foul-smelling, nasal discharge. The discharge had begun a year previously with pain in the right side of face, in right eye and forehead, following an attack of acute nasal catarrh.

For some months past the nasal obstruction had been complete, and "a growth," which bled freely on being touched, had appeared at the entrance to the right nostril. The neuralgic pains in cheek, eye and forehead had of late become very severe, disturbing her rest, and she became greatly reduced in her general health.

Her medical attendant had diagnosed syphilis, and treated her vigorously with mercurials till her teeth became loose and her tongue ulcerated, but without producing any effect on the nasal obstruction or the neuralgic pains.

The patient looked pale and thin, and there was considerable deformity of the face, produced by the swelling of the cheek along the right side of the nose. She also suffered from epiphora.

The entrance to the nostril was obstructed by a fold of hypertrophied mucous membrane, as in the former case, but here it was bright red in colour and eroded on the surface, so that it bled freely on being pushed aside by the probe. The nasal cavity was filled throughout by the same foul-smelling, cheesy material. After clearing this out, and snaring the hypertrophied mucous membrane, all the symptoms disappeared under the use of an alkaline and antiseptic nasal wash. There was no dead bone nor ulceration inside the nose, beyond the superficial erosion already referred to.

Both the above cases have been examined by me quite recently, and remain free of any painful symptoms or disagreeable discharge.

The sequence of events in the above cases appears to have been as follows: An acute nasal catarrh, extending to one of the accessory cavities, most probably the frontal sinus, with swelling and inflammatory hypertrophy of the mucous membrane, leading to gradual occlusion of the
nostril and retention of the discharge, which gradually filled the nasal cavity, became inspissated, and, through pressure, gave rise to pain and deformity. Disease of the antrum is excluded by the cessation of all symptoms after the removal of the obstruction.

The Eustachian Bougie.

By W. Robertson, M.D., Surgeon Throat and Ear Hospital, Newcastle-on-Tyne.

I am bound to say, from all I hear and read, that this is a much neglected and abused instrument, and will certainly come into more frequent use, notwithstanding that (pro tem.) English and American aurists have come to discontinue its employment. The obvious reason for this is no doubt the fear of laceration of the mucous membrane of the Eustachian tube, and the subsequent aerocele developed in neighbouring parts, or the development subsequently of otitis media purulenta. Such results have happened, and are recognized. These, however, have occurred where Politzer’s bag has been employed to subsequently douche the tube after the use of the bougie.

The following detail of what I have found to be invariably a perfectly harmless method of using the Eustachian bougie may form the basis of remarks. Premising of course that there is no inflammation of the middle ear, no redness round the margins of the drum, or red streaks down the handle, and that the case is otherwise suitable—no adenoid growths, Eustachian synechias, etc.—the nares and post-nasum are gently irrigated with a mild carbolic lotion. An Eustachian catheter (Continental form) is introduced, and Lucae’s air douche is used (with Hartman’s insufflation capsule attached, filled with granules, composed of menthol, iodine, and camphor) to inflate the ear, the otoscope being used to determine results. The air douche is now detached, and a two per cent. solution each of cocaine and resorcin in distilled water (a few drops) is injected into the catheter, and blown up into the tube by the air douche. The bougie, well cleansed and marked to protrude about two centimetres beyond the beak of the catheter, is now carried up the tube; its arrival in situ being recognized by means of the otoscope by a gentle click. The bougie is left in situ for ten minutes or so, and withdrawn, and Lucae’s air douche is applied with perfect confidence. In common with others, I suppose, I have to record mishaps after the use of the bougie when I employed Politzer’s bag subsequent to the withdrawal of the bougie. In some way or other abrasions of the tubal mucosa must have been effected and allowed entrance of air (to surrounding parts, down the lateral wall of pharynx and in front of the epiglottis, etc.) driven too forcibly by means of Politzer’s bag. Since the disuse of Politzer’s bag, and under the same circumstances, I have had no accident to record since adopting Lucae’s air douche instead. With this reservation, I have no hesitation in saying that with ordinary precaution the procedure is devoid of risk. After extensive experience, such has been the case in my own practice. A