CORRESPONDENCE.

A CASE OF PYORRHOEA ALVEOLARIS FOLLOWING OPERATION UPON THE NASAL SEPTUM.

To the Editors of THE LARYNGOSCOPE:

DEAR SIRS—In the May number of THE LARYNGOSCOPE I was interested in reading an article on "The Relation of the Teeth to the Ear, Nose and Antrum," by Dr. O. F. Gambati.

The importance of this relationship was impressed upon me this past winter by the following case, which, on account of its rarity, will, I trust, warrant the liberty I take in reporting it:

Mr. N., aged 40 years, applied for treatment December 10, 1896, for the relief of a long-standing catarrh and nasal obstruction. Examination of the nose revealed a large spur on the right side of the septum, posteriorly, constituting a true exostosis. On the left side was found another spur, corresponding almost exactly to the one on the right side, except that it was longer in its antero-posterior diameter, involving a part of the cartilaginous septum.

In both cases these spurs were situated sufficiently above the level of the floor to make their removal with the saw comparatively easy.

I emphasize the point of their position in relation to the floor of the nose to show that there was no possibility of injuring this region during the operations.

I first removed the spur on the right side. Following the operation there was no reaction, except a rather severe neuralgia, affecting the teeth of the upper jaw, which disappeared from all the teeth by the second day, except from the first upper right incisor, at which time the patient noticed also that this tooth was loose.

I referred him to his dentist, who wrote me that he found nothing abnormal and could not account for the pain and looseness, unless it was dependent upon the operation. The pain continued until the fourth day following the operation, when, on examining the mouth, I noticed a swelling and redness at the base of this tooth, posteriorly, and on incision found a considerable amount of pus. After this the pain ceased, and in a few days the tooth was perfectly firm.

One month later I removed the spur from the left side. The same neuralgic pain followed the operation, becoming centralized in the first *left* upper incisor. Practically the same clinical history repeated itself—the loosening of the tooth and formation of pus, the

evacuation of which stopped all symptoms—and five months after the operation the teeth appear perfectly normal.

The condition of the Pyorrhœa Alveolaris is usually due to the accumulation of tartar, resulting from neglect of the teeth. Sometimes it occurs after the death of the nerves, or its removal by the dentist. In either case it is usually a chronic condition.

In my patient, however, these conditions did not exist, and, moreover—the sudden appearance following directly upon the septul operation—the involvement of the incisor on the same side of the median line corresponding to the side of the septum on which the spur was located and from which it was removed, make it self-evident that the condition was dependent upon the nasal operation, perhaps by the injury of the naso-palatine nerve as it crosses the septum on its way to the Ant. Palatine Foramen.

That a neuralgia affecting the teeth should follow this operation is not surprising or uncommon, but the complication of a true pyorrhœa is not so easy of explanation, and I have been unable to find any mention of such a condition following this operation.

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Pyæmia and Sinus Thrombosis. Dr. Leutert (Halle). *Archives of Otolaryngology*, April, 1897.

The conclusions arrived at by the author are: 1. That pyæmia without sinus thrombosis has not as yet been shown to exist, and can be excluded in making the diagnosis. 2. The diversity of metastasis following sinus thrombosis in acute and chronic otitic suppurations is explained by the various kinds of thrombi. 3. In every case of empyema of the mastoid following an acute otorrhœa and where the temperature is 39° C or over, notwithstanding free drainage from the tympanium, we should operate and expose the sinus. 4. In acute cases, if the fever has not fallen on the third day or after a fall of temperature, high fever again sets in with or without chills, the sinus should be freely opened. 5. If the case is acute and high fever has existed for several days, or, in a chronic case, if high fever appears for a number of days, even if the mastoid involvement is not marked, the sinus should be opened at the first operation, meningitis must be excluded by lumbar puncture. 6. High temperature in small children has not the same diagnostic significance, but the possibility of a sinus thrombosis must be kept in mind. 7. Isolated thrombi at the jugular are usually caused indirectly by bacteria which have passed through the diseased sinus wall. M. D. L.