

TORONTO ACADEMY OF MEDICINE.

SECTION OF OPHTHALMOLOGY AND OTO-LARYNGOLOGY.

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DR. R. A. REEVE, CHAIRMAN.

PRESENTATION OF CASES.

Ear Case for Diagnosis. By PERRY GOLDSMITH, M. D.

Case of young man with almost total occlusion of the external auditory canal, due to fibro-cartilaginous or inflammatory overgrowth. The Doctor intends to allow the swelling to subside and then to do a radical operation.

DISCUSSION.

DR. WISHART thought that the pit over the mastoid tip on one side was most probably due to retraction after removal of the bony tip. The facial paralysis in this case was interesting as a radical operation had not been performed.

Papilloma of the Nose. By PERRY GOLDSMITH, M. D.

Hypertrophic Folds in the Mucous Membrane of the Septum Mistaken for Spurs. By PERRY GOLDSMITH, M. D.

Case of Frontal Sinus Disease. By J. PRICE-BROWN, M. D.

This case had already been reported and was shown to the Section so that the members might note the present condition. Two and a half years had elapsed since the doctor did a radical operation by which a running discharge from the site of a former operation beneath the eyebrow had been cured. The patient was under observation after recent removal of a synechia that had formed in the corresponding nasal cavity, and which was in process of healing. During the interval of over two years since the operation upon the sinus no treatment had been required.

DISCUSSION.

DR. GOLDSMITH thought the case an interesting one. The diagnosis in his opinion was not quite clear. Evidently there had been a frontal periostitis due to sinus disease, frontal or ethmoidal. Removal of dead bone had allowed the inflamed wound to heal. Drainage into the nose he thought still imperfect. He would resect the

septum so as to drain better and if necessary curette the ethmoid cells. Of course, if the discharge was slight, and the patient satisfied, he would let well enough alone.

DR. WISHART congratulated Dr. Brown on the cosmetic effect as there was no deformity and the scar was very slight; but as there was some pus in the nose, he considered this objectionable. He thought more space in that nostril was essential. The pus probably came from the anterior ethmoid cells for which a Killian's operation or a modification of it offered the best results.

DR. REEVE, who had assisted at the operation thought that the anterior ethmoid cells were well cleaned out at the time.

DR. STEWART did not believe that external operations upon frontal sinus cases should be undertaken too lightly. He would first remove the middle turbinate. This gives good drainage and in most cases is sufficient.

DR. PRICE-BROWN, in reply, said that prior to the operation on the sinus, he had removed the anterior end of the middle turbinal, and also the lower half of the inferior turbinal, as that side was almost completely occluded. The anterior ethmoid cells were also partially removed by drill as noted by Dr. Reeve. The present defective space and drainage were due to the irritation caused by the removal of the synechia and would be of a temporary character. As this receded, he believed the space would be ample for drainage and ultimate cure without further operation.

Cases of Nose, Throat and Ear Disease which Produced Orbital Symptoms. Reported.

DISCUSSION.

DR. STEWART quoted one in which there was swelling of the inner angle of the orbit, accompanied by optic neuritis and blindness on that side. On removing the middle turbinate, which was cystic and obstructed drainage, there was a gush of fluid from the fronto-ethmoidal cells, giving relief to the prominent symptoms.

DR. McCULLOUGH had seen two cases of suppuration of the ethmoid associated with optic neuritis. He had also seen two cases of nystagmus with involvement of the semi-circular canals.

DR. COLIN CAMPBELL read notes of two cases of recurrent iritis of such frequency as to cause disability. In one of these there was blindness for a year. Both had septic tonsils. After complete tonsillectomy there had been complete cessation of iritic symptoms.

DR. REEVE quoted a case in which he had operated for cataract. Some time later the patient developed a follicular tonsillitis, which

was followed by a violent iritis in the eye he had operated upon. The tonsil on that side was removed. Some months later tonsillitis in the remaining tonsil occurred which was at once followed by a fulminating iritis in the corresponding eye. Removal of the tonsil prevented further attacks. He always examined the tonsils in iritis of obscure origin. He knew also of cases of asthenopia which owed their origin to the pressure of carious teeth.

Dr. Royce quoted cases in which after mastoid operations, the cap of the horizontal semi-circular canal having been removed, there was horizontal nystagmus.

January, 1910.

PRESENTATION OF CASES.

Mastoid Operations with Healing by Blood Clot. By PERRY GOLDSMITH, M. D.

The only complication in this case was a slight facial paralysis ascribed to exposure. The doctor had been unable to find any antrum, but suppuration within the labyrinth was dealt with.

Adenoids and Tonsils. By T. ALEXANDER DAVIES, M. D.

The writer reviewed some interesting historical facts, showing that history may be said to repeat itself even in the surgical world.

Czermak, in 1860, was the first to observe and describe adenoid enlargement in the naso-pharynx, and the term "adenoid vegetation" was first applied by William Meyer, of Copenhagen, in his exhaustive treatise in 1868. A thorough curettage with a Gottstein curette or suitable modification of it was the method of operating advocated by the writer, stress being laid on a careful selection of the size of the curette-blade which should be as long as the pharynx is wide.

In Ballenger's new work, published last year, on the subject of "Tonsils and Adenoids," his radical methods are much in evidence; that this is no new departure from that of old famous surgeons can be shown by reference to the work of Celsus, who, in A. D. 10, advised removal of tonsils by enucleation with the finger or by means of hook and scalpel. Aetius, in A. D. 490, Paul Aegina in 750, and Albucasis in A. D. 1120, advise similar operations. After that the operation seemed to fall into disuse, and in 1509, the dread of removing the tonsils was so great that Paré advised tracheotomy when serious enlargements of tonsils existed and gave a hint of ligaturing the hypertrophied glands but made no remark as to their excision. Dionis, in 1672, recognized a physiological import-

ance in the glands, and condemned any kind of removal. Heister, in his popular text-book in the eighteenth century, said this operation was not only too severe and cruel, but also too difficult of performance to come into practice among the moderns, because of the obscure situation of the tonsils. It was not until the latter half of the eighteenth century that tonsillectomy became a recognized surgical procedure and from that time operators began to improve instruments and invent new ways of performing the operation. Scissors were first used by Louis, in Paris, in 1774, and to-day are used in a modified form in Robertson's operation. To Benjamin Bell in America, in 1783, we are indebted for the tonsillotome, which was simply an enlargement of the uvulotome invented by Dr. Bell. Dr. Physick, of Philadelphia, was the first to use the tonsil guillotine and it is this instrument, with some slight modifications, which we to-day call McKenzie's tonsillotome. Fahnstock, of Lancaster, Pa., in 1832, devised an instrument which he called a "sector tonsillarum." Guersane, of Paris, 1864, altered the shape from circular to elliptical, and on the suggestion of Veldeau, added the forks. With some slight modification, this is the Mathieu tonsillotome so frequently used to-day, but often with eventually unsatisfactory results.

The radical methods for the extirpation of the doomed tonsils advocated by our Chicago confrères, seem to be taking a firm hold on many of our practitioners, if one can judge from the statement of one of our leading instrument dealers who says he has sold more tonsil knives in the past six months than he has sold in three years previously. Will there be a reaction, just as there was in the sixteenth century?

DISCUSSION.

DR. PRICE-BROWN thought that the removal of adenoids in children and adults called for different methods of operation. He approved of the advocacy of curettage in removing adenoids; but as one could never see the field while operating on children, he always used the digital nail as well, particularly to clean out the tubal tonsil from the fossa of Rosenmüller. In fact, in very young children, he frequently did the operation with the digit alone, under general anesthesia. In adults, the operation being done under local anesthesia, and direct observation of each step of the operation being obtainable, he depended upon the curette.

In children the enlargement of the faucial tonsils, when it was simply hypertrophy of normal tissue, demanded only reduction ap-

proximately to normal size. He believed that complete tonsillectomy in these cases was uncalled for, as during child-life the gradual enlargement and recession while in a normal condition proved that they had some distinct physiological function to perform which should not be interfered with. In adults, when the tonsils were diseased, he would remove them intact, as their functional activity is passed.

DR. TREBILCOCK coincided with the opinion that the first duty of the pharyngeal surgeon is to prevent too much pharyngeal surgery.

DR. REEVE asked if the tonsil might not have a function to perform in furnishing some internal secretion. He had never practiced entire tonsillectomy, and questioned the wisdom of complete removal.

DR. BELL coincided with Dr. Reeve's opinion.

Pathology and Treatment of Alveolar Abscess. S. L. McCURDY,
Jour. A. M. A., Oct. 8, 1910.

S. L. McCurdy believes that dentists should realize the seriousness of the most frequent operation they perform, namely, that of devitalizing and extracting pulp, since infection and serious bone destruction arise from this source. The symptoms are well known to all, and, especially if complicated with syphilis, may be very uncomfortable. Destruction of the bony floor of the antrum does not necessarily mean perforation of the membranous floor or infection. An alveolar fistula leading into a cavity containing a considerable portion of the tooth requires extraction of this tooth before recovery can be obtained. Persistent headaches and general reduction of health are frequently caused by very insidious alveolar abscess. He thinks it desirable, in case of necrosis of the mandible calling for removal of bone, to establish drainage through the chin and approximate the gingival margins with sutures so as to shut off the pus cavity from the mouth. Naso-oral fistula, which sometimes occurs, especially in syphilitics, can be cured after due constitutional treatment by a membranous flap from the roof of the mouth. Tincture of iodine is recommended in all suppurative conditions of the mouth as a disinfectant.