DISCUSSION.

Dr. RANDALL opened the discussion with the remark that the views of Dr. Getchell were in full accord with what he had seen. Many of the pupils of the Pennsylvania Deaf and Dumb institution in Philadelphia came under his care as consulting aurist, but Dr. A. A. Bliss, the attending laryngologist and aurist, had examined most painstakingly all of the pupils. He found many affected with adenoid overgrowths, but it is questionable if it is more frequent than in other children. A number were relieved of their adenoids to their great advantage, but so far as he knew without any gain in hearing. Much may be done to improve the speech, and incident to teaching this, much exercise will be given to the auditory apparatus and centers beyond, and the renewal of hearing, which is commonly present, may be made the most of, if not improved.

ADENOID VEGETATIONS IN THE NASOPHARYNX.

Presented to the Section on Laryngology and Otology, at the Forty-ninth Annual Meeting of the American Medical Association, held at Denver, Colo., June 7-10, 1898.

BY JOHN O. McREYNOLDS, B.Sc., M.D.

DALLAS, TEX.

In this brief paper on adenoid vegetations in the nasopharynx I shall confine myself to a consideration of the measures which I have employed at different times, and especially those that I have found most satisfactory in the management of this condition. Its pathology and its importance are both so generally conceded that nothing appears to be required in order to establish these facts which are set forth in all works on laryngology. But as the method of dealing with this trouble has varied widely in the hands of different authorities, it might be well to briefly review these different procedures in the light of our individual experience. The treatment may be either medical or surgical, or the two may be very happily combined. In my judgment the surgical procedures are by far the most efficient, and they consist in the radical removal of the growths.

The question of anesthesia is the first to be considered, and in actual practice it is of the greatest importance. Formerly I always employed a general or a local anesthetic and I have never had any unfortunate results from its use, but during the last few years I have completely abandoned both of these for the following reasons: the local anesthetic does not penetrate deep enough to do any material good, while the effect is sometimes depressing and very frequently unpleasant. The general anesthetic always involves some risk, and especially is this true in operations where blood-clot is liable to form across the rima glottidis, while the sensibility of the larynx is obtunded and the reflex act of coughing is not induced by the presence of a foreign body in the larynx. And then the time and labor and extensive preparation involved in the operation with a general anesthetic will cause an unnecessary amount of anxiety on the part of the friends and relatives of the patient, while the patient will experience as much suffering from the administration of the anesthetic and the subsequent nausea and vomiting as would be incurred by the operation itself. So the entire operation, as I perform it, seldom consumes more than thirty seconds of time, is perfectly free from danger, is quite satisfactory in results, and involves the minimum degree of bodily distress to the patient and of mental solicitude on the part of all concerned. For the removal of these growths I have repeatedly used various instruments, including different forms of curettes and forceps designed for this purpose, and I still employ

them in those exceptional cases in which the amount of fibrous tissue is unusually large. But in the vast majority of cases I find that a first-class mouth-gag and the index finger of my right hand will supply all the armamentarium required. I do not even resort to the long, sharp-pointed finger-nail, but I keep all my finger-nails trimmed close and use a method of expression for the removal of the growths. By this procedure the entire nasopharyngeal cavity can be thoroughly explored and effectually cleared of all obstructive lymphoid tissue, and that without any possible injury to the soft, delicate structures of a child's throat. Indeed, I regard a thin layer of lymphoid tissue in the nasopharynx of a child as a perfectly normal condition, and any operation which will be liable to scrape away everything, down to the periosteum, will lay the foundation for subsequent atrophic changes more difficult still to control. Thus, the removal of the adenoids with the finger will restore the proper capacity to the nasopharynx, relieving the postnasal and Eustachian obstruction, and leaving a velvet-like lining which is normal in quantity and in quality and will naturally and gradually diminish as the child advances in age. The details of the plan I employ are as follows:

The child sits in the lap of an assistant with its head leaning against the right shoulder of the assistant, who embraces the child with his arms, holding its body and its hands firmly, while its feet are grasped and secured by the knees of the assistant. Then passing my left arm around the head of the child, I hold the mouth-gag in place with my left hand, while my right hand remains free to remove the growths, which, together with the blood, fall into a basin held in the hands of a second assistant. The subsequent treatment varies according to the special indications presented by each case. Some of the most entirely satisfactory cases that I have ever known have required nothing at all at my hands beyond the operation itself, which did not consume more than thirty seconds.

Cases of this character I provide with an alkaline and antiseptic solution for keeping clean the upper respiratory passages, and this is supplemented by an albolin, an antiseptic solution which I find is very conveniently applied to the wounded nasopharynx by means of an ordinary medicine dropper slightly introduced into the anterior nares. But many cases require also the internal administration of alterative tonics and the more or less prolonged local use of sorbefacient remedies. In my experience the good results of the operation have been pronounced in patients of all ages where I have found these growths present, and I have sometimes operated on infants under one year old with the result of promptly arresting middle-ear suppuration that for many weeks had resisted careful treatment applied through the external canal.

In concluding this very imperfect review of the treatment of adenoid vegetations of the nasopharynx I feel justified in saying that the necessary operation can be performed within a very few seconds, without danger or serious discomfort to the patient, and with the certainty of securing beneficial results that will amply reward our labors.

DISCUSSION.

Dr. B. A. RANDALL—The discussion of adenoids at this and each previous meeting shows considerable diversity among us, but there will always be much to be said on each side. If we consider the physiologic structure and variation in this region, we must recognize that total removal of the adenoid tissue is

absolutely impossible, since it extends far up the Eustachian tube mouths, as well as in the Rosenmüller fossa, and numerous nodules may be found upon the upper surface of the palate. Each will have his own choice of instruments and of procedure in general; but while, once for all, operations are quite possible, they risk overdoing, if they go beyond the removal of what is already pathologic. Cases are seen in which the pharynx has been stripped to the aponeurosis.

Dr. FRANK D. BOYD, Fort Worth, Texas—I simply desire to endorse Dr. Parker's idea of the operation for adenoids. I would suggest that the use of some instrument to be introduced through the nares, following the curetting, is of vast importance, as we often find the adenoids extending high up in the nares, which it is nearly impossible to reach with the curette or fingers.

Dr. MAYER—One point in making a diagnosis of adenoids in children has been overlooked, and that is the existence of adenoid tissue on the posterior pharyngeal wall. When present it is always diagnostic of the presence of adenoids. I note that an objection to anesthesia in these cases is that it is too cumbersome and requires more assistants than without anesthetics. Dr. McReynolds uses two assistants and I use no more for anesthesia, hence his objections are not germane. I consider nitrous oxid too evanescent, but if ether is given directly after the patient has become unconscious from the nitrous oxid, we will have anesthesia sufficiently prolonged and absolutely safe. Once more do I wish to protest against the finger-scraping method, and from the discussion of yesterday and my own knowledge, I am glad to see that these views are those of the majority of the profession.

Dr. HARLAN related a case of chronic pseudo-membrane of the conjunctiva which had existed four years, and which developed genuine diphtheria of the conjunctiva and pharynx after the use of jequirity. The case was reported in full in the *Journal of Eye, Ear and Throat Diseases*.

Dr. McREYNOLDS, closing discussion—Gentlemen of the Section, I wish to thank you for the free discussion which you have accorded my very imperfect paper, and I would say that I should have been surprised indeed if all the members present had coincided with me in every particular; and I wish especially to express my sincere appreciation of the endorsement of our chairman, Dr. Randall of Philadelphia.

AFFECTIONS OF THE EXTERNAL EAR.

Presented to the Section on Laryngology and Otology, at the Fortyninth Annual Meeting of the American Medical Association, held at Denver, Colo., June 7-10, 1898.

BY B. ALEX. RANDALL, M.D.

PHILADELPHIA.

Although affections of the external ear constitute one-fourth of aural practice, they may well be said to be its simplest part and, in view of their rare seriousness, to be little worthy of much consideration. Perhaps it is this very simplicity and openness to rational measures of general surgery that accounts for much of the neglect they have received, but more potent are the unfortunate traditions of centuries of unintelligent empiric measures to which they have been subjected. When ear-drops were the only known way of treating ear disease, such were indefinitely multiplied, and as ultimate relief followed the use of many medicaments, their supposed potency is a hardly challengeable portion of medical belief. As well save your breath as to argue that laudanum and sweet-oil is not the best possible relief for earache, or that oil or glycerin need not be dropped into the ear for the relief of impacted cerumen.

With the pathology of the ear fairly understood, there should be little need of more than mentioning many of the conditions to have the remedial measures suggest themselves with no great amount of choice or complexity; but even some aurists have not sufficiently clarified their comprehension of these matters, so it is natural that the general practitioner remains befogged. I have no wish to enlarge upon the common and simple affections, with which most of you are as familiar as I can claim to be; but I may be pardoned

if I lay stress upon a few points that make for simplicity and clearness.

The external affections make up fully 25 per cent. of all our practice, and more than half of this consists of infected cerumen—about 14 per cent. Of the remainder, diffused inflammations of the auricle and canal, which we can group as eczematous, make up about 5 per cent., and furunculosis, generally sequent upon the eczema, 2 per cent.; leaving a host of rarities to aggregate the remaining 4 per cent. Pardon, all those of you who know that a little hot water will remove any wax plug, when I insist upon this simple point. Use a syringe, alongside of which you can illumine and observe your work, with water of 110 degrees F., and two fluid ounces in as many minutes will almost invariably complete the cleansing. If not, it is because the wax is largely epithelial and probably attached to the walls by incomplete desquamation. The same device will remove almost every foreign body, will relieve many of the furuncles, and never harm if it fail to cure the diffuse inflammations. "But you would not use water when there is a seed in the ear to absorb it and swell?" I am sometimes asked. You may be slow enough to "let the grass grow under your feet," but you must be slower, and lack the sense to dehydrate with a little alcohol, if you are to let such seeds grow under your hands. If you must needs use a traction instrument, try a loop of horse-hair, gut or fine wire, before you risk injury by hooks

Diagram of drumhead showing sites of 1000 perforations.

or forceps. Don't be too surgical and ingenious, like the man who with mercury floated up a leaden bullet that would have fallen out of its own gravity had the ear been directed downward. No aural surgeon needs to be reminded that foreign bodies in the ear are harmless unless driven in by firearms or a meddlesome extractor. Whether microbes cause the diffused inflammation or only accompany it, we know that they make an unclean condition which needs thorough cleansing, which must be not only of the surface, but must penetrate the tissues as far as they are invaded. Yet few of the books so much as speak of hydrogen dioxid in this connection, although it is one of the few efficient agents at our command. When it has brought to view some subcuticular foci, and our incision has been used until these grew transparent again, you can feel fairly satisfied with the beginning you have made in curing these sometimes very obstinate affections. Treat it promptly and carefully, and your patients will avoid many a furuncle which would have resulted from scratching. Where the furuncle is a fact, use pressure by a tampon covered with the yellow oxid of mercury ointment, and you will rarely fail to hasten relief and forestall recurrence.

It is out of the remaining 4 per cent. of cases that I have chosen most of my illustrations, believing that these rarities will be of interest. Some of them, like