THE LARYNGOSCOPE.

VOL. V. ST. LOUIS, MO., NOVEMBER, 1898. No. 5.

ORIGINAL COMMUNICATIONS.

(Original communications are received with the understanding
that they are contributed exclusively to THE LARYNGOSCOPE.)

NASAL HYDRORRHŒA.*

BY ST. CLAIR THOMSON, M.D., M.R.C.P. LOND., F.R.C.S. ENG.

Physician to the Throat Hospital, Golden Square; Surgeon to the Royal Ear Hospital,
London.

Attention appears to have been first attracted to this subject by Bosworth in 1889 by a chapter devoted to nasal hydrorrhœa in his well-known "Diseases of the Nose and Throat." He therein collected and published eighteen cases of which he considered the details were sufficiently clear to warrant them being embraced under the heading of nasal hydrorrhœa. A critical examination of these eighteen cases has forced the author to the conclusion that six of them were undoubtedly instances of other morbid affections and that nine were most probably dependent upon pathological conditions quite unconnected with the nasal mucosa, so that of the original eighteen cases only three really justify their association under the title of nasal hydrorrhœa. The author has been led to this view by his studies in connection with a case shown before the Laryngological Society of London, where, in an otherwise perfectly healthy subject, cerebro-spinal fluid with rare intermissions escapes day and night from one side of the nose. This case, together with

*Author's abstract of a paper read at the Edinburgh Meeting of the British Medical Association, 1898.

the reports by other observers of seven undoubtedly similar cases, and twelve cases which were most probably identical, will be found fully recorded in Vol. lxxxii of the *Medical and Chirurgical Transactions*, 1898. It is claimed that of Bosworth's eighteen cases of nasal hydrorrhœa no less than thirteen were most probably instances of what should be called cerebro-spinal rhinorrhœa. In the communication to the *Medical and Chirurgical Transactions* each of these thirteen cases is considered separately.

The writer deals at length with the chemical and clinical signs which distinguish cerebro-spinal fluid from intra-nasal secretion, and considers the question of the possibility of the hydrorrhœa originating in the accessory sinuses of the nose. Excluding all cases in which the discharge simply traversed the nose on its way from other cavities and all those in which it is due to direct or reflex irritation, the conclusion is arrived at that what has been regarded as a distinct morbid entity is in the majority of cases but a symptom of various affections. Yet it is held that the term of nasal hydrorrhœa may still be preserved if we limit it by defining the affection as one in which there is profuse watery discharge secreted by the nasal mucosa and not dependent on intra-nasal or neighboring sources of irritation. The amount of the fluid may vary from only what the patient would term a slight running, up to as much as a pint in the twenty-four hours. The clinical picture of nasal hydrorrhœa shades off in one direction into cases of what are generally called hay fever or paroxysmal rhinitis, with symptoms of intense local irritation, while in the other direction they may consist of a passive and almost painless watery discharge from the nose.

It appears to be an affection of adult life affecting males and females indifferently. Although it may be more marked on one side than on the other, the flow usually takes place from both nostrils. When handkerchiefs are soaked with it they generally dry stiff.

The author's contribution only claims to have advanced the matter one step by distinctly differentiating those cases where the nasal watery flow is really an escape of cerebro-spinal fluid. The importance of making this differential diagnosis is obvious. When such a character of the fluid is suspected it is important to avoid any local interference, from the risk of infection. In the cases presenting the conditions to which it is proposed to limit the term nasal hydrorrhœa the treatment can be only such as we have all tried in cases of hay fever. That is to say, quite empiric, with occasional brilliant results and frequent failures. A plea is entered for mod-

eration in the energy with which so many practitioners use the galvano-cautery. The mucous membrane is easily destroyed, and while the formation of scar tissue may give a sense of immediate relief, the after results may be worse than the original disease. Careful general treatment, hygienic, dietetic and climatic, with possibly a visit to a suitable spot will generally secure very satisfactory results.

Purulent Discharge from the Nose; Clinical Significance and Differential Diagnosis—GEORGE E. SHAMBAUGH, Chicago—*Med. Standard*, September, 1898.

In a discussion of the subject the author arrives at the following conclusions:

1. Purulent discharge from the nose is a common symptom of intranasal disease.

2. Its presence may be detected by the patient, but often he complains only of the secondary symptoms produced by the pus.

3. Older writers described all these cases as "purulent rhinitis," etc., and never suspected what we now know to be true, that in the majority of cases the pus has its origin in one of the accessory cavities of the nose.

4. Pus in the nose may come from (*a*) disease in the nose itself (*b*), suppuration in the accessory sinuses (*c*), or suppuration in post-nasal space.

5. The diseases in the nose are (*a*) purulent rhinitis, found in children, in acute infectious fever, in acute rhinitis and gonorrhœal infection (*b*), ulceration, either traumatic as the erosion in the anterior nares, the idiopathic perforation, ulceration due to action of chemical agents, foreign bodies, larvæ of insects and perichondritis; or tubercular or syphilitic.

6. The accessory sinuses of the nose form two groups: the first group, including the maxillary and frontal sinuses and the anterior ethmoid cells, opens into the middle meatus of the nose. The second group, including the sphenoid and posterior ethmoid cells, opens into the olfactory space between the middle turbinated bone and the septum.

7. A differential diagnosis of diseases of these cavities is one of the most difficult problems in rhinology. It requires a knowledge of the whole field of the technic of intranasal examination and a thorough knowledge of the complicated anatomy of the nose and its accessory sinuses.

STEIN. (BISHOP.)