NASAL INSUFFICIENCY DUE TO EXAGGERATED PROMINENCE OF THE ANTERIOR ARCH OF THE CERVICAL VERTEBRÆ.*

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The condition of which I wish to speak very briefly this evening has a relation to the perennial subject of lymphoid hypertrophy in the pharyngeal vault. After all that has been written on this topic, one may well apologize and especially to the members of this Section for daring to reopen the subject. Since its masterly exposition by Wilhelm Meyer some thirty years ago, very little has been added to alter our general conceptions of this morbid condition. Its outlines were so graphically sketched by a master hand that later writers have done little more than to fill in comparatively unimportant details. We have learned that the possibility of certain complications must be borne in mind and the great number of operations done has in certain ways enlarged our range of thought.

In my own work, I have in two instances met with a condition which I have not seen mentioned in any of the text-books nor until recently in any current publication.

In 1895 in a paper read before the French Society of Laryngology, under the title of "A Critical Examination of Certain Rare Cases", Castex said that "numbers of children pass for cases of adenoid disease who have only a scolio-sis of the septum or who have the vault of the nasopharynx shortened in its antero-posterior axis or with a wall projecting forward, the latter caused by an exagger-

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ated hypertrophy of the atlas or of the odontoid process of the axis. In some instances the patient seems to have adenoid disease when he has not, or more rarely may appear free from it when he really has it."

In passing it may be remarked that he says also that adenoids of the posterior wall of the pharynx and not in the vault are more common than is generally taught and that copious hot irrigations with the Weber siphon will prevent the necessity of surgical interference in very young children. Of the truth of the first of these two statements, I am quite convinced; of that of the second, I am somewhat sceptical.

In a paper read before the same society in 1896 by Escat, under the title of "Congenital Stenosis of the Nasal Fossæ and of the Naso-Pharynx," he observes that this stenosis, found especially in individuals of mental deficiency, included among others, cases of prominence of the posterior wall of the pharynx but in such cases this deformity was but an anatomical detail among others which together constituted the general atresia of the naso-pharynx. Escat calls attention to the fact that both Ziem and Delavan were able to induce an arrest of development in animals of the bones of the face and thorax by causing occlusion of the upper air passages. In an examination of 113 children in one of the waif-colonies in France, Balme found 56 cases of adenoids or of other tonsillar enlargements but among these classic deformities there were other deformities manifestly not due to adenoids, such as multiple deformities of the skull and skeleton which constituted stigmata of degeneration.

Some writers with a vivid imagination have tried to deduce from this the conclusion that adenoids themselves are stigmata of degeneration but for the sake of the rising generation of the city in which we live, it is to be devoutly hoped that this latter conclusion is false.

In May of the present year, Mendel (in a paper still before the same Society) gave a brief study of this condition basing his statements on four cases which had been under his personal observation. He divided them into three categories:

1. Those with an osseous projection situated at the level

of the buccal pharynx with the coexistence of adenoids, one case.

2. Those with an osseous projection in the rhino-pharynx with the coexistence of adenoids, two cases.

3. Those with an osseous projection in the rhino-pharynx without the coexistence of adenoids, one case.

CASE 1 was that of a boy aged seven years with obstruction to nasal breathing. There was an osseous projection in the middle line of the buccal pharynx. It did not extend up into the rhino-pharynx and was regularly rounded. Adenoids were present. An especial symptom in this case was dysphagia. Breathing was better at night than in the day time. This paradox is explained by Mendel as due to the fact that in the day time the tonicity of the soft palate kept the latter in contact with the projection thus shutting off the air current from the rhino-pharynx. At night however, the palate was relaxed and so there was free space.

CASE 2 a girl of 8 years with classical adenoid characteristics. Osseous projection in the naso-pharynx; above it were adenoids.

CASE 3 a girl of 4 years. Rhino-pharyngeal projection causing almost total occlusion of breathing through the nose. The vault of the pharynx was free from adenoids.

None of these children presented any suspicion of hereditary or acquired syphilis or tuberculosis. A rather curious fact is that the father of case 1 presented the same anatomical peculiarity as the child but had no symptoms therefrom.

Two pertinent inquiries made by Mendel: should we operate for adenoids in these cases when they are present and if we do, what is the prognosis as to effectual removal of symptoms of obstruction?

In reply to the first, he advises operation. The osseous projection, he says, constitutes two-thirds, so to speak, and the adenoids one-third of the obstruction. If we cannot remove the latter entirely, let us do what we can.

As to prognosis, it is well to caution parents against expecting too much from the operative procedure. They should be informed as to the double condition present and be made to understand that it is partly removable and partly not. Otherwise if the symptoms continue, the physician may be charged with having done a useless opera-

tion and one not necessary or he may be accused of having done it improperly.

Some modification of the customary use of instruments may be necessary in these cases for it may be difficult to introduce the usual curettes and forceps into the vault owing to the osseous projection. Smaller instruments than those usually employed may suffice or the finger may be relied upon. As the patient grows older the projection gradually becomes relatively less in size and finally as in the case of the father above referred to, cease to give any trouble whatever.

I have met with two cases in which this condition was present. In neither was there sufficient bony obstruction to prevent the employment of the customary size of forceps or curette. In both the vegetations present covered the mucosa stretched over the projection in the rhino-pharynx and ran up beyond it into the vault. One case occurred some two years ago at the Demilt Dispensary but did not return after the operation and I have not been able to follow it up. The other case was that of a ten year old son of a colleague. In this case, there was a moderate amount of obstruction but the results of curetting have been all that could be desired.

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