AN OPERATION FOR CORRECTING DEFORMITIES OF THE NASAL SEPTUM.

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Of late a great deal has been written on the subject of nasal obstruction, due either to a deflected septum or to spurs growing from the septum, projecting into the nasal cavity. And various operations have been suggested and accurately described for the relief of this condition. This, of itself, is adequate proof that the results obtained in this particular branch of nasal surgery is by no means always gratifying, either to operator or patient.

It must be admitted by all that each case is a law unto itself, and no one method can always be adopted in operating in the nasal cavity. But we can adhere to the rule, in general surgery, and it is here that I wish to apply that rule in making an effort to obtain union by first intention, which is next to impossible by the methods of operating now generally employed, especially where it is necessary to remove a part of the septum. And following these methods of operating, the result has almost invariably, in my practice, been a delay in healing of the cut surface, and in some instances it has been a slow and tedious process, so much so that where patients were unable to remain under my immediate care but for a few days I have declined to operate.

We all know it is almost impossible to keep a wound in the nasal cavity aseptic any length of time, and this can only be done at all by packing the cavity with some antiseptic material. This the patient soon rebels against, and the dressing has to be removed and the wound treated as an open wound. Hence, it becomes our duty to make an effort to obtain union by first intention. This, I think, can nearly always be accomplished when the operation is done as directed in the two following cases which I report as illustrations:

Case 1. R. B., age thirty-five, farmer, gives the following history: At the age of nine he fell from a horse and fractured his nose; was attended by family physician; made a rapid recovery without any perceptible deformity; respiration was never quite free on the right side; has gradually grown worse, and for the past five years has been wholly unable to breathe through his right nostril; has been treated by several physicians without relief; complains of his throat and thinks he has catarrh.

On examination, I found his right nasal cavity completely closed by the septum, which was greatly thickened and deviated to the right. It was lying in contact with the inferior turbinated body, which presented a sodden appearance, completely obstructing respiration on that side. The nasal cavity was larger than normal on the left side and respiration free. The pharynx presented a granular appearance. The nasal cavity was sprayed with Dobell's solution. I then wiped out the cavity with small pledgets of cotton, wound around an applicator. This was repeated until the nasal cavity was thoroughly cleansed. I then applied a four per cent solution of cocaine to the mucous membrane of the septum and turbinated bodies. A plug of antiseptic cotton was next introduced into the nasal cavity beyond the seat of the intended operation, to prevent any secretion from flowing over the field of operation, and the blood from flowing into the pharynx, thereby delaying the operation, by the patient expectorating blood. The surface to be operated on was again cleansed, and five minims of a four per cent solution of cocaine was injected beneath the mucous membrane over the structure to be removed. I then bound a towel around the face, letting it come over the mouth and up to the nose, thus preventing the blood from flowing into the mouth. A horizontal incision, three-fourths of an inch in length, was then made through the mucous membrane, over the most prominent part of the septum, with a small Beer's cataract knife. The edges of the wound were grasped with a pair of straight iridectomy forceps, and the mucous membrane dissected from the underlying structure, both above and below, some little distance beyond the point which I desired to remove. This was done to prevent the soft parts from being injured by the saw. The wound was next separated, as wide as possible, with a pair of forceps. I then introduced a small Bosworth saw beneath the denuded surface, with the cutting edge up, and removed a large piece of the protruding septum (about one-half inch in length). The saw did not communicate with the left nasal cavity, thus leaving a thin portion of the septum to separate the two nasal cavities. Hemorrhage was only moderate and readily arrested by hot water and compression. The edges of the mucous membrane were brought together and retained by three interrupted sutures of thin silk.

In closing these wounds in the nasal cavity we only have a very limited space to work in, and it can only be done with a short curved needle, held in a slender needle-holder, beginning at the posterior extremity of the wound, passing the needle through the upper flap from above downward, then grasping the needle near the point and

pulling it through; then catch up the lower flap of the mucous membrane with a pair of iridectomy forceps and pass the needle through, as in the above; grasp the needle again on the other side and pull it through, then tie as in any other wound. This is continued until a sufficient number of sutures have been introduced to close the wound, which will generally take from one to three. The posterior plug is now removed, the whole surface thoroughly cleansed, and the cavity lightly packed with small strips of iodoform gauze. This was changed daily until the third day when it was entirely removed. Union had taken place by first intention and the sutures were removed on the fourth day. Patient discharged one week after operation, wound thoroughly healed, respiration free.

Case 2. H. C., age twenty-four, lawyer, no history of traumatism; general health good; catarrh for past four years.

On examination I found a bony projection from the nasal septum, almost filling up the left nasal cavity, coming in contact with the inferior turbinated body. There was no depression on the opposite side. I at once determined to operate. After preparing the parts, as in case 1, I made an incision over the bony projection and dissected up the mucous membrane from over the part to be removed. Applied the Bosworth saw as in the above case. Hemorrhage was soon arrested and the wound closed. The technique of this differed in nowise from case 1. The dressing was changed daily until the third day. It was then discontinued and the stitches removed. Union had taken place by first intention, and the patient was discharged, with free respiratory tract on operated side.

The main point in the above operation to which I desire to call attention is the comparatively short time it takes the wound to heal. These cases can always be discharged in from three to seven days, and it is rarely necessary for the patient to carry out any further treatment. This cannot be said of any operation in which the mucous membrane has been destroyed over a considerable surface, as must necessarily follow an operation on the nasal septum, as it is done by the usual method of operating. However, I do not claim that my method can be adopted in all cases, neither do I expect it to succeed all previous methods of operating, but I do believe that it can be employed in the majority of cases, and that a careful comparison with the usual methods of operating on the nasal septum will commend it. The technique is simple and can be carried out by anyone accustomed to operating in the nasal cavity. In conclusion, I would add that I have only followed the principles of general surgery to get union by first intention, and in no way do I claim to be original.