

SOCIETY PROCEEDINGS.

NEW YORK ACADEMY OF MEDICINE.

SECTION ON LARYNGOLOGY AND RHINOLOGY.

Regular Meeting, December 18, 1907.

THOMAS J. HARRIS, M.D., Chairman.

PRESENTATION OF CASES.

A Case of Harelip Operated by a New Method. By WM. W. CARTER, M. D.

To be published in full in a subsequent issue of THE LARYNGOSCOPE.

A Case of Infiltration of the Larynx, Probably Syphilitic. By J. E. NEWCOMB, M. D.

The patient first came under observation a few months ago, at the Out-Patient Department of the Roosevelt Hospital. He is 36 years of age, family and personal history negative. No specific history. He is a gardener and furnace man and has been able to continue his work right along with the exception of a short time in the spring. His eyes have been somewhat prominent ever since he was an infant. Up to about nine or ten years ago he was in perfect health, but then his larynx box became somewhat prominent and he experienced a little trouble in breathing, though not until two years ago did he have any real dyspnoea. Since then he has had considerable difficulty in breathing and was referred to the hospital by Dr. Deming. No satisfactory explanation has been discovered for the condition present. For lack of more definite knowledge, he was put upon iodid. After that, his dyspnoea increased, and he was admitted to the hospital as it was thought that a tracheotomy might be necessary. The urgency of his symptoms passed off, however, and he was able to resume attendance at the Out-Patient Department. He has not been taking much iodid, but his difficulty in breathing seems to have lessened under that treatment. There is a general infiltration of the larynx. The left side moves slightly, and the right side not at all. On the median aspect of the arytenoid there is loose flabby tissue which flaps back and forth in an irregular way.

Dr. Newcomb said that he presented the case with the hope of getting some suggestions as to further therapeutic treatment. Thus far the case had been treated on the presumption that it was syphi-

litic, but there was no more definite reason for this than the argument of exclusion.

DISCUSSION.

DR. SIMPSON said that it seemed to him, notwithstanding some of its peculiar features, that the case might not be specific. The element of time must of course be taken into consideration. It was evidently a very slow, indolent type of infiltration, but hardly seemed to be anything else. The cartilage was not involved. The peculiar annular shape has included some of the anterior portion of the larynx. It seemed to be an ideal case for the dilation treatment, by intubation, beginning with the small tubes and increasing them. The tissue is too dense to be incised before using the tube. He also suggested the injection of bichloride.

DR. POOLEY said that the patient showed marked symptoms of exophthalmic goitre. The slow descent of the eyelids when the eye looked downward, together with the enlargement of the thyroid gave distinct evidence of that disease, though he would not undertake at the moment to say whether this had any bearing upon the laryngeal condition.

DR. NEWCOMB replied that the possibility of the case being one of exophthalmic goitre had not been overlooked, but it had to be remembered that the exophthalmos dated back to the patient's infancy. He stated that he and his colleagues had not been able to assure themselves that there was any enlargement of the thyroid, and the patient had not the characteristic pulse of Graves' disease. He had not taken large doses of iodid, and the therapeutics had been limited by the fact that he lived at a long distance. He had been taken into the wards for a short time for purposes of observation, and the trouble passed off and he had been able to resume his work of gardening until the last few weeks, when he took a severe cold. He would try treating him with injections of bichloride or salicylate of mercury.

Hyperplasia of the Larynx. By J. W. GLEITSMANN, M. D.

Dr. Gleitsmann said that he had brought the patient on account of the diagnosis and with the hope of obtaining some suggestions as to the best method of treatment. Two weeks ago, he first came to the office for treatment. The diagnosis of the laryngeal affection was made, and operation advised, and to-day he was admitted to the hospital. The sputum had not yet been examined, but the patient had no temperature, and according to the report of his former physician, no pulmonary affection. Two weeks ago there was a slight

dullness in front of the sternum on the right side, and on the middle lobe dullness and exaggerated breathing.

Two weeks ago the patient was told that an operation should be performed without much delay, as he had been suffering for a year, and began now to have dyspnoea. Three or four weeks before he came under observation he complained of difficulty in swallowing.

Inspection of the larynx shows an infiltration of both ventricular bands; the vocal cords are visible on forced deep inspiration, and are not affected by the infiltration. Their epithelium has been shed off at the edge. An extended infiltration of both arytenoids and at the posterior wall is easily seen. The most peculiar and interesting feature of the case is that though the infiltration of the larynx is very extensive the cords approximate, but complete aphonia exists, which may be due to an extension of the infiltration of the posterior wall below the cords.

Dr. Gleitsmann said that he had considered the case very carefully during the two weeks that the patient had been at home, and it seemed inadvisable to attempt to remove the arytenoid. There would be no difficulty in removing the ventricular bands. Such cases occur very frequently, and they can be removed, but he would not like to operate intralaryngeally on account of the uncertainty of the condition of the subglottic space. His choice would be to perform at least a thyrotomy. If this was decided upon, he could perform preliminary tracheotomy and the thyrotomy at the same time.

He would like to know the opinion of the members present as to whether, if the infiltration of the posterior laryngeal wall goes down sufficiently deep, there would be any prospect of removing it.

DISCUSSION.

DR. FREUDENTHAL said that he had seen many similar pictures of the larynx, but was not at the moment prepared to say whether or not the present case was tuberculous. Dr. Gleitsman, however, had examined the patient thoroughly and believed the lesion to be tubercular. He had removed similar granulations of the posterior wall, not with a view of curing the case, but simply to relieve the dyspnoea, when tracheotomy was not allowed. He thought, however, that the future treatment of such cases would be the thorough removal of the larynx and affected parts. Of course, this would probably result in a large death rate, but this would be better than the inevitable and indefinite suffering.

DR. COBURN suggested that the matter of diagnosis would be simplified by the injection of tuberculin, or the application to the eye of

tuberculin for the ophthlmo-tuberculin reaction of Calmette. One would then know positively whether he was dealing with a new growth or a tubercular one.

DR. BEAMAN DOUGLASS said that clinically the case seemed to be one of proliferative tuberculosis of the larynx. The tendency is to operate intra-laryngeally and give as much relief as possible, and failing in that to do a thyrotomy. He had failed in thyrotomy operations in tuberculous cases last year. After splitting the larynx and removing the growth, the patient died of the asthenia or of an extension of the tuberculosis in the lung or in the larynx.

DR. HARRIS inquired whether Dr. Gleitsmann had considered the procedure of a pure tracheotomy without attempting to remove the larynx. This has been done, with favorable results.

DR. GLEITSMANN, closing, responded that he had brought the case before the section first to consider the diagnosis. In his opinion, that was established. The examination of the sputum would be made the next day, and his views in regard to the condition of the lungs would be confirmed or negated.

In regard to the diagnosis made by tuberculin in the eye, it is a comparatively new feature. An excellent paper has recently been written by Dr. Baldwin, but he himself had had no experience in that line. He had no doubt that it is a safe and correct method, but on the other hand there is no doubt that the diagnosis can be absolutely and correctly established by the ordinary measures employed.

In his opinion, the appearance of the larynx indicates tuberculosis of a slow type, which approaches the tuberculomata, and which can exist for a year or more before breaking down. It was probable that this patient could go on for a little while longer without the infiltration breaking down although recently he had noted a slight change in this respect. Two weeks ago the larynx was clean and free from discharge, but at present there is a slight discharge, and shedding off of the epithelium in some places.

Some time ago he had presented a similar case before the Section, which no doubt many of those present would remember. It was a true hyperplasia, and had been so declared by several others beside himself. Pieces of the infiltration were examined by different pathologists who pronounced it to be undoubtedly hyperplasia. A preliminary tracheotomy was performed, followed by a laryngotomy, and the growth was excised thoroughly, Dr. Delavan kindly consenting to be present. The patient made a good recovery, is perfectly well now, but speaks with a slight degree of hoarseness as the thy-

roid plates do not come together laterally, one overriding the other a little.

He had done some endolaryngeal work along this line and was very well satisfied with the results obtained. He would not hesitate to make an attempt at endolaryngeal removal, but it would be impossible to remove sufficient of the infiltration, which he considers to be tubercular, to reach healthy tissues. At least three operations would be required to remove this enormous infiltration and he was inclined to operate externally, but the exact procedure has not yet been determined. A tracheotomy alone would be only a palliative measure. He would live longer, if the tuberculoma did not progress too quickly, but he had not at all considered the question of a tracheotomy alone. He wished to emphasize the fact that the closure of the glottis does not indicate a paralysis. Both cords move slightly, and the movements are symmetrical. The infiltration of the posterior wall of the larynx is very great, but there is danger of its going downward, extending to the subglottic space. He had operated on a similar case before, and had excised the infiltration in a girl who did very well at first, but a recurrence took place. A laryngotomy was then performed, and the girl died finally of exhaustion.

A Case of Tumor of the Pharynx. By D. B. DELAVAN, M. D.

DISCUSSION.

DR. INGALS showed a pair of forceps which he had had made for use in just such cases. The first instrument was not quite right, of course, but after two or three trials a very satisfactory one was secured. The design is to introduce it into the naso-pharynx where it fits the posterior wall. It is then clamped onto the tumor and locked. The blades of the forceps are covered with ivory so that they are insulated, and the loop of the galvano-cautery draws up over them and cuts off the tumor, the ivory preventing a short circuit. The instrument had been used in several cases and works very satisfactorily.

Radiographs Illustrating the Normal Topography of the Pneumatic Sinuses of the Face. (With Description.) By

SINCLAIR TOUSEY, M. D.

To be published in full in a subsequent issue of THE LARYNGOSCOPE.

Intra Nasal Drainage of the Frontal Sinus. By E. FLETCHER INGALS, M. D., Chicago.

DISCUSSION.

DR. MYLES said that he had struggled with this subject for twenty years and that he feels much indebted to Dr. Ingals for the pre-

sentation of his method and his experiments, for any work in an original field like this must be more or less experimental. For a long time Dr. Myles advocated the open external route, but his observations, corroborated by those of others, have led him to believe that if a large opening could be made by the internal route the pathological conditions would do much better, in the average case. These conditions inside the sinus are more or less temporary, and with ventilation and free drainage the parts will become more normal. This has been demonstrated in the antrum of Highmore, in the sphenoidal cells, and in the large air cells (mastoid and ethmoid)—so the question has naturally arisen, why not do the same thing for the frontal sinuses? In ten per cent of the frontal sinus cases the radical operation may be necessary. He has had some instruments made very similar to those of Dr. Ingals, but has never succeeded in introducing them as Dr. Ingals has done, and has never been able to get them to work satisfactorily. He abandoned the procedure of drilling but continued to work along the same line, although a little differently. He now removes the middle turbinate, and the floors of the ethmoidal labyrinth, and uses the medial wall of the ethmoid as a shelf to prevent the closure of the aperture leading into the frontal sinus. If one studies these specimens carefully one can see that if large openings were made into the sinuses, nearly all of these cavities would drain well and have an opportunity to become normal again. The operation which has secured his best results has been the removal of the floor of the anterior and middle cells and intercellular walls, and then cutting away the nasal process of the superior maxillary bone. One of the best instruments for this work is the chisel that cuts outward. Most of these chisels are too elastic in the shafts and are not hard and small enough at the cutting edge. Then he has found the different forceps which he has presented to this Section very serviceable. He has not used the drill very much, for he found that after the use of the drill the aperture was completely denuded of the mucosa on all sides, and a law of nature is that contraction after drilling through a duct takes place in a circular fashion and frequently obliterates the duct.

DR. BEAMAN DOUGLAS said that admitting at the outset that the intra-nasal operation is the most desirable one, providing we can have a safe one, at present his views on the subject are radically different from those presented by Dr. Ingals. It was impossible to do justice to the other side of the question in the short time permitted by the lateness of the hour, so he would not present the negative side

at all, but would simply say that if he had a frontal sinus disease, even knowing what he does of Dr. Ingals' skill and luck, he certainly would not submit to an operation by this intranasal method.

DR. CHRISTIAN R. HOLMES agreed with Dr. Douglass that one could scarcely present the opposite side of the question in two or three minutes, and it was hardly worth while to try, but he would like to call attention to certain specimens which he had with him. He knew that Dr. Ingals had had some cases that were at least temporarily relieved but only time could tell whether there has been a cure or only relief of pain on account of drainage, and even that may be temporary.

In order to study the subject carefully and thoroughly, one should take sections which show the whole relation of the duct to the various parts and to the cribriform plate. For this reason he had brought these specimens, which he would like the members to observe. He has studied this subject for many years, and when one looks upon such specimens and notices the paper-like thinness of the bony walls it is evident that in the majority of cases it would be impossible to make an opening without causing the drill to impinge upon the dura. The drill may not open the dura, but he would certainly object very much to having his own dura treated in that manner, even in Dr. Ingals' skilled hands. He wished, however, to express his objection to anyone adopting this operation until he has become exceedingly skilful. He feared that many young men who have not given much study to nasal anatomy, would be misled by Dr. Ingals' optimistic statement to think that a very easy and safe operation, which would be bound to lead to serious consequences. He is not prepared to say that a certain number of cases can not be operated upon by this method, but after dissecting several hundreds of specimens, he could not believe that it would be safe to do this, excepting in a small percentage of cases.

DR. COAKLEY was prevented from attending the meeting, but sent the following expression of his views on the subject.

"The very ingenious method of draining the frontal sinus presented to us to-night was first described very minutely by the reader of the paper at the meeting of the American Laryngological, Rhinological, and Otological Society in Boston, in the early part of June, 1905.

"In discussing the paper at that time, I pointed out the possible danger of accidental perforation of the brain, and promised Dr. Ingals that I would give his method a trial. The more I considered

the subject, however, the less favorably did it impress me, and I have felt that I could not safely carry out my promise. I believe the method to be exceedingly dangerous for the patient, difficult to perform, and, reasoning from analogy, cannot see how any more can be gained by this method of treatment than from others which are more simple.

"No one can study the conformity of the naso-frontal duct without realizing the danger of perforating the cavity by any trephine, even when guided by a director. I should never be willing to allow even so skillful an operator as Dr. Ingals to attempt this procedure on me; I would very much prefer an external operation.

"The principle of tube drainage was thoroughly tried for many years in diseases of the maxillary sinuses. Unquestionably a great many cases were cured, but many of them were not, as is evidenced by an occasional case that comes into our hands even nowadays when this method is employed. At the present day, we know we can do better work on the antrum by large intra-nasal openings than we can by inserting a drainage tube through either the alveolus or the canine fossa. There is no reason why tube drainage of the frontal sinus should be any more satisfactory than the tube drainage of an antrum.

"I believe that the cases which Dr. Ingals has cured by the introduction of his gold tube could have been cured by properly removing the obstructions around the outlet of the naso-frontal duct with cutting forceps. The passage of a trephine and the consequent removal of the mucous membrane from the naso-frontal duct is bound to result in a cicatricial contraction of the canal on the removal of the tube. This contraction, I think, would be sufficient to produce the same stricture that one occasionally sees after too vigorous curettage of the naso-frontal duct. The stricture does not prevent subsequent infection of the frontal sinus, but yet is of sufficient density to retain the secretion within the cavity until considerable pressure has developed, when a small amount is forced out. To my mind, these are the worst cases which come to us for treatment. It is impossible for us to insert a probe into the sinus, and an external operation is the only one which gives relief in these cases.

"I cannot understand how it is possible for the reader of the paper to expect a tube in the frontal sinus to drain the large orbital recesses that one frequently meets with and that communicate with the frontal sinus. Neither can I understand how it is possible for a tube inserted into the frontal sinus to thoroughly drain that cavity,

any more than a tube inserted into the antrum thoroughly drains it.

"When the tube is in situ, reinfection of the frontal sinus is probable with each attack of acute rhinitis.

"I regard the writer's method as a most ingenious one, fraught with dangers, unsurgical so far as establishing the required drainage, unnecessary, because cases that can be cured by his method can be cured by simpler ones, and, lastly, ineffectual in that type of cases that demands rational surgical treatment, whereby the sinus is laid open, the diseased membrane removed, and the cavity obliterated, so that no future nasal inflammation may extend to and involve it."

DR. BEAMAN DOUGLASS was again requested to express his views on the subject, and said in part:

The views expressed by Dr. Coakley meet my approval and I endorse them all. I think that the subject is important enough for us to put ourselves on record for or against it, but hope that the presentation of the opposite side of the question of an intranasal operation on the frontal sinus will not be considered discourteous by our guest.

We may admit at the outset that an intranasal operation upon frontal sinus is desirable providing that it is not dangerous to the patient, that it gives as good results as other methods, and that it can be as easily performed by the operator possessed of an average amount of technique. The objection in this country to an external sinus operation is the resultant scar. The idea in regard to scars are different here and on the European continent. There where the civilization is still permeated with the idea of chivalry, where it is not unusual for a man to have a scar and where the women of the nation look upon them as marks of honor, a cicatrix is not objected to; but in this country where the idea of unblemished beauty predominates, scars are looked upon with distaste and aversion. Therefore if an intra-nasal operation upon the frontal sinus can be done safely it is certainly desirable from the American point of view, and such an operation as Dr. Ingals has presented, with only two failures in twenty-one cases merits our closest attention.

We must now consider the objections to the intra-nasal operation. These points were extensively discussed in my paper published in the Laryngoscope two or three years ago on "The Dangers of the Intra-nasal Operation upon the Frontal Sinus," and I would refer you to it for the nearer details, mentioning now only one or two of the more important objections. The real danger of the

intra-nasal operation is the danger of perforating the exterior wall of the sinus with the burr, and subsequent death of the patient from pachymeningitis, or a perforation of the olfactory groove, with the same result. While there are many cases in which there is a large naso-frontal duct with a posterior sinus well out of reach of the operating instrument, there are also a number of cases in which the space between the orbit and the olfactory groove is so narrow that no considerable enlargement of the naso-frontal duct is possible without injury to the eye or the olfactory groove. There are also many other cases where the posterior wall of the sinus is so oblique that it bears an immediate relation to the naso-frontal duct, and it would not be possible to use a burr upon such sinuses without perforation of the posterior sinus wall. It is also a fact that these dangerous relations which may induce a fatal result cannot be determined before the operation.

In my opinion, all that can safely be done intra-nasally to secure better frontal sinus drainage is the removal of the middle turbinate body, the processus uncinatus, and the processus angularis, with the subsequent irrigation of the sinus and the application of various medicaments. It is very questionable whether it will do any good to attempt the enlargement of the naso-frontal duct, for this stirs up granulation tissue, and we have all seen even large intra-nasal sinus openings which closed months after an operation, thus interfering with drainage.

Finally, it is impossible by any intra-nasal operation to reach the pockets in large frontal sinuses or to drain the sinus where it extends posteriorly—sometimes as far as the sphenoid. In such sinuses the only benefit to be obtained from an intra-nasal operation is the relief of pain, and this can be secured by simple irrigation. Such large sinuses subdivided by septa and containing recesses in which infected granulation tissue is lodged can only be successfully operated upon by an external method. It seems to me that in the Killian operation we have an ideal operation upon the frontal sinus with a minimum of external deformity.

DR. INGALLS said that he certainly accepted in the most friendly spirit the criticisms which his paper had received. Dr. Douglass, however, had failed to appreciate what he had said about the modified burr with shield which makes the burr absolutely cut forward. It cannot cut backward. The canal without a drainage tube will close with the drainage tube it cannot close. Several other objec-

tions had been brought forward, but he knew of no better answer than to say that "The proof of the pudding is in the eating," and he is sure that those who try it as he has done will be pleased with it. The external operation is desirable in a few cases, but not often.

DR. QUINLAN moved that the thanks of the Section be extended to Dr. Ingals for coming before them and giving them this very new and very carefully prepared paper.

The motion was carried.

A Nasal Syringe for Infants (Mouche-Bebe). DR. ESCAT, DE TOULOUSE. *Presse med.* Aug. 25, 1906.

Very young children, suffering from coryza and not knowing how to clear the nostrils, are exposed to two kinds of complications due to the obstruction which results from the accumulation of mucus in the nostrils: First, a state of partial asphyxiation; second, an obstacle to nursing, due to this nasal obstruction. On this account, nutrition may be seriously interfered with.

To prevent these results, it is necessary to clear the nostrils of the child, several methods having been suggested for this purpose: First, the liquid douche, which may cause infection of the ears or irritate the lower respiratory passages of the child; second, the dry douche, by means of the Politzer bag, a method less difficult, but having the same risk as the liquid douche; third, cleansing the nostril by means of a tampon of cotton, a dangerous method unless performed by an experienced hand.

In view of the disadvantage of the above methods, Escat has devised a little instrument which he thinks will become popular, and which he has called a "mouche bebe."

This consists of a glass cup, one end of which ends in a conical opening adapted to the nostril of the child. Into the other end of the cup a tube is inserted, to the outer end of which a bulb is attached in order to create a suction within the cup. When the conical tip is applied to the nostril and the compressed bulb released, the diminished air pressure causes a suction which frees the nostril of its secretions. By removing the instrument and compressing the bulb, the secretions are expelled from the cup, which may afterwards be sterilized by boiling water. SCHIEPPEGRELL.