SOME POINTS ON THE RESECTION OF THE CARTILAGINOUS SEPTUM.*

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It is my purpose in this paper to call attention to a few points in connection with the resection of the triangular deflection of the cartilaginous septum, and it is to this particular form of septal deflection that my remarks apply, and I do not intend this paper to cover any other form of deflection.

The resection of a portion of the triangular cartilage is by no means a new procedure, but recently there has been a tendency to advocate, I think, a too radical method. The saving of the mucous membrane and a portion of the cartilage, also the prevention of scar tissue, is the essential features in this operation. In the triangular deflection much difficulty has been experienced in freeing the mucous membrane at the point of angle and at that point there is great danger of perforation and ulceration. In such cases I have followed with excellent success the following method: By forcing the finger into the occluded nostril the triangular cartilage can be shoved over sufficiently to force it out on the open side. I then make an incision through the mucous membrane, just a little beyond the junction of the skin and mucous membrane, cutting down directly over the anterior edge of the triangular cartilage. By stretching open this incision and making pressure with the finger in the occluded nostril the cartilage can be pushed forward through the incision. It is extremely necessary in order to dissect successfully the mucous membrane from the cartilage that the incision should be carried through the perichondrium to the cartilage; once this is done the mucous membrane can be stripped from the cartilage very easily. Personally, I prefer the dural separator to any of the knives devised for the purpose. My reason for this is, that it is more flexible, blunt pointed and less likely to cause perforation. When the mucous membrane is dissected back on the occluded side to the apex of the triangle, then, instead of trying to dissect around the angle, I force the cartilaginous septum over into the median line by means of the nasal dilator. By doing this two or three times the septum is sufficiently pushed over or rendered sufficiently pliable that it can be held almost in the median line by pressure from the finger. You will notice that the cutting and dissection has all been done through the wide open nostril on the opposite side from the obstruction, there being no incision made on the obstructed side. The mucous membrane, up to this point, is already separated from the cartilage back

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to the angular part of the deflection; at this point some difficulty is usually experienced, owing to the fact that the mucous membrane having been subjected to irritation by continued chronic inflammatory changes, is adherent. This tendency to adhesion is more marked usually at the floor of the nose. Then after the septum is shoved over and the angle reduced to a straight line, begin the resection over this point at the top of the septum. There less adhesion will be found and you can get past the line of the angle and dissect from above downward, keeping the little finger in the originally obstructed nostril so as to keep the septum as nearly in the median line as possible and the finger is also kept directly over the wide blade of the separator. In this way you will avoid perforation and do away with all triangular dissection instruments. If the mucous membrane is dissected back of the apex of the angular deflection you are now ready to use the swivel-knife for the removal of the cartilage. Personally, I prefer to start at the floor of the nose, cutting the cartilage free back past the point of the greatest deflection, then, instead of carrying it up to the highest point of the cartilage, I cut diagonally toward the tip of the nose; this removes a triangular piece of cartilage, but leaves the upper portion of the cartilage for nasal support. I have had no trouble with a tendency of the remaining portion of the cartilage to deflect either way. It is not necessary to use any intranasal tube or splint for support. The only wound that has been made is the one in the open nostril almost at the junction of the skin and mucous membrane. In order to hold the mucous membrane in place, I always put in three or four sutures, allowing them to remain from two to four days.

As you can readily see, there is no injury done to the mucous membrane, and this lessens the tendency to ulceration. As I said in the beginning, this paper has only to do with this particular kind of deflection. I certainly do not agree that the entire cartilage should be resected, and as I have seen evidence of the tendency of the drooping of the nose when the entire cartilaginous support has been removed. In this method the support is still retained and the primary object of the operation, that of establishing nasal breathing, has been accomplished. Another great advantage is that very few instruments are required, as I have repeatedly successfully performed this operation by the use of a cutting blade for the first incision, Allis dry dissector, dural separator, nasal dilator and the swivel-knife, occasionally using the small alligator biting forceps for the removal of small pieces of cartilage.