

watery discharge for some six months. Examination of the nose revealed a growth in each nostril in exactly the same situation as in the previous case. It was the same size, and had the same appearance and consistency. There was this difference, however: the growth on the right side was very slightly ulcerated at its anterior end, and the mucous membrane on each side of the septum appeared to be infiltrated for about a quarter of an inch above the growth. The appearance of this portion of the mucous membrane was similar to that seen in early lupus of the nose before it has begun to ulcerate.

I removed a small portion of the growth from the right nostril, including the ulcerated area. Microscopically the growth was of the same character as in the first case, but Dr. Shaw Dunn reported that there were in addition numerous tubercle bacilli present in the tissue round the ulcerated area.

A few days later I removed the growth, taking with it the infiltrated mucous membrane. This I did by cutting out a portion of the septum and chiselling out the bone beneath the attachment of the growth. I insufflated some iodoform powder on to the surface of the exposed bone, and with this exception treated the case with my after-treatment for intra-nasal operations. The nose healed without any trouble, and a month later the area which had been operated upon was completely covered by healthy tissue. The discharge had stopped and no disease was apparent in the nostrils.

I have seen this case at intervals since, and the nose remains clean and healthy.

There are several unusual features common to both these cases. The growths were present in both nostrils. They healed rapidly without recurrence, and there was no tendency to bleeding. Most text-books tell us that nasal tuberculomata recur after operation, and that healing is always slow.

It is now five and a half years since I removed the growth in the first case, and four and a half years in the second case. The first patient is enjoying perfect health, and there is no sign of recurrence. The second case is of interest in that while the nasal condition remains healed the patient is at present in a sanatorium suffering from slight pulmonary tuberculosis.

THREE CASES OF ACCESSORY NASAL SINUS SUPPURATION.

By W. M. MOLLISON.

(1) *Loss of Memory from the Presence of a Single Nasal Polyp.*—The patient was a man, aged sixty, active mentally and physically. In April, 1916, he began to suffer from very severe frontal headache; the headache had wakened him regularly at 2 a.m. For three weeks he had been unable to attend to business on account of the pain.

For a few days he had complete loss of memory for intervals of a few hours. For example, his partner would come to discuss business; later, and after the interview, he would be astonished to hear that his partner had been, and could remember nothing about it.

A large nasopharyngeal polypus was seen and subsequently removed. Three days later the headache was much relieved, but the patient had complete loss of memory for four hours. The patient recovered completely and was able to resume business within a month.

Such a case might be of considerable medico-legal importance.

(2) *Acute Sphenoidal Sinus Suppuration Simulating Acute Mastoiditis.*—A lady, aged twenty-five, suffered from some nasal catarrh in February, 1918. A few days later she developed right-sided earache; she had a rigor, and the temperature rose to 105° F. During the following week

there was slight otorrhœa, and the temperature fell gradually to normal; she had, too, profuse epistaxis; there was slight tenderness over the right mastoid and some pain in the left ear. During the following (second) week the temperature was intermittent, rising to 103° and 104° F. daily, and at the end of this week the patient had rigors on three succeeding days. Towards the end of the second week she suffered daily from loss of memory for a few hours: she would in the evening remember nothing of her husband's visit in the afternoon.

The mastoid tenderness in conjunction with slight otorrhœa and rigors was suggestive of lateral sinus infection. The presence of mucopurulent nasal discharge suggested sinus infection, and exploration with Watson-Williams' needle and syringe revealed 2 c.c. of creamy pus in the right sphenoidal sinus. The sinus was opened freely: it was washed out daily, and the patient made a slow recovery. The ear suppuration ceased.

(3) *Severe Supra-orbital Neuralgia Dependent on Latent Frontal Sinus Suppuration.*—In 1913 a doctor, aged thirty, had an attack of cellulitis about the right shoulder; was operated upon and made a good recovery. During the attack, however, he began to suffer from pain over the left eye; the pain was continual, but varied in intensity; exposure to cold intensified it.

After some months alcohol was injected into the supra-orbital nerve but this only gave relief for two days. In 1914 a piece of the supra-orbital nerve was excised, without relief. In 1914-15 the pain was very severe, and on the advice of a neurologist injections of salvarsan were given, also inunctions of mercury, though the Wassermann reaction was negative. No relief was afforded. During 1915 and 1916 the pain continued, and, indeed, became worse; the eye was often covered, as the slightest draught brought on an acute paroxysm. In February, 1917, an attack of influenza increased the pain and life became a burden. In May the supra-orbital nerve was again explored and the central end found bulbous; excision only relieved the pain for a short time. Examination of the nose showed no sign of pus on two occasions, but X-ray examination showed the left frontal sinus slightly more opaque than the right. An intranasal operation was performed, but the fronto-nasal duct could not be entered on account of a bony projection in its anterior wall. Operation made the pain worse. In August, 1917, alcohol was injected into the Gasserian ganglion, but unfortunately the only result was that the pain spread to the second and third divisions of the fifth nerve. The patient became desperate. The question of removal of the Gasserian ganglion was discussed: before this was arranged a rhinologist of wide experience examined the patient and was convinced there was no disease of the frontal sinus. Nevertheless, on the X-ray finding the frontal sinus was explored through an external incision; it contained pus. Drainage into the nose was established.

In three months' time the pain had completely disappeared, and the patient was an active member of the R.A.M.C.
