DR. HARMON SMITH said that some years ago he had seen a case of atresia in a girl 5 years of age, the result of the removal of adenoids. Cicatricial adhesions between the soft palate and post-pharyngeal wall had formed, so that only a probe could be introduced into the naso-pharynx. In this instance he had liberated the palate from the pharyngeal wall and had held the same apart by introducing two catheters, one through each nostril, which were held to the outer angle of the wound by the junction of their two ends at the outer angle of the mouth. These were kept in place for a period of two months and at frequent intervals were moved backwards and forwards so that the scar tissue would not bind the catheters, for a period of two years, and was presented to the Section at about the end of this period. There was a perfect result and ample space in the naso-pharynx.

He had had two other cases, one of which had been materially benefited by passing an obturator behind the palate over a period of several years. This also was the result of an attempt at the removal of adenoids by an inexperienced operator.

Another was in a child of specific parentage, in which the palate had been ruptured by the employment of the Brandigee forceps. The parts of the palate adhered laterally to the median rent, and the attempts at correction were only in a measure successful.

Dr. Smith said that he mentioned these traumatic cases to show that not all cases of atresia were due to infection or syphilis.

DR. MACKENY said that he had six cases on which he did his own plastic operation for the relief of naso-pharyngeal atresia. In his opinion the plastic operation is far superior to the older methods (as shown in the exhibited case) for the reason that the operation is completed in one sitting, no irksome tubes or wires are worn for weeks by the patient, and the results are better. Leaving catheters in for two weeks could not possibly produce dermatization of the angles. Two months would be more sensible. It is a question in his mind if this theory of dermatization is not all wrong, and in his opinion it does not occur in any given time by the method described. The plastic method is not difficult. It is time to leave the old methods where they belong, as interesting stages in the development, and as historically interesting, but no more.

DR. DOUGHERTY said that he had operated upon two cases of atresia in which instead of using the catheter he had, at the suggestion of Dr. Dawbarn, employed corgile membrane as a posterior flap bringing up the stitches, as was done in Dr. MacKenty's operation. Both cases were fairly successful.

External Nasal Deformity (Broad Nose). DR. H. H. FORBES.

DR. FORBES said that he had brought this patient in place of the one he had intended to have come, as he wished some suggestions in regard to the operation. This is a trauma not more than two years old. The nasal bones had been separated at time of trauma and there was a callus. The question of internal or the external operation had come up.

DISCUSSION.

DR. MACKENY said that in his opinion the case operated upon should be done by the internal method, removing the redundant bone with chisel and rasp. No breaking operation was indicated.

DR. CARTER said that he had seen the case and had also seen a number of others very similar to this one. They usually result, as in this instance, from trauma, and in traumatic conditions of the nose the bones nearly always have a tendency to separate. In three or four instances he had removed a wedge-shaped piece (the base of the wedge being upward) from the upper portion of the septum. An intra-nasal chisel is the proper instrument to use. After the tissue had been removed, the nasal bones may be mobilized by means of the Adams forceps, and brought together and held in position by means of a copper plate lined with absorbent cotton. The work is all done intra-nasally.

DR. HAYS said that he had operated on two similar cases of deformity, and in both instances did the external operation, making a small incision with a bone knife down the center of nose and separating the periosteum. After having done this a small chisel was inserted at the outer edge of the nasal bone, which was fractured, as high as possible, and then through the small opening where the two nasal bones come together he drove a chisel into the septum, making a wedge. He thought the external operation was the only one that would succeed in this case. In the two cases which he had operated upon the nasal bones came together very easily.

Demonstration of the Technique of Suspension Laryngoscopy. DR. ROBERT C. LYNCH.

To be published in a subsequent issue of THE LARYNGOSCOPE.

DISCUSSION.

DR. LYNCH said that he had arrived late, and had expected to be a good listener rather than a speaker. The technique which Dr. Lynch had demonstrated was of the greatest value, as well as the additions to his armamentarium, for all of us meet with difficult cases in which the application of the technique laid down by Dr. Lynch would be of the greatest assistance. He said that he was familiar with the apparatus of Killian, as well as the bivalve spatula. He told of two instances in which the larynx was so deep that the spatulas of the Killian model were not long enough to enable him to see the cords, even with the epiglottis-holder. The long spatula devised by Dr. Lynch would enable one to see much further. The high table was also very essential to those who were doing suspension work, for the usual standard table which we are accustomed to use in the hospital for other operations is not of sufficient height to enable the operator to sit in a comfortable position and perform satisfactory operations.

DR. GUTTMAN said that so far as he knew, Killian never claimed to be able to see the anterior commissure with his instrument. If Dr. Lynch could bring this about with his instrument it was a great achievement.

DR. YANKAUER said that he had come to receive instruction and felt that he had learned a great deal. The work is so new that we have not yet reached the end of the improvements. Those shown by Dr. Lynch to-night are along lines that will be appreciated by all who have met with some of the disadvantages of the instruments now in use. The necessity for a longer horizontal motion than that possessed by the original Killian apparatus, had been felt by him, but he had generally managed to overcome that by taking care that the patient did not slip up on the table.