

TRANSACTIONS OF THE SOCIETY OF GERMAN LARYNGOLOGISTS.

Seventeenth Meeting at Dresden on May 11 and 12, 1910.

President.—Prof. Dr. JURASZ, Lemberg.

Abstract permitted by Dr. F. BLUMENFELD, Wiesbaden, Secretary.

May 11.

DEMONSTRATION BY MESSRS. MANN AND HOFFMANN IN JOHANNSTADTER AND FRIEDRICHSSTÄDTER HOSPITALS IN DRESDEN.

A number of interesting preparations were demonstrated.

May 12.—Business Meeting.

Frankfort was chosen as the place for the next meeting. Profs. Killian and Seifert were selected as President and Vice-President. The B. Fränkel prize was given to Prof. Killian at the request of Prof. B. Fränkel.

Scientific Meeting.

ON THE PRINCIPLES OF INTRA-NASAL SURGERY.

BY HERR L. POLYAK (Budapest).

Polyak is of the opinion that the rhinologist should attempt to complete any operative procedure on the nose or the accessory sinuses in one sitting. The tendency to divide it up into a number of sittings dates from the time when there were no efficient hæmostatics. The ambulant treatment is, however, not possible, and the patient ought to lie up; plugging is then usually unnecessary. For twelve years Polyak has made it a rule to finish the work on one side of the nose at one sitting, and for two years he has completed both sides of the nose at one sitting. During the period from May 1, 1908, to March 31, 1910, he has performed 220 nasal operations, of which 87 were unilateral and 133 bilateral. Of the 87 unilateral cases (which included 11 submucous resections of the septum) 57 were simple cases; in the remaining 30 cases combined operations were performed. The simpler operations, such as removal of hypertrophies of the inferior turbinated bodies, nasal polypi, etc., were most satisfactorily treated in this way. Cases of lupus or tuberculosis of the mucosa were more difficult, owing to the bleeding. Polyak has only made one exception to this prin-

ciple, in that he performs no other operation in the nose at the same time that he resects the septum, in case a subsequent hæmorrhage should occur requiring packing, which might endanger the weakened septum. Katz, however, considers that turbinal hypertrophies may be treated at the same time.

Polyak has completed the operation in 90 per cent. of his bilateral cases at one sitting. Hæmorrhage and tendency to syncope occasionally necessitated a postponement of part of the operation. Usually slight bleeding occurred after the action of the adrenalin had ceased, but not sufficient to require plugging.

In 20 per cent. of the cases more considerable bleeding occurred, which ceased on spraying with a 1:10,000 solution of adrenalin; only 5 per cent. of the cases required plugging of one or other of the nasal chambers.

In three cases the posterior nares had to be plugged. A case of bilateral hæmorrhage did not occur.

The preparation of the patient and asepsis were discussed.

Anæsthesia was produced by a 10 to 20 per cent. solution of cocaine. In more serious operations morphia was injected half an hour previous to the operation. After the operation rest in bed and frequent inspection of the pharynx, especially during the time that hæmorrhage was to be expected. Nose not to be blown for twenty-four to forty-eight hours.

Herr von EICKEN (Basel) agrees as to the necessity of laying the patient up. The best plug is the india-rubber sponge, or what is simpler, a rubber finger-stall is introduced into the nose; it is then inflated and the mouth tied up.

Herr KRETSCHMANN (Magdeburg) remarks that this principle has already been practised by Aufrecht.

Herr WINCKLER (Bremen) agrees with the principles expressed by the author of the paper. Recommends the taking of a skiagram in cases of multiple empyemata.

Herr ROSENBERG (Berlin) makes some historical references as to the use of a rubber finger-stall as a nasal plug.

Herr DENKER (Erlangen): Herr Polyak recommends the introduction of a tampon of wool at the end of the operation. D. does not use this, as he thinks the passage of air through the nose tends to assist the coagulation of the blood.

Herr KREBS (Hildesheim): In certain cases, especially hypertrophic rhinitis, a single operation is not possible. Hæmorrhages are to be avoided by recommending the patient to inspire deeply through the nose and breathe out through the mouth.

Herr KILLIAN (Freiburg) has always admitted patients to hospital, for from one to three days who are to undergo an intra-nasal operation. Operations on the inferior turbinals are almost always performed on both sides at one sitting, and after two or three applications of a solution of peroxide of hydrogen a pledget of wool is introduced into the nostril.

In other cases, also, Killian usually operates on both sides at once, but each case must be judged on its merits.

Herr RUPRECHT (Bremen): Operations in one sitting are disadvantageous from the point of view of the principle of retaining structures which may return to the normal. In operations on the tonsils without narcosis, enlargements of the turbinals can be dealt with at the same time.

Herr POLYAK (Budapest), in conclusion, remarked that the discussion showed that the general opinion on the whole agreed with his contentions. Hæmorrhage was not more frequent in cases in which both sides were treated at once if the patients were admitted to hospital.

ON THE RADICAL OPERATION FOR CHRONIC EMPYEMA OF THE
MAXILLARY ANTRUM UNDER LOCAL ANÆSTHESIA.

BY HERR PROF. DENKER (Erlangen).

Denker performs the radical operation after his method in the following way: Half an hour before an injection of morphia is given (0.01–0.02), cocaine solution, 10 to 20 per cent., is painted on the gums; subperiosteal injection of novocain, 1 per cent. solution, containing eighty drops suprarenin solution 1:1000. The injection is made first in an upward direction towards the supra-orbital margin, then forwards and upwards towards the piriform aperture, and finally towards the point of exit of the infra-orbital nerve. Now a pledget of wool dipped in a 10 per cent. solution of cocaine containing suprarenin is laid against the outer wall of the inferior meatus of the nose.

Ten minutes after the beginning of the infiltration the incision is made; a portion of the facial wall of the antrum the size of a sixpenny bit is removed with a chisel; the mucous membrane of the antrum, which is now exposed, is covered with a tampon of gauze dipped in a 10 per cent solution of cocaine containing suprarenin. Then from the piriform aperture a subperiosteal injection of novocain and suprarenin is made along the lateral wall of the inferior meatus of the nose (2 to 3 cm.).

The exposed portion of the mucous membrane of the antrum is then excised and a gauze pledget soaked with the 10 per cent. cocaine solution is laid in the antrum. In sensitive individuals novocain may be injected at the posterior part of the antrum. As a rule, 10 to 12 c.cm. novocain solution are injected in a unilateral operation; if it is bilateral, 20 c.cm. may be injected without risk. Denker has operated upon forty-one cases after his method, some of them being very difficult and old-standing cases, and always with a permanently successful result.

Denker's operation is better than Sturmann's endonasal operation in that better access is obtained during the operation, healing is more rapid, and the after-treatment is shorter.

Herr WASSERMANN (Munich) uses a solution of novocain and alypin as a regional anæsthetic introduced from the surface. He introduces the needle directly into the nerve within the infra-orbital foramen, he also recommends scopolamine morphine narcosis. He has modified Langenbeck's retractor by adding three sharp prongs. The soft parts are thereby better retracted.

Herr STURMANN (Berlin), in support of his own method, states that satisfactory access can be obtained from the nose; that the patients need not be admitted to hospital. He has experienced such severe hæmorrhage in operating from the canine fossa that he was unable to finish the operation.

Herr DENKER (Erlangen), in conclusion, disapproves of scopolamine narcosis. He thinks Wassermann's regional anæsthesia worthy of a trial, but it is not essential. The toxic effect which Herr Sturmann fears does not occur. Surgeons use much larger doses of novocain even in children. He does not admit the superiority of Sturmann's operation, and has not experienced uncontrollable hæmorrhage when operating by his method.

THE LINE OF INCISION IN SUBMUCOUS RESECTION OF THE NASAL SEPTUM.

BY HERR WINCKLER (Bremen).

In those cases in which the bridge of cartilage, which is left in front after resection, causes obstruction to breathing, the incision advocated by Hajek and Menzel over the free margin of the cartilage appears to be best. A nasal speculum is not required for this. As soon as the cartilage has been exposed at one point, the remainder of the flap is easily raised by a small elevator.

If the anterior border of the cartilage is not so deviated and may be permitted to remain, Winckler then makes his incision further back and retains a bridge of cartilage. There is difficulty in separating the mucous membrane from broad crests lying close to the floor of the nose. In these cases the incision must be prolonged backwards. The mucous membrane is always retained. In cases where there is a low-lying crest a bow-shaped incision is made at once along the nasal floor, extending up along the anterior edge of the cartilage. The separation of the perichondrium and mucous membrane is certainly more difficult; it is easier if it is begun from the floor of the nose, working inwards and upwards. Winckler pushes a strip of gauze soaked in a solution of peroxide of hydrogen below the separated flap.

The advantages of Menzel's incision are: (1) Anterior deviations of the cartilage are easier to remedy; (2) no assistance is required; (3) the apposition of the edges of the wound and the insertion of stitches is rendered easier.

Herr EDM. MEYER (Berlin): The suggested incision was recommended by Mienzel independently of Hajek.

Herr KILLIAN (Freiburg) asked if Winckler removed the anterior portion of the septum in every case.

Herr WINCKLER (Bremen): The incision he described is intended for cases with crests lying well forwards and towards the floor of the nose.

Herr KILLIAN (Freiburg) lays stress on the advantage of leaving a strip of cartilage in front.

TREATMENT OF SYNECHIÆ OF THE NOSE.

BY HERR VON EICKEN (Basel).

There are two new methods of treating synechiæ of the nose:

(1) Submucous resection of the septum, with division of the synechiæ and plugging for a few days. The raw surface is rapidly covered with epithelium.

Siebenmann has used the second method in marked cases with the greatest success, even where the vestibule has been involved.

After a submucous resection of the septum and division of the synechiæ Thiersch flaps are laid on the raw surface. The flaps are removed from the upper arm or thigh, and are spread on gauze folded into eight to sixteen layers, and rung out of boric lotion, thus making a fairly firm plug; the external surface of the flap lies against the gauze. In four to six days the plug is removed from the nose after it has been softened by a solution of peroxide of hydrogen. The flap has meanwhile become attached. In a case of adhesion of the soft palate to the posterior pharyngeal wall this method was also successful.

Herr DENKER (Erlangen) asked what became of the flap in the nose, and if it caused crusting, etc.

Herr von EICKEN (in conclusion): No metaplasia of the transplanted skin takes place, but in some way a kind of mucous secretion is given off.

ON AN OPERATION FOR A FIBROMA SITUATED IN THE SPHENOPALATINE FOSSA.

BY HERR HANSBERG (Dortmund).

A labourer, aged sixteen, had suffered from blocking of the right side of the nose for one year, and swelling of the right malar

region ; more recently from frequent hæmorrhage from the right side of the nose. The posterior part of the right nasal cavity is filled with a red tumour, which bleeds readily when touched. The naso-pharynx is nearly filled with a rounded smooth-surfaced tumour, attached by a broad base to the side of the posterior nasal cavity. Diagnosis : Tumour springing from the sphenopalatine fossa, and sending a prolongation towards the malar region. The latter could readily be felt from the outside.

The greater part of the tumour, to the size of a small hen's egg, was removed through the anterior nasal opening with forceps. Bleeding slight. Microscopic examination showed cellular fibroma.

The idea was abandoned to remove the tumour from the sphenopalatine fossa by the natural passages, on account of the sensitiveness of the patient. Denker's operation was therefore performed. The posterior part of the mesial wall of the antrum was found to be already destroyed in great part by the tumour. After removal of the posterior and outer wall of the antrum, the tumour was easily seized by forceps and completely removed. Its insertion was found in the sphenopalatine fossa. Patient was discharged healthy ; no return after half a year.

The great value of Denker's operation was pointed out, especially in cases of tumour situated in similarly unfavourable situations ; also its superiority to other preliminary operations.

Herr HOPMANN (Cologne) sees in Herr Hansberg's remarks a confirmation of the method of completely removing naso-pharyngeal fibromata, recommended years ago by Herr Hopmann, sen. Too large prolongations of the growth should not be seized by forceps in this way.

Herr KAHLER (Vienna) : In Chiari's clinic the external operation for naso-pharyngeal fibroma is also performed. On account of the risk of bleeding, Kahler recommends Koschier's elastic ligature. Denker's operation is performed in combination with Langenbeck's incision, and with the removal, if necessary, of the whole outer wall of the nose. Prolongations to the cheek may be left alone.

Herr ZARNIKO (Hamburg) remarks that good results may be obtained by less severe operations. He recommends electrolysis, especially of vascular tumours.

Herr KÜMMEL (Heidelberg) : Cases occur which should be treated after the manner advocated by Herr Hansberg. In very vascular naso-pharyngeal tumour, when the period of immunity will not be reached for many years, that is, in patients aged from thirteen to fourteen years, a radical operation should be performed at once. Kümmel recently observed a case where there was a return accompanied by such severe bleeding that the patient died of collapse in spite of a successful operation.

Herr KILLIAN prefers the intra-nasal route where the tumour is not widespread. In the remaining cases Killian recommends Denker's method, but first seeks the vessels which enter the tumour from without.

Herr IMHOFER (Prague) inquires as to the histological nature of the tumour.

Herr RUDOLF PAUSE (Dresden) points out from the experience of one case of the possibility of curing these tumours by a permanent ligature.

Herr DENKER shares Herr Kümmel's opinion that the tumour should be removed as far as possible at its base and not in pieces. The galvano-caustic snare does not ensure bloodlessness. In one case Denker succeeded in removing the tumour at its base with a specially constructed pair of forceps after loosening it with the finger. Where there is a well-marked temporal prolongation recourse must be had to external operation.

Herr RUPRECHT (Bremen) recommends the electrolytic method with a corkscrew-shaped needle designed by himself.

Herr KUTTNER (Berlin): The electrolytic method introduced by himself and Grünbeck has proved itself of value. None of the so-called non-mutilating operations ensure against severe bleeding. In surgical treatment that method is best in which the bleeding vessels can be directly seized. The temporary resection of the jaw appears to be the most satisfactory method.

Herr HABERMANN (Graz) reports a case in which a wrong diagnosis was made owing to adenoid vegetation being superimposed on the tumour.

Herr JURASZ recommends the galvano-caustic snare. Bleeding is not to be feared even with an angio-fibroma. The snare must be used at a red heat, not at a white heat. Electrolysis is also to be recommended. It cannot be used with large tumours; it is very valuable after removal of the tumour to destroy the stump.

Herr HANSBERG (Dortmund), in conclusion: Microscopic examination showed the tumour to be a cellular fibroma. Herr Hansberg is a believer in radical operation except in the case of tumours with pedicles. With broad-based tumours even when there were adhesions, removal was carried out in one or two sittings.

ON EXOSTOSES AND MUOCOCELE OF THE FRONTAL SINUS.

By HERR MANASSE (Strassburg i E.).

A boy, aged sixteen, complains of protrusion of and swelling over the right eye of seven months' duration. Examination showed the region of the right supra-orbital margin to be markedly bulged by a tense elastic tumour, exophthalmos, globe of eye displaced downwards and outwards. Fundus: The veins on both sides are dilated and tortuous, on the right side more than the left; right disc, fairly defined margin, but redder than left. Physiological excavation marked on both sides. Movements of the eyeball restricted in an upward direction on the right side. Pupils normal, right side $\frac{1}{20}$, left side $\frac{6}{6}$. Puncture showed the tumour to contain colourless fluid, with living ciliated epithelium. Operation under general anæsthetic. Exposure of the grey-blue tumour. The outer wall of the frontal sinus is seen to be as thin as paper and partially destroyed. On further exposure, watery fluid and

gelatinous masses were evacuated. In the sinus hard rounded ivory masses project, directed towards the middle line and the ethmoidal region. The supra-orbital margin, which is remarkably thinned out, is removed. The exostoses, which are attached to the cerebral wall of the sinus, are removed. This is a case of exostoses combined with mucocele; probably the exostoses were the primary condition. They closed the naso-frontal duct, and thus led to a formation of a mucocele.

Demonstration of another exostosis of the frontal sinus given to the author by Wolf, of Metz.

Demonstration of a third exostosis which had been attached to the infra-orbital margin of a man aged eighteen, and which had displaced the eye upwards. During its removal the antrum was opened, and was found to be healthy.

Herr von EICKEN (Basle) is of the same opinion as the author as to the relation of the mucocele to the exostosis.

Herr STURMANN (Berlin) makes further remarks on the ætiology of mucocele.

Herr KRETSCHMANN (Magdeburg) demonstrates an ivory exostosis springing from the ethmoidal region.

Herr MANASSE (Strassburg), in conclusion: Exostoses are frequently found in young individuals; this suggests congenital disposition.

SUBMUCOUS TURBINOTOMY.

BY HERR ZARNIKO (Hamburg).

In the numerous cases where the enlargement of a turbinated body is due to the size or unusual shape of the bone, the author recommends submucous resection of the turbinal bone instead of the undesirable removal of the whole structure (turbinectomy).

Description of the operation, which is carried out in the following stages: Vertical cut with the scissors at the anterior end, dividing the mucous membrane down to the bone. Elevation of the mucosa from the convex side by a suitable elevator, beginning at the incision. Division of the mucous membrane by a probe-pointed knife from within outwards. Elevation of the mucous membrane from the concave side. Breaking off and removal of the turbinal bone as far as is necessary. Smoothing the edge of the bone and reposition of the flaps of mucous membrane. Packing only in the case of severe hæmorrhage (rarely necessary).

The operation offers a few small technical difficulties, which can, however, always be overcome.

The author has performed the operation over thirty times during the last two years, making a careful selection of his cases, and is well satisfied with the results. He considers it as a necessary adjunct to many cases of submucous resection of the septum.

Herr WINCKLER (Bremen) found Zarniko's method very useful in one case, but could not do without packing.

Herr SEIFERT (Würzburg) recommends a wedge-shaped excision of the turbinal tissues with Moure's knife, which is recommended for the removal of septal crests. If in such well-marked hyperplasia the turbinal structures are pressed within the window of the knife and cut out from behind forwards, including the corresponding portions of bone, the upper raw surface can then be pressed against the lower by suitable packing, and a diminution in size is obtained without disturbing the function of the turbinated body.

Herr RITTER (Berlin) asked if there was no danger of damaging the nasal end of the tear-duct in Zarniko's method.

Herr KILLIAN (Freiburg) recommends in certain cases the fracture of the inferior turbinated body by means of the speculum designed by himself.

Herr DENKER (Erlangen) has also tried turbinotomy where otherwise resection would have been carried out. He will report on his experiences further.

Herr ZARNIKO (Hamburg), in conclusion, has never seen damage done to the tear-duct. Here Denker's suggestion should be given further trial.

(To be continued.)

PROCEEDINGS OF THE PARISIAN SOCIETY OF LARYNGOLOGY, OTOTOLOGY, AND RHINOLOGY.

January 10, 1910.

COMPLICATIONS OF ADENECTOMY.

BY M. PARREL.

The speaker mentioned as immediate mishaps, burns, breaking of instruments, and as remote complications, synechiæ, adenitis, latero- and retro-pharyngeal inflammations, pulmonary abscesses and lastly, generalised septicæmia. To avoid them he advised operating in Rose's position under chloride of ethyl, to abstain from hurrying, to pay attention to asepsis, and to carry out a *technique* strictly surgical.